Organisation panaméricaine de la Santé

Organisation mondiale de la Santé
Bureau régional des Amériques

53e CONSEIL DIRECTEUR

66e SESSION DU COMITÉ RÉGIONAL DE L'OMS POUR LES AMÉRIQUES

Washington, D.C., ÉUA, du 29 septembre au 3 octobre 2014

Point 4.1 de l'ordre du jour provisoire

OD348
18 août 2014
Original : anglais

RAPPORT FINAL SUR LE PLAN STRATÉGIQUE DE L'OPS 2008-2013 ET ÉVALUATION EN FIN DE PÉRIODE BIENNALE DU PROGRAMME ET BUDGET 2012-2013

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I. RÉSUMÉ ANALYTIQUE

1. Le but de ce rapport est de présenter aux Organes directeurs de l'Organisation panaméricaine de la santé (OPS) les résultats de l'évaluation finale de la mise en œuvre du Plan stratégique de l'OPS 2008-2013. Bien que le rapport mette l'accent sur la période de six ans couverte par le Plan, il inclut également les résultats de l'évaluation en fin de période biennale du Programme et budget 2012-2013.

2. Le rapport est conforme à l'engagement de l'Organisation en matière de responsabilisation et de transparence ainsi qu'au cadre de gestion fondée sur les résultats (GFR) de cette dernière. Il se fonde sur les deux rapports d'étape intermédiaires présentés antérieurement aux Organes directeurs de l'OPS et incorpore les recommandations des États Membres.

3. Le rapport repose sur l'information fournie par le processus de contrôle et d'évaluation de la performance réalisé dans l'ensemble du Bureau sanitaire panaméricain (BSP). Il est composé d'analyses d'exécution programmatique et budgétaire par objectif stratégique (OS) et par chaque niveau de l'Organisation. Des informations sont fournies sur les efforts de mobilisation des ressources du BSP pour couvrir le déficit de financement pour les trois Programmes et budgets approuvés pour la mise en œuvre du Plan (2008-2009, 2010-2011 et 2012-2013). Le rapport fournit également une analyse de l'affectation des ressources par priorités programmatiques.

4. L'évaluation montre que l'Organisation a maintenu un taux constant de mise en œuvre dans l'ensemble des trois exercices biennaux couverts par le Plan. En l'an 2013, sept des 16 objectifs stratégiques (OS) avaient été pleinement atteints (avec 100 % des cibles atteintes ou dépassées) et neuf partiellement atteints. Des neuf qui avaient été partiellement atteints, huit dépassaient 75 % de leurs cibles d'indicateurs et un seul (OS1– maladies transmissibles) atteignait moins de 75 % de ses cibles. Sur 90 résultats escomptés à l'échelle régionale (RER), 75 (83 %) avaient été pleinement réalisés et 15 seulement partiellement. Sur 256 cibles d'indicateurs de RER en 2013, 233 (91 %) au total avaient été atteintes. Elles n'avaient pas seulement été atteintes : dans 127 cas (54 %) elles avaient même été dépassées.

5. Au cours des six dernières années, la Région a accompli des progrès notables en vue de l'atteinte des cibles de niveau d'impact en matière de santé publique, telles que spécifiées dans le Plan stratégique. Par exemple :

a) Tous les pays de la Région sauf un ont réduit la mortalité infantile à moins de 32,1 décès pour 1000 naissances vivantes. Les décès d'enfants dus à des maladies évitables par la vaccination seulement ont enregistré une réduction estimée de 53 % au cours de la période 2002-2012.

b) La Région a réalisé des progrès significatifs en vue de l'atteinte des objectifs d'élimination des maladies infectieuses négligées (appelées NID pour « neglected infectious diseases »). 18 pays au total ont réussi à éliminer la lèpre au niveau national et infranational. Dix-sept pays ont éliminé la rage humaine transmise par les chiens. 17 autres pays ont pu mettre fin à la transmission par vecteur de la maladie de Chagas en réduisant l'infestation des foyers dans la zone définie à moins de 1 %.

c) Il convient de noter que la Colombie a été le premier pays au monde à éliminer l'onchocercose, tel que vérifié par l'OMS.

d) Il y a eu une réduction de 49 % dans l'incidence du paludisme dans la Région au cours de la période 2006-2012. Le taux de mortalité pour la dengue a baissé de 0,07 % en 2010 à 0,05 % en 2013.

e) L'incidence des infections au VIH est passée à 15 % en 2012 : une baisse par rapport au taux de 16,9 % en 2006. Dix-neuf pays de la Région ont pu réduire la transmission mère-enfant du VIH à moins de 5 %. D'autre part, 75 % des patients atteints du VIH/sida avaient accès au traitement antirétroviral (TAR) en 2012. De plus, 13 pays avaient atteint leur objectif d'élimination de la syphilis congénitale de moins de 0,05 cas pour 1000 naissances vivantes en 2012.

f) L'incidence de la tuberculose (TB) a continué de baisser, passant à 29 cas pour 100 000 en 2012, comparé à 39 cas en 2005, avec une baisse similaire de la mortalité due à la tuberculose.

g) L'analyse des tendances en matière de mortalité précoce (dans la population âgée de 30 à 69 ans) pour les quatre groupes principaux de maladies non transmissibles (appelées NCD pour « non communicable diseases ») a montré que des taux ajustés en fonction de l'âge pour 100 000 ont baissé de 379,9 en 2000 à 318,7 en 2010, pour atteindre une diminution générale de 16,1. À la fin de 2013, huit pays avaient atteint une réduction de 10 % dans la prévalence de l'usage du tabac, comparé à seulement trois pays en 2007.

h) La mortalité quotidienne dans les populations touchées par des urgences majeures était en-dessous de 1 pour 10 000 au cours de la phase initiale d'intervention d'urgence dans toutes les situations d'urgence évaluées au cours de la période 2008-2013.

i) La Région a atteint l'objectif 7 du Millénaire pour le développement (OMD) qui vise une amélioration de l'accès à l'approvisionnement en eau potable, en obtenant une couverture générale de 97 %.

6. Au nombre des autres réalisations importantes, mentionnons :

a) Le pourcentage de la population couverte par tout type de régime de protection sociale dans la Région est passé de 46 % en 2003 à 60 % en 2013. Les dépenses du secteur public consacrées à la santé en tant que pourcentage du PDB sont

passées de 3,1 % en 2006 à 4,1 % en 2010 mais ont marqué une légère baisse à 3,8 % en 2011.

b) Dix-neuf pays de la Région ont incorporé le principe du droit au meilleur état de santé possible dans leur constitution ou dans leur législation nationale sur la santé. Plus de 30 pays ont signé des traités internationaux qui préconisent ces mêmes principes. De plus, 15 pays et territoires ont une législation qui vise à accroître l'accès à la santé et aux soins de santé. Trois pays ont amélioré leur législation sur la santé pour incorporer le droit à la santé et reconnaître l'objectif de la couverture sanitaire universelle.

c) Trente-et-un pays et territoires ont renforcé leurs systèmes de santé basés sur les soins de santé primaires. Douze pays ont mis en œuvre des régimes d'assurance et des régimes de soins de santé à l'échelle nationale pour accroître la couverture sanitaire par des garanties de soins de santé explicites, alors que huit pays ont adopté des politiques et/ou des mécanismes financiers destinés à réduire ou éliminer le risque financier associé à la maladie et aux accidents.

d) Le nombre de pays qui ont obtenu la densité recommandée de personnel sanitaire, soit 25 pour 10 000 habitants ou plus, a plus que doublé depuis 2006 passant de 12 à 25 à la fin de 2013.

e) Six États parties remplissaient les critères du Règlement sanitaire international (RSI) en matière de capacité fondamentale de surveillance et de réponse.

7. En dépit de réalisations et progrès significatifs, plusieurs défis demeurent. Par exemple, la réduction du taux de mortalité maternelle est encore lente. Il se manifeste encore un besoin d'étendre et de coordonner l'action multisectorielle dans la lutte contre les maladies non transmissibles et leurs facteurs de risque, et de traiter les déterminants sociaux de la santé. Pour dépister, répondre et gérer de façon adéquate les urgences en santé publique soulevant des préoccupations à l'échelle internationale, les pays doivent renforcer leurs capacités de base nationales et faire en sorte qu'elles répondent aux exigences du RSI. De plus, les systèmes et services de santé doivent être mieux organisés et gérés afin d'obtenir une réalisation progressive de la couverture sanitaire universelle et de traiter les inégalités en santé, en particulier celles qui affectent les groupes de population vulnérables. Les difficultés liées aux systèmes d'information et à la fiabilité des données entravent également la capacité des pays et de la Région en général d'évaluer pleinement la situation sanitaire et de prendre des décisions éclairées pour remédier à des problèmes de santé clés et à leurs déterminants.

8. En ce qui concerne le financement du travail de l'Organisation panaméricaine de la Santé, le segment approuvé du programme de base du PB 2012-2013 était de US$ 613 millions,[1] qui était financé à 86 % ($525 millions) pour la période biennale. Parmi les fonds disponibles, le taux de mise en œuvre était de 95 % ($500,7 millions).

[1] Sauf stipulation contraire, toutes les valeurs monétaires dans le présent rapport sont exprimées en dollars des États-Unis.

9. En 2012-2013, l'Organisation a également reçu un financement de $10,6 millions pour la réponse aux flambées épidémiologiques et aux crises (OCR) et $565 millions provenant des contributions nationales volontaires. Le taux de mise en œuvre pour ces fonds était de 97 % ($10,2 sur $10,6 millions) pour OCR et 68% ($387 sur $565 millions) pour les contributions nationales volontaires.

10. Le montant cumulatif du financement pour les programmes de base disponibles pour la période du Plan stratégique 2008-2013 était de $1,66 milliard, dont 93 % ($1,54 milliard) ont été mis en œuvre.

11. Au cours de la période du Plan stratégique, $82,7 millions ont été disponibles pour OCR, et $1,1 milliard ont été reçus en contributions volontaires nationale. Le taux général de mise en œuvre pour ces fonds a été de 97 % ($80 millions) pour OCR et de 63 % ($715 millions) pour les contributions volontaires nationales. Le taux de mise en œuvre relativement bas pour les contributions volontaires nationales était dû à un afflux de fonds à la fin de l'exercice biennal 2012-2013, les soldes non dépensés étant alors reportés au nouvel exercice biennal 2014-2015.

12. Davantage de ressources sont devenues disponibles pour les Objectifs stratégiques prioritaires au cours de la mise en œuvre du Plan stratégique 2008-2013. En particulier, au sein des cinq priorités principales, le SO4 (santé maternelle et infantile) a augmenté de 75 %, alors que le financement pour les SO3 (maladies non transmissibles)[2] et SO1 (maladies transmissibles) a enregistré une croissance de 22 % et 5 % respectivement.

13. Au cours de la période 2008-2013, le BSP a introduit des initiatives visant à améliorer l'efficience et l'efficacité des programmes de coopération technique de l'OPS, y compris l'élaboration et la mise en œuvre de la gestion basée sur les résultats (RBM) et l'adoption des Normes comptables internationales du secteur public (IPSAS). Il convient de noter que le Plan stratégique 2008-2013 était le premier des Plans stratégiques à être formulé, mis en œuvre et évalué conformément au cadre de RBM de l'Organisation.

14. Même si des progrès significatifs ont été réalisés dans la mise en œuvre de la gestion basée sur les résultats au cours de cette période, des questions clés auxquelles il est nécessaire de porter attention pour pleinement consolider le processus de RBM à tous les niveaux de l'Organisation incluent : renforcer les mécanismes de responsabilisation et l'évaluation indépendante, et améliorer la documentation systématique et l'application des leçons apprises. De plus, des mécanismes doivent être établis pour renforcer l'évaluation et le suivi par le BSP et les États Membres, et ce de façon conjointe, des progrès réalisés en vue de la réalisation des objectifs au niveau de l'impact et des résultats. Il est

[2] Les termes *maladies non transmissibles*, *maladies chroniques non transmissibles* et *maladies chroniques* sont utilisés comme synonymes dans l'ensemble de ce document et, de façon générale, partout au sein de l'Organisation.

également nécessaire de promouvoir et de mettre en œuvre des approches inter-programmatiques, en particulier pour relever les nouveaux défis et explorer de nouvelles modalités pour étendre la portée de la coopération technique de l'OPS.

II. INTRODUCTION

15. Le Bureau sanitaire panaméricain (BSP) a le plaisir de présenter le troisième et dernier rapport sur la mise en œuvre du Plan stratégique 2008-2013 (dénommé ci-après le Plan) de l'Organisation panaméricaine de la Santé (OPS).

16. Tel qu'établi dans le Plan stratégique pour 2008-2013, le BSP doit présenter tous les deux ans des rapports d'étape sur la mise en œuvre du Plan aux Organes directeurs de l'Organisation. Ce rapport couvre la totalité de la période sexennale du Plan ainsi que le dernier Programme et budget 2012-2013, approuvé pour la mise en œuvre du Plan.

17. Le rapport repose sur l'information fournie par le processus de contrôle et d'évaluation de la performance réalisé dans l'ensemble du Bureau sanitaire panaméricain (BSP) à intervalles réguliers au cours de la mise en œuvre du Plan stratégique. Il est composé d'une analyse de la performance de l'Organisation, y compris l'exécution programmatique et budgétaire. Le rapport inclut également une information sur la mobilisation des ressources par le BSP pour couvrir les lacunes de financement dans les Programmes et budgets 2008-2009, 2010-2011 et 2012-2013, ainsi que l'affectation des ressources par niveau organisationnel et par objectif stratégique.

18. Le rapport incorpore des recommandations fournies par les États Membres au sujet des deux rapports d'étape antérieurs présentés au 50e Conseil directeur de l'OPS en 2010 et à la 28e Conférence sanitaire panaméricaine en 2012. Des conseils fournis par la huitième session du Sous-comité du programme, du budget et de l'administration (SPBA) en mars 2014 ont également été incorporé dans le rapport. Le rapport final, qui sera présenté au 53e Conseil directeur en septembre 2014 inclura toute autre recommandation de la 154e Session du Comité exécutif de l'OPS en juin 2014.

19. Les sections I, II et III de ce rapport contiennent le résumé analytique, l'introduction et la vue d'ensemble du processus de suivi et d'évaluation de la performance. La section IV fournit un résumé des principales réalisations et défis en matière de santé publique dans la Région au cours de la mise en œuvre du Plan stratégique 2008-2013. La section V est une analyse générale de la performance programmatique et la section VI inclut la performance budgétaire et l'analyse de la mobilisation des ressources. La section VII résume les conclusions et recommandations, et la section VIII contient six annexes : l'annexe A décrit chacun des 16 Objectifs stratégiques (OS) avec leurs résultats escomptés à l'échelle régionale (RER) et les indicateurs de RER; l'annexe B, les indicateurs de RER qui n'ont pas été réalisés et les principales raisons de cette non réalisation; l'annexe C, un résumé du Programme et budget 2012-2013; l'annexe D, une liste des pays et territoires; l'annexe E, une liste d'abréviations.

III. APERÇU DU PROCESSUS DE SUIVI ET D'ÉVALUATION DE LA PERFORMANCE (PMA) À L'OPS

20. En accord avec le processus de suivi et d'évaluation de la performance (PMA), l'évaluation finale du Plan stratégique 2008-2013 a été réalisée à la fin de la mise en œuvre du Programme et Budget (PB) 2012-2013, qui a été le dernier PB approuvé pour terminer la mise en œuvre du Plan. Les résultats de l'évaluation du PB 2012-2013 ont été incorporés dans l'évaluation finale du Plan, qui est cumulative et couvre la période de planification de six ans 2008-2013 ainsi que les trois PB approuvés pour la même période (2008-2009, 2010-2011 et 2012-2013).

21. Le processus de suivi et d'évaluation de la performance implique tous les responsables des entités du BSP (y compris les représentants de l'OPS/OMS dans les pays) et leurs équipes, ainsi que la haute direction (EXM).

22. Au cours de cet exercice, le BSP a examiné ce qui suit : *i)* la performance de chacune des 70 entités du BSP, *ii)* les progrès réalisés en vue de l'atteinte des 16 objectifs stratégiques (OS), avec les résultats escomptés correspondants à l'échelle régionale (RER) et les indicateurs de RER du Plan stratégique de l'OPS 2008-2013. Cet exercice a fourni le principal intrant pour la préparation du rapport aux organes directeurs de l'OPS.

23. L'évaluation inclut des méthodes tant quantitatives que qualitatives, qui sont décrites ci-après.

24. Premièrement, l'atteinte des cibles d'indicateurs du RER fixées pour la fin 2013 a été évaluée sur la base de l'information fournie par les responsables des entités. Cette partie de la méthodologie est quantitative—soit la cible a été atteinte, soit elle ne l'a pas été—et les responsables des entités sont chargés d'effectuer l'évaluation et de faire rapport sur l'obtention des résultats sous leur responsabilité ; ils assument également la responsabilité de l'information qu'ils fournissent. Pour des indicateurs du type « nombre de pays », les rapports des responsables d'entités dans les pays sont regroupés pour déterminer si la cible d'indicateur de RER a été atteinte. Par la suite, une analyse qualitative des RER est effectuée. Cette information fournit la base d'une analyse qualitative finale des OS. Dans les deux cas, le nombre de cibles des indicateurs de RER qui ont été atteintes est pris en considération.

25. Des taux de 75 % et plus pour la mise en œuvre programmatique et de 90 % pour l'exécution budgétaire sont considérés comme une performance acceptable à la fin de la période de planification, tel qu'établi dans le Plan stratégique 2008-2013.

26. Une brève description de la méthodologie utilisée dans chaque composante du processus de PMA est incluse ci-après.

Évaluation programmatique

27. *Analyse par cible d'indicateur de RER*: l'évaluation des indicateurs de RER est effectuée par le facilitateur d'indicateurs de RER. La réalisation des indicateurs de RER est mesurée par l'atteinte de leurs cibles respectives fixées pour la fin de la période d'évaluation. Sur cette base, chaque indicateur est soit réalisé, soit non réalisé.

28. *Analyse par RER* : l'évaluation des RER est effectuée par les facilitateurs de RER sur la base du niveau de réalisation des cibles d'indicateurs de RER (évaluation quantitative). Les critères suivants sont appliqués :

- atteinte totale : toutes les cibles d'indicateurs ont été atteintes ou dépassées.
- atteinte partielle : une ou plusieurs cibles d'indicateurs n'ont pas été atteintes.
- non atteinte : aucune cible d'indicateur n'a été atteinte.

29. *Analyse des OS* : l'évaluation des objectifs stratégiques est effectuée par les facilitateurs d'objectifs stratégiques, en tenant compte de la réalisation des RER. Le statut de chaque objectif stratégique est déterminé en fonction des critères suivants :

- atteinte totale : tous les RER ont été pleinement atteints ou dépassés.
- atteinte partielle : un ou plusieurs RER n'ont pas été atteints.
- non atteint : aucun RER n'a été atteint.

30. Les facilitateurs d'objectifs stratégiques doivent également effectuer une évaluation qualitative, qui inclut une documentation des progrès, des défis, des recommandations et des leçons apprises relativement à chaque objectif stratégique au cours de la mise en œuvre du Plan stratégique 2008-2013.

Évaluation budgétaire et analyse des ressources

31. L'évaluation budgétaire et l'analyse des ressources examine les fonds disponibles pour mettre en œuvre le programme, le niveau de mise en œuvre de tels fonds, le déficit de financement et les efforts de mobilisation des ressources pour combler les déficits. L'analyse couvre une évaluation cumulative des trois Programmes et budgets (2008-2009, 2010-2011 et 2012-2013) approuvés pour la mise en œuvre du Plan stratégique 2008-2013 de l'OPS.

32. *Exécution budgétaire* : ce facteur est évalué pour l'Organisation dans son ensemble, par niveau fonctionnel (entités de pays, infrarégionales et régionales) et par objectif stratégique. L'exécution par source de financement (fonds du budget ordinaire et d'autres sources) est également analysée. Le taux d'exécution budgétaire est calculé en divisant les fonds déboursés par le montant des fonds disponibles pour la mise en œuvre du programme.

33. *Analyse des ressources :* le document de Programme et budget fixe le niveau estimé de ressources (coût prévu) demandées par le BSP dans son ensemble pour mettre en œuvre le programme de travail approuvé par les organes directeurs pour une période

biennale donnée. Le Programme et budget établit également le montant estimé des fonds requis pour chaque objectif stratégique. Au cours de la période biennale, les ressources sont mobilisées pour combler l'écart de financement par rapport au Programme et budget approuvé. L'écart de financement corporatif est progressivement réduit au cours de la période biennale alors que les ressources sont mobilisées et affectées aux niveaux fonctionnels et objectifs stratégiques correspondants. La tendance d'affectation des ressources par objectif stratégique et niveau de priorité programmatique est analysée pour déterminer si l'Organisation a été en mesure de suivre les conseils des organes directeurs pour fournir des affectations appropriées aux objectifs stratégiques prioritaires, tel que défini dans le Plan stratégique 2008-2013. Cette analyse est faite en comparant le montant total des fonds disponibles pour un objectif stratégique d'une période biennale à l'autre.

IV. APERÇU DE LA SANTÉ DANS LA RÉGION

34. Cette section résume les progrès accomplis dans la mise en valeur des priorités de la santé publique de la Région au cours de la mise en œuvre du Plan stratégique de l'OPS 2008-2013. Elle met en évidence quelques-unes de plus importantes réalisations au niveau de l'impact et des résultats, ainsi que les principaux défis qui se sont présentés au cours de la mise en œuvre du Plan. Un résumé des réalisations et des défis du BSP est également inclus dans cette section. Des renseignements détaillés sur chacun des objectifs stratégiques (OS) est fourni dans les rapports respectifs (annexe A).

35. Cet aperçu est organisé par sous-sections correspondant aux OS du Plan stratégique 2008-2013, comme suit :

A. Maladies transmissibles (OS 1 et 2)
B. Maladies non transmissibles et facteurs de risque (OS 3 et 6)
C. Santé des mères, des enfants, des adolescents et des personnes âgées, et nutrition (OS 4 et 9)
D. Préparatifs dans les situations d'urgence et catastrophes (OS5)
E. Déterminants sociaux, économiques et environnementaux de la santé (OS 7 et 8)
F. Systèmes et services de santé (OS 10 à 14).

A. Maladies transmissibles

36. Au cours de la période 2008-2013, la Région a fait des progrès dans la réduction du fardeau sanitaire, social et économique des maladies transmissibles, y compris les maladies évitables par la vaccination (MEV), les maladies à transmission vectorielle, les maladies tropicales négligées, le VIH/sida et la TB. Des réalisations et défis clés sont mis en évidence ci-après. Des détails additionnels sont fournis dans les rapports sur les OS1 et OS2 de l'annexe A.

Réalisations

a) À la suite d'une couverture vaccinale accrue dans la Région contre les maladies les plus couramment associées à la mortalité infantile, notamment celles qui sont provoquées par le rotavirus, le pneumocoque, le méningocoque et *Haemophilus influenzae* type b, la mortalité infantile due aux MEV a baissé de 47 pour 100 000 enfants de moins de 5 ans en 2002 à 35,2 en 2012. Entre 2002 et 2012, il y a eu une réduction de 53 % de la mortalité infantile due aux MEV les plus couramment associées à la mortalité infantile. Trente-huit pays et territoires de la Région ont réussi à maintenir leur statut d'éradication certifiée de la poliomyélite et ont également obtenu et maintenu l'élimination de la rougeole, de la rubéole et du syndrome de rubéole congénitale (SRC). Le tétanos néonatal a été éliminé dans l'ensemble de la Région sauf en Haïti.

b) Le taux de mortalité pour la dengue a baissé de 0,07 % en 2010 à 0,05 % en 2013. 2 376 869 cas de dengue ont été signalés par les pays en 2013, avec une incidence de 435,5 cas pour 100 000 habitants, et 1,6 % des cas ont été caractérisés comme des cas de dengue grave.

c) La Région a obtenu une réduction de 49 % dans l'incidence du paludisme au cours de la période 2006-2012. Au cours des deux dernières années, il y a eu une réduction annuelle moyenne de 16 %. Les 19 pays à paludisme non endémique continuent de maintenir leur statut. De plus, six pays sont dans la phase de pré-élimination et 14 pays sont exempts de la transmission locale du paludisme.

d) La Région a réalisé des progrès significatifs en vue de l'atteinte des objectifs d'élimination des maladies infectieuses négligées (appelées NID pour « neglected infectious diseases »). 18 pays au total ont réussi à éliminer la lèpre en tant que préoccupation de santé publique au niveau national et infranational. Dix-sept pays ont éliminé la rage humaine transmise par les chiens. Dix-sept pays ont pu mettre fin à la transmission par vecteur de la maladie de Chagas en réduisant l'infestation des foyers dans la zone définie à moins de 1 %. La Colombie a été le premier pays au monde à recevoir une vérification de l'OMS relativement à l'élimination de l'onchocercose. L'Équateur a présenté une demande de vérification de l'élimination en 2013. Si l'élimination est vérifiée, le pays deviendrait le deuxième pays de la Région à obtenir ce statut.

e) L'incidence des infections au VIH dans la Région a été réduite d'un taux estimé à 16,9 % pour 1000 000 habitants en 2006 à 15 % en 2012. En 2012, 75 % des patients atteints du VIH/sida avaient accès au traitement antirétroviral (TAR), comparé à 72 % en 2006. Les données disponibles indiquent que la Région est sur la bonne voie pour atteindre l'objectif de 80 % pour l'accès universel au TAR.

f) À la fin de 2013, 19 pays de la Région avaient pu réduire la transmission mère-enfant du VIH à moins de 5 % et 13 pays avaient atteint leur cible d'élimination de la syphilis congénitale de moins de 0,05 cas pour 1000 naissances vivantes en 2012. La réalisation liée à la syphilis congénitale représente un progrès marqué par rapport à 2006, lorsque seulement deux pays avaient atteint la cible d'élimination.

g) L'incidence de la tuberculose (TB) a continué de baisser, passant à 29 cas pour 100 000 en 2012, comparé à 39 cas en 2005. La prévalence et la mortalité ont également diminué au cours de la période 1990-2012 : la prévalence de 62 % et la mortalité de 61 %.

h) Six pays ont signalé qu'ils avaient atteint et maintenu les capacités de base minimales en matière de surveillance, de réponse et de points d'entrée établis dans le RSI en juin 2012. Au cours de la période 2010-2013, les capacités de base en matière de RSI ont atteint 15 % ou plus dans les capacités suivantes : préparation, législation et politique, réponse, laboratoire, événements zoonotiques et surveillance.

Défis

a) Des différences significatives dans la couverture vaccinale persistent au sein des pays. Alors qu'un grand nombre d'entre eux ont accompli des progrès importants en vue de l'obtention et du maintien d'une couverture vaccinale nationale, il existe encore des poches de personnes non vaccinées ou insuffisamment vaccinées.

b) La circulation des virus de la rougeole et de la rubéole dans d'autres régions du monde représente un risque élevé de réintroduction du virus dans les Amériques. Les défis continus incluent le renforcement des systèmes de surveillance des pays pour assurer la notification en temps utile des cas présumés de rougeole et de rubéole et pour obtenir une couverture vaccinale soutenue et homogène pour la rougeole et la rubéole au niveau municipal.

c) En dépit de l'importance croissante de la résistance antimicrobienne dans le domaine de la santé publique, l'appui dans les Amériques n'a cessé de diminuer. Cette situation met en péril les progrès réalisés à ce jour dans la Région et entravera la surveillance de la résistance antimicrobienne, le renforcement des capacités des laboratoires et les efforts de confinement.

d) Des défis persistants à l'extension du traitement du VIH et des programmes de soins incluent : des systèmes de santé défaillants, des approches verticales, la dépendance à l'égard de fonds extérieurs dans certains pays et des obstacles à la prestation de services pour des populations clés, y compris les hommes qui ont des rapports sexuels avec d'autres hommes et la population transsexuelle.

e) L'atteinte du taux souhaitable de réussite dans la détection et le traitement de la tuberculose a été entravé par ce qui suit : le besoin de justifier l'intégration des programmes dans les soins de santé primaires, l'utilisation d'estimations controversées du fardeau de la maladie au niveau mondial, des retards dans l'introduction de nouveaux outils de diagnostic et de traitement, des difficultés dans le suivi des patients et le fait de ne pas inclure d'autres intervenants/secteurs au niveau des pays.

f) Pour être en mesure de contrôler et d'éliminer de façon continue les maladies infectieuses négligées dans la Région, les ministres de la Santé doivent travailler pour assurer le maintien d'un engagement politique soutenu. Des actions intégrées sont nécessaires pour traiter les déterminants de la santé liés à ces maladies, en particulier eau potable, assainissement de base et éducation à l'hygiène.

g) Au nombre des défis persistants dans la lutte contre la dengue figure le besoin de développer et de mettre en œuvre un système intégré de surveillance de la dengue et de renforcer les capacités du personnel de santé au niveau des soins de santé primaires pour détecter les flambées et, par la suite, prévenir les cas de dengue grave et éviter les décès. La lutte contre la dengue doit inclure la sensibilisation et l'engagement soutenu des foyers, communautés et autres secteurs, ainsi qu'une action intersectorielle.

h) Le traitement et la réponse opportune aux cas de paludisme sont souvent entravés dans certains pays par des défis qui se présentent dans l'établissement et le maintien de systèmes de surveillance solides dans des régions éloignées et difficiles d'accès. Des systèmes de surveillance peu fiables peuvent également entraver les capacités nationales permettant de suivre l'évolution de la résistance aux antipaludéens. Des défis persistent dans la rationalisation du traitement antipaludique et l'intégration des interventions dans le cadre d'une réponse de plus grande portée du système de santé.

i) La réponse à la grippe pandémique H1N1 de 2009 a mis en évidence plusieurs défis pour les pays, y compris le besoin de disposer : *i)* de données cliniques, épidémiologiques et virologiques en temps réel sur des cas graves, *ii)* de systèmes d'alerte précoces adéquats et de capacité d'alerte et de réponse, *iii)* de laboratoires compétents, *iv)* de systèmes de santé avec la capacité d'assurer la sécurité des patients et les soins de qualité.

j) Les principales difficultés rencontrées par les États parties dans l'atteinte des capacités essentielles du RSI incluent le traitement adéquat des situations d'urgence chimique, des situations d'urgence radionucléaire et des problèmes de points d'entrée. D'autres difficultés incluent : *i)* l'institutionnalisation des capacités essentielles du RSI pour qu'elles soient pertinentes pour chaque pays spécifique tout en évitant le scénario « taille unique », *ii)* le renforcement des efforts de suivi et d'évaluation liés à la mise en œuvre du RSI pour assurer une responsabilité mutuelle, *iii)* l'utilisation du RSI comme un outil efficace pour encourager les mécanismes de coordination intersectorielle.

B. Maladies non transmissibles et facteurs de risque

37. Au cours de la période 2008-2013, les efforts déployés pour lutter contre le fardeau croissant des maladies non transmissibles et leurs facteurs connexes ont été renforcés dans la Région. Les réalisations et défis clés sont décrits ci-après. Des détails additionnels sont fournis dans les rapports sur l'OS3 et l'OS6 de l'annexe A.

Réalisations

a) L'analyse de tendance de la mortalité prématurée (dans la population âgée de 30 à 69 ans) pour les quatre groupes principaux de maladies non transmissibles montre que les taux ajustés en fonction de l'âge pour 100 000 a baissé de 379,9 en 2000 à 318,7 en 2010, pour atteindre une diminution générale de 16,1 %. Le changement de pourcentage annuel moyen était de -1.7%, ce qui est statistiquement significatif.

b) Le taux de mortalité moyen de la Région dû aux accidents de la route a été réduit à 16,1 pour 100 000 personnes en 2010, comparé à la moyenne estimée de 16,7 en 2000-2004.

c) L'engagement politique de lutte contre les maladies non transmissibles (MNT) comme partie du programme de développement a été bien établi à l'échelle mondiale et dans la Région. Le cadre opérationnel pour obtenir une réduction de 25 % de la mortalité prématuré a également été établi. Les efforts menés par la Région ont culminé dans un engagement politique exprimé dans le cadre de la Réunion de haut niveau des Nations Unies sur la prévention et la maîtrise des maladies non transmissibles, en 2011, et qui a été incorporé dans le Cadre mondial de suivi pour les maladies non transmissibles et les Plans d'action mondial de l'OMS et régional de l'OPS sur les maladies non transmissibles.

d) Plusieurs pays ont révisé leurs plans, programmes et règlements nationaux sur les MNT (notamment les maladies cardiovasculaires, les principaux cancers et le diabète), la santé mentale, les handicaps, la sécurité routière, la prévention de la violence et des traumatismes, la santé oculaire et l'hygiène buccale, conformément aux directives et cadres actualisés de l'OPS/OMS.

e) Les systèmes de surveillance pour les maladies non transmissibles ont été renforcés, tel qu'illustré ci-après :

   i. tous les pays produisent des rapports sur la mortalité propre aux maladies non transmissibles;
   ii. 28 pays produisent des rapports sur les handicaps;
   iii. 21 pays participent au Rapport de situation sur la prévention de la violence dans le monde;
   iv. 21 pays signalent avoir des systèmes d'information sur la santé mentale;
   v. 19 pays ont contribué au rapport mondial sur les ressources pour la prévention et le traitement des troubles liés aux substances;
   vi. la première comparaison régionale de données représentatives du pays sur la violence contre les femmes a été élaborée;
   vii. 11 pays ont des registres nationaux des maladies avec des données sur le cancer, les accidents vasculaires cérébraux ou le diabète;
   viii. la plupart des pays de la Région font partie de l'Observatoire régional de la sécurité routière.

f) Il convient de noter que des progrès marquants ont été accomplis en matière de surveillance des facteurs de risque : *i)* 25 pays ont adopté la stratégie d'approche par étapes de la surveillance des facteurs de risque (Pan Am STEPS) ou se sont alignés sur ce système de surveillance, *ii)* 27 pays participent à l'Enquête mondiale réalisée en milieu scolaire sur la santé des élèves, *iii)* 30 ont mis à jour au moins une des composantes du système mondial de surveillance du tabagisme (30 ont mis à jour l'Enquête mondiale sur le tabagisme chez les jeunes, cinq ont mis en oeuvre l'Enquête mondiale sur le tabagisme chez les adultes et 19 ont mis en œuvre l'Enquête mondiale auprès des étudiants des professions de la santé). La surveillance des facteurs de risque est essentielle à l'élaboration d'une solution solide pour les politiques de "meilleurs options" et celles qui sont fondées sur des

preuves scientifiques pour freiner l'épidémie des maladies non transmissibles dans la Région.

g) En 2013, huit pays ont obtenu une réduction de 10 % de la prévalence du tabagisme comparé à seulement trois pays en 2007. De plus, des progrès ont été accomplis relativement à la mise en œuvre de la Convention-cadre de l'OMS pour la lutte antitabac :

   i. 29 États Membres sont parties à la Convention-cadre de l'OMS pour la lutte antitabac;
   ii. 17 pays ont une politique d'interdiction générale de fumer dans les endroits publics fermés, les lieux de travail fermés et les transports publics;
   iii. 13 pays ont une interdiction totale ou presque sur la publicité, la promotion et les commandites du tabac;
   iv. 19 pays satisfont aux exigences minimales de l'article 11 de la Convention-cadre de l'OMS pour la lutte antitabac, qui régit la règlementation sur l'emballage et l'étiquetage des produits du tabac;
   v. six pays ont modifié leur structure de la taxe sur le tabac pour réduire l'accessibilité;
   vi. deux pays ont approuvé l'utilisation des revenus du tabac pour le financement de la santé publique.

h) Des progrès importants ont été accomplis dans la mise en œuvre de politiques ou normes nationales pour promouvoir une alimentation saine et l'activité physique. La Région mène des efforts liés à la lutte contre l'épidémie d'obésité, en particulier chez les enfants.

i) Le Forum panaméricain d'action sur les maladies non transmissibles a été créé dans le but d'établir des partenariats et des réseaux, et de mobiliser des ressources à l'appui de la coopération technique de l'OPS. L'initiative du cancer chez les femmes et l'initiative sur la réduction de la teneur en sel sont deux exemples de réussite de partenariats public-privé relativement au Forum panaméricain d'action sur les maladies non transmissibles.

Défis

a) La volonté politique ne se traduit pas toujours en actions concrètes pour traiter le fardeau croissant des maladies non transmissibles et leurs facteurs de risque.

b) Bien que les systèmes de surveillance des maladies non transmissibles et les facteurs de risque dans la Région aient fait des progrès, ils demeurent inégaux et non durables, et ils sont caractérisés par le double emploi.

c) Des approches structurées et coordonnées sont nécessaires pour engager les secteurs non sanitaires dans la réponse aux maladies non transmissibles et leurs facteurs de risque.

d) Il convient de reconnaître la nécessité de services de qualité intégrés pour les maladies non transmissibles dans le cadre de l'approche de couverture sanitaire universelle.

e) Certains problèmes de santé publique, notamment la prévention de la violence, ne sont pas encore reconnus comme des priorités de santé publique importantes, en dépit de leur magnitude et de leur importance comme une des principales causes de mortalité.

f) Un changement du paradigme de la santé des soins aigus vers les soins chroniques exigera une mobilisation d'investissements additionnels pour la formation des prestataires, l'établissement de directives fondées sur des données probantes et l'offre d'incitatifs pour des soins continus plutôt que des soins épisodiques.

g) L'interférence des industries du tabac, des boissons alcoolisées, du sucre et des aliments transformés sape les avancées enregistrées par les pays relativement à la réduction des facteurs de risque des maladies non transmissibles. Les litiges et différends, basés sur des motifs commerciaux ou d'investissement, qui voient actuellement le jour en matière de lutte antitabac, pourraient, s'ils aboutissent, menacer, voire anéantir les réalisations obtenues en matière de santé publique et entraver les progrès accomplis pour s'attaquer à d'autres facteurs de risque. Les accords commerciaux bilatéraux et régionaux sont une préoccupation majeure s'ils ne protègent pas clairement la santé publique.

h) Le travail multisectoriel est difficile au niveau national. Les efforts à déployer pour s'attaquer aux facteurs de risque ne sont pas la responsabilité exclusive des ministres de la santé. Les efforts pour promouvoir l'approche de *Santé dans toutes les politiques* devraient se poursuivre à l'OPS et au niveau national.

i) Un accroissement continu de la consommation d'alcool dans la Région, allié à la lenteur des progrès dans la mise en œuvre de politiques économiquement rationnelles pour réduire une consommation d'alcool nocive, pose encore des défis. Cette situation est d'autre part aggravée par les investissements réalisés par l'industrie des boissons alcoolisées pour augmenter sa part du marché dans certains des pays d'Amérique latine et des Caraïbes.

j) Il est nécessaire d'assurer une plus grande intégration de la promotion de la santé et de la prévention dans les systèmes de soins de santé, en particulier dans les soins de santé primaires, pour traiter les maladies non transmissibles et les facteurs de risque.

C. Santé de la mère, de l'enfant, de l'adolescent et de la personne âgée et nutrition

38. Les pays et territoires ont continué de faire des progrès dans la réduction de la morbidité et de la mortalité ainsi que dans l'amélioration de la santé tout au long de la vie, y compris la santé sexuelle et génésique et la santé des enfants, des adolescents et des personnes âgées. Des progrès importants ont également été accomplis dans la mise en

œuvre de politiques et programmes en matière de nutrition, sécurité alimentaire et innocuité des aliments. Les réalisations et défis clés sont décrits ci-après. Des détails additionnels sont fournis dans les rapports sur l'OS4 et l'OS9 à l'annexe A.

Réalisations

a) Tous les pays de la Région, à l'exception d'Haïti, ont déclaré des taux de mortalité chez les enfants de moins de 5 ans inférieurs à 32,1 pour 1000 naissances vivantes. Selon les indicateurs de base de l'OPS pour 2013, le taux de mortalité pour les moins de 5 ans pour 1000 naissances vivantes était de 19,7 en Amérique latine et dans les Caraïbes. Sur la base des progrès réalisés, la Région est censée réaliser l'OMD 4 en 2014.

b) Selon les indicateurs de base de l'OPS pour 2013, 92,5 % des accouchements ont été suivis par du personnel qualifié en Amérique latine et dans les Caraïbes.

c) Des améliorations notables ont été constatées dans la santé des enfants âgés de moins de 5 ans en Amérique latine et dans les Caraïbes (ALC), y compris des réductions dans la proportion de l'insuffisance pondérale de 7,5 % en 2002 à 1,4 % en 2010, et la proportion d'enfants rachitiques de 11,8 % en 2005 à 7,4 % en 2010. La proportion d'enfants qui sont en surcharge pondérale ou obèses s'est stabilisée à 3,8 %, alors que la proportion d'enfants anémiques est tombée de 29,3 % en 2005 à 24,9 % en 2011.

d) En 2013, 19 pays et territoires ont des taux de prévalence contraceptive supérieurs à 60 %, comparé à 13 pays en 2006. De plus, 20 pays ont signalé un taux de fertilité chez les adolescentes qui était inférieur à 75,6 pour 1000 jeunes femmes âgées de 15 à 19 ans, comparés à huit pays en 2006.

e) Trente pays ont mis en œuvre les normes de l'OMS sur la croissance de l'enfant, et plus de 20 pays sont en train de mettre en œuvre des stratégies et programmes pour promouvoir l'allaitement, prévenir les carences en micronutriments et promouvoir des habitudes alimentaires et des modes de vie sains.

f) Vingt-cinq pays ont des systèmes d'information et des systèmes de surveillance pour suivre l'évolution de la santé sexuelle et génésique ainsi que la santé de la mère, du nouveau-né et de l'adolescent, avec une information désagrégée.

g) Seize pays ont une politique sur l'accès universel à la santé sexuelle et génésique, et 20 pays ont adopté des stratégies globales sur la santé génésique.

h) Dix-huit pays ont des programmes fonctionnels de santé et de développement pour les adolescents et les jeunes, et 22 mettent en œuvre une gamme complète de règles et de normes pour fournir des services de santé adéquats pour ce groupe d'âge. En même temps, 18 pays mettent en œuvre des programmes multisectoriels à base communautaire pour aborder la question du vieillissement sain.

i) Une réduction de 18 % dans les maladies diarrhéiques transmises par les aliments a pu être obtenue, avec une baisse dans le nombre de cas de 4667 en 2006 à 3663 en 2013.

j) Pour la première fois depuis l'introduction de la fièvre aphteuse dans les Amériques en 1870, 33 mois se sont écoulés sans qu'un cas ne soit signalé.

Défis

a) Il est devenu de plus en plus important d'adopter et de mettre en pratique l'approche du parcours de vie au sein du système de santé et au-delà, au moyen d'une coordination intersectorielle avec les secteurs de l'éducation, du travail et de l'environnement pour traiter les déterminants sociaux de la santé.

b) Une plus grande attention doit être portée aux besoins spécifiques de santé des adolescents et pour assurer qu'ils bénéficient d'interventions préventives.

c) La pression exercée sur la demande de soins se fait de plus en plus forte en raison du vieillissement de la population.

d) La controverse au sujet de l'avortement médical entrave la rapidité des progrès vers des services exhaustifs de santé sexuelle et génésique.

e) Alors que la malnutrition aiguë n'est pas un problème majeur dans la Région, des flambées de malnutrition aiguë sont périodiquement observées dans des groupes de population spécifiques.

f) Le surpoids et l'obésité sont en hausse dans la Région, avec la plus forte prévalence au Mexique et aux États-Unis.

g) D'autres efforts sont nécessaires pour prévenir de façon efficace la fièvre aphteuse dans les pays et zones de la Région, d'abord par la vaccination puis avec une prévention et une surveillance améliorées, et des outils d'urgence dans le cadre du Plan d'action 2011-2020 du Programme continental pour l'éradication de la fièvre aphteuse.[3]

D. Préparatifs dans les situations d'urgence et les cas de catastrophe

39. Au cours des six dernières années, les pays de la Région, avec l'appui du BSP, ont été en mesure d'améliorer leurs capacités d'intervention et de préparation aux catastrophes dans le secteur de la santé. Les réalisations et défis sont décrits ci-après. Des détails additionnels sont fournis dans le rapport sur l'OS5 de l'annexe A.

Réalisations

a) La mortalité quotidienne dans les populations affectées par des urgences de grande ampleur était en-dessous de 1 pour 10 000 au cours de la phase initiale d'intervention d'urgence dans toutes les urgences évaluées au cours de la période 2008-2013. En Haïti, le taux de mortalité due à l'effondrement des structures matérielles était plus élevé que ce ratio, mais le taux de mortalité journalier était

[3] http://bvs1.panaftosa.org.br/local/File/textoc/PHEFA-PlanAccion-2011-2020ing.pdf

inférieur à 1 pour 10 000 habitants au cours de la phase initiale d'intervention d'urgence.

b) Au cours de la période 2008-2013, toutes les interventions d'urgence ont été lancées dans les 24 heures de la réception de la demande y compris les grandes catastrophes qui ont frappé la Région : les séismes de 2010 en Haïti et au Chili, la pandémie de grippe H1N1 de 2009, les flambées de choléra en Haïti et en République dominicaine, l'ouragan Sandy en Jamaïque, en Haïti, aux Bahamas et à Cuba en 2012, les tremblements de terre au Guatemala et au Costa Rica en 2012, les inondations en Bolivie, en Colombie et en Amérique centrale (Guatemala, Honduras, Nicaragua, Panama et El Salvador) en 2010-2011et les éruptions volcaniques en Amérique du Sud.

c) Tous les réseaux de santé ont été opérationnels dans un délai d'un mois suivant les catastrophes qui se sont produites au cours de la mise en œuvre du Plan stratégique. De plus, des progrès substantiels ont été accomplis en matière de réhabilitation et de reconstruction.

d) L'Initiative des hôpitaux intelligents (*SMART Hospitals Initiative*), une approche novatrice qui intègre la préparation au changement climatique et aux risques de catastrophes dans le secteur de la santé, a été lancée et est devenue une force catalysatrice pour stimuler l'intérêt et la participation des partenaires et des autorités nationale.

e) L'index de sécurité des hôpitaux a été élaboré et appliqué dans plus de 2900 hôpitaux et autres établissements de santé dans 33 pays et territoires, la plupart d'entre eux mettant en application des mesures correctives dans des établissements de santé prioritaires. Cet index fournit aux autorités nationales une vision générale du niveau de sécurité dans leurs services de santé, tout en leur permettant de prioriser les interventions et de mettre á jour leurs plans d'intervention en cas de catastrophe sanitaire, le cas échéant. Il est également utilisé par plus de 20 pays dans d'autres régions de l'OMS.

f) Le renforcement du système d'alerte et de riposte en Haïti est allé bien au-delà des épidémies et a couvert toutes les catastrophes, y compris les inondations, les événements comportant une grand nombre de victimes et les flambées de maladie. Cette entreprise a inclus l'élaboration d'un système d'alerte précoce et d'intervention rapide pour le contrôle de qualité de l'eau dans les établissements de santé et les abris d'urgence.

Défis

a) Il existe encore des difficultés pour mobiliser des fonds pour les préparatifs et la réduction des risques, et la situation a été exacerbée par la crise financière. De nombreux donateurs humanitaires qui avaient l'habitude de financer les programmes de préparation et d'atténuation mettent de plus en plus l'accent sur la préparation et l'intervention. Cette réorientation a eu un impact négatif sur

l'ensemble du personnel ainsi que sur le rythme du progrès dans la coopération technique.

b) Le secteur de la santé en Amérique latine et dans les Caraïbes est encore mal préparé pour faire face à des catastrophes chimiques, radiologiques et technologiques de grande ampleur. Les catastrophes technologiques constituent un risque potentiel important pour les pays qui ont atteint un certain niveau de développement industriel mais ont peu fait en termes de règlementation et/ou de prévention.

c) En dépit des progrès accomplis dans le cadre de l'initiative des hôpitaux sûrs, veiller à ce que tous les nouveaux établissements de santé soient à l'abri de catastrophes et améliorer la sécurité des établissements existants demeurent des défis majeurs. Alors que de nombreux facteurs contribuent à cette situation, des limites financières et la volonté politique sont au nombre des plus importants.

d) En dépit des efforts réalisés pour fournir une formation en gestion des catastrophes pour les ressources humaines de la Région au cours de ces dernières années, il existe encore une pénurie de ressources humaines et institutionnelles pour répondre à ces événements, en particulier les menaces émergentes telles que catastrophes chimiques ou radionucléaires potentielle, à un niveau qui correspond aux attentes nationales et internationales. La durabilité des interventions à la lumière des mesures d'attrition dans les ministères de la santé constitue un autre défi.

e) C'est un défi que de maintenir une équipe d'experts pour l'équipe régionale d'intervention en cas de catastrophe, avec des connaissances et des aptitudes actualisées, tout en essayant de faire face au niveau élevé de rotation des membres et/ou leur non disponibilité pour un déploiement immédiat. Cette équipe, établie à la demande des organes directeurs de l'OPS, facilite la coordination internationale en santé et fournit une aide en santé publique dans les pays affectés.

E. Déterminants sociaux, économiques et environnementaux de la santé

40. Au cours de la mise en œuvre du Plan stratégique 2008-2013, les pays de la Région ont fait des progrès notables dans le traitement des déterminants sociaux et économiques sous-jacents de la santé en élaborant et en mettant en œuvre des politiques et des plans qui mettent l'accent sur l'équité en santé et le recours à des approches basées sur l'égalité des sexes et les droits de la personne. Au cours de cette période, l'OPS/OMS, en étroite collaboration avec d'autres organismes des Nations Unies, tels que le PNUE, la CEPALC, l'OIT et le PNUD, a appuyé des actions et des efforts conjoints au niveau régional et national en utilisant une approche intersectorielle pour promouvoir un environnement plus sain et traiter les racines des menaces environnementales pour la santé. Les réalisations et défi clés sont décrits ci-après. Des détails additionnels sont fournis dans les rapports sur l'OS7 et l'OS8 de l'annexe A.

Réalisations

a) Six pays de la Région ont inclus des indicateurs de santé nationaux ventilés par sexe et statut socioéconomique, y compris le coefficient de Gini, les courbes de Lorenz, les courbes de concentration et les mesures contre les écarts en matière d'équité.

b) Vingt pays de la Région ont mis au point des initiatives qui insistent sur la nécessité de renforcer la coordination locale en matière de stratégies de santé conjointes pour assurer que les mesures de santé publique atteignent l'ensemble de la population.

c) Les inégalités en santé et les déterminants sociaux de la santé ont été inclus dans le document final de la Conférence des Nations Unies sur le développement durable. Ces résultats sont le fruit d'une collaboration multi-acteurs, y compris des États Membres et le BSP. D'autre part, en collaboration avec 54 centres collaborateurs de l'OPS/OMS, les recommandations de cette conférence ont été utilisées pour la préparation à la Conférence de Rio+20 sur le développement durable.

d) Le Plan d'action régional sur l'égalité des sexes (2009-2014) a été approuvé et 33 pays mettent en œuvre des plans pour promouvoir l'égalité des sexes dans le secteur de la santé. Des accords politiques et techniques importants ont également été consolidés avec le Système d'intégration d'Amérique centrale (SICA) et la Communauté andine des nations (CAN) pour l'égalité des sexes dans le secteur de la santé.

e) Seize pays mettent actuellement en œuvre des politiques, plans ou programmes pour améliorer la santé de groupes ethniques/raciaux spécifiques.

f) La Région a atteint l'OMD 7 sur l'accès à des services d'eau potable améliorés. L'accès à des sources d'eau potable améliorées a augmenté de 95 % en 2002 à 97 % en 2011 dans les centres urbains, et de 69 % à 82 % dans les zones rurales, pour une couverture générale de 97 %.

g) L'accès à un assainissement amélioré a augmenté de 84 % en 2002 à 94 % en 2011 dans les zones urbaines, et de 44 % à 62 % dans les zones rurales, pour une couverture générale de 88 % dans la Région.

h) Vingt-cinq pays mettent en œuvre actuellement des plans de salubrité de l'eau et les Directives de l'OMS sur l'eau.

i) Le nombre de pays qui mettent en œuvre des plans nationaux sur la santé des travailleurs a doublé, passant de 10 en 2007 à 20 en 2013. De plus, un Groupe inter-agences sur le travail des enfants (GITI) a été établi en collaboration avec le Bureau international du Travail, et neuf autres agences collaborent dans les Amériques pour éliminer le travail domestique des enfants dans la Région.

j) Vingt pays ont un cadre juridique pour les pesticides, avec des différences en termes de protection de la santé publique. Dix pays ont des programmes

nationaux sur la qualité de l'air, mais la majorité des États Membres ne suivent pas les lignes directrices OMS relatives à la qualité de l'air sur l'exposition annuelle moyenne à la fraction inhalable de particules atmosphériques, et le Mexique révise actuellement sa législation existante en la matière. Quinze pays ont inclus le droit à l'eau dans leur législation nationale.

Défis

a) Il y a encore une participation seulement limitée du secteur de la santé au niveau national à la formulation d'objectifs de développement durable qui seront incorporés dans le Programme d'action des Nations Unies en faveur du développement au-delà de 2015.

b) Des questions complexes comme l'identité et l'expression de genre, les droits génésiques et l'orientation sexuelle et la capacité légale des adolescents, des personnes handicapées et des personnes âgées continuent de présenter un défi. Un grand nombre de ces questions peuvent être règlementées par des lois nationales (y compris les codes pénal et civil) qui n'ont pas été révisées pour s'assurer qu'elles sont conformes aux traités et normes applicables en matière de droits de la personne.

c) La collecte systématique, l'analyse, l'utilisation et la surveillance des données ventilées pour traiter les déterminants de la santé restent un défi dans la Région.

d) Des activités de plaidoyer accrues sont nécessaires pour convaincre les professionnels de la santé que les inégalités en santé peuvent être réduites par une action axée sur le traitement des déterminants sociaux de la santé.

e) Les initiatives de santé interculturelles de santé intégrées dans des plans de développement de plus grande envergure sont souvent fragiles, manquent de données statistiques suffisantes et comportent des lacunes importantes qui empêchent une véritable participation à la formulation d'interventions qui répondent aux besoins spécifiques de groupes ethniques/raciaux.

f) Il est nécessaire de disposer de plus d'outils et d'une capacité institutionnelle accrue pour surveiller et analyser les inégalités en matière d'exposition aux risques environnementaux et professionnels.

g) Des ressources et moyens limités sapent la capacité des autorités nationales de la santé de mettre en œuvre et de renforcer les stratégies de santé en matière de santé environnementale et de santé au travail, y compris la sécurité sanitaire des produits chimiques.

h) Il y a une intégration intersectorielle insuffisante au niveau national pour accroître la sensibilisation et mettre en œuvre les Lignes directrices OMS relatives à la qualité de l'air et traiter de façon systématique la question de la pollution de l'air dans la Région.

F. Systèmes et services de santé

41. Les pays dans l'ensemble de la Région ont fait des efforts pour renforcer leurs systèmes et services de santé pour fournir à tous les citoyens des services de santé complets axés sur l'être humain et sur les soins de santé primaires. Les efforts ont été centrés sur le renforcement des politiques, lois et règlements nationaux en matière de santé et sur l'élaboration et la mise en œuvre de stratégies et de plans. Les services de soins de santé se sont sensiblement améliorés en termes de qualité et de disponibilité, avec des augmentations tant du nombre que de la proportion de gens qui y ont recours. Les réalisations et défis clés sont décrits ci-après. Des détails additionnels sont fournis dans les rapports sur l'OS10 et l'OS 14 de l'annexe A.

Réalisations

a) Le pourcentage de la population de la Région couverte par un régime de protection sociale a augmenté de 46 % en 2003 a 60 % en 2013.

b) Dix-neuf pays de la Région ont incorporé le principe du droit à posséder le meilleur état de santé capable d'être atteint dans leur constitution ou leur législation nationale en matière de santé, et plus de 30 pays ont signé des traités internationaux qui appuient ces mêmes principes. De plus, 15 pays et territoires ont une législation visant à accroître l'accès à la santé et aux soins de santé. Certains pays, comme El Salvador, le Pérou et la République dominicaine, ont amélioré leur législation en matière de santé pour incorporer le droit à la santé et reconnaître l'objectif d'une couverture sanitaire universelle.

c) Trente-et-un pays et territoires ont renforcé leurs systèmes de santé basés sur les SSP. Les initiatives de réformes du secteur de la santé ont inclus des engagements pour étendre la couverture des services de santé, qui ont été reflétés dans les stratégies et plans nationaux de la santé. Douze pays ont mis en œuvre des régimes d'assurance et des plans de santé nationaux pour étendre la couverture de santé par des garanties explicites de soins de santé, alors que huit pays ont adopté des politiques explicites et/ou des mécanismes financiers cherchant à réduire ou à éliminer le risque financier associé aux maladies et aux accidents.

f) Six États parties ont satisfait aux critères du Règlement sanitaire international (RSI) en matière de capacités essentielles de surveillance et de réponse.

g) Les dépenses publiques en matière de santé en tant que pourcentage du PNB dans la Région ont augmenté de 3,1 % en 2006 à 4,1% en 2010 mais ont connu une légère réduction à 3,8 % en 2011.

h) Tous les pays ont formulé des politiques et des plans à moyen et à long terme ou ont défini des objectifs nationaux en matière de santé.

i) Dix-sept pays ont fait état d'une gouvernance améliorée de leurs systèmes de santé, tel que reflété dans des évaluations de leurs fonctions essentielles en matière de santé publique.

j) Dix-sept pays ont incorporé la stratégie IHSDN (réseaux de prestation de services de santé intégrés) dans la réforme et la réorganisation de leurs services de santé dans le but d'améliorer la qualité, l'efficience et l'équité dans la prestation de soins. Dix-huit pays et territoires ont mise en œuvre des initiatives pour intégrer les programmes prioritaires dans un modèle de soins exhaustifs, avec un renforcement du premier niveau de soins et une approche des soins de santé plus axée sur la famille et la communauté.

k) Le nombre de pays en conformité avec la densité recommandée de personnel de santé, soit 25 pour 10 000 habitants, ou plus, a augmenté de 12 en 2006 à 25 en 2013. Vingt-neuf pays et territoires ont élaboré des plans de ressources humaines, et neuf d'entre eux ont mis à jour leur législation sur les cheminements de carrière dans le secteur de la santé publique.

l) Quinze pays ont mis en place des processus pour améliorer la qualité et la couverture de leurs systèmes d'information sanitaire, que ce soit pour une évaluation du système d'information, une formation du personnel de santé, la mise en place d'outils pour améliorer les processus, renforcer les diagnostics ou réduire les sous-déclarations.

m) Treize pays ont renforcé leurs mécanismes nationaux pour assurer la qualité, la sécurité et l'efficacité des technologies de la santé. Vingt-quatre pays ont renforcé leurs processus nationaux pour la gestion des achats et des approvisionnements des technologies de la santé. À la fin de 2013, sept autorités réglementaires nationales ont été reconnues comme autorités réglementaires nationales de référence de l'OMS/OPS et fonctionnaient à plein niveau.

Défis

a) Des barrières à l'accès aux soins de santé continuent de présenter un défi majeur dans la Région. Environ la moitié des pays n'ont pas encore mis en œuvre des régimes visant une couverture sanitaire universelle avec des garanties de soins explicites et des mécanismes financiers appropriés. Approximativement 30 % de la population n'a pas accès aux soins pour des raisons financières et 21 % sont dissuadés de rechercher des soins en raison de barrières géographiques. Ces barrières affectent de façon disproportionnée les groupes qui en ont le plus besoin et qui se trouvent dans les situations les plus vulnérables, ce qui entraîne des inégalités en matière de santé.

b) En dépit de l'augmentation générale du pourcentage de la population couverte par des régimes de protection sociale, il existe une grande différence entre les pays et en leur sein.

c) Les services de santé fragmentés sont mal adaptés pour répondre aux besoins actuels en soins de santé des populations. Cette situation est aggravée par le profil épidémiologique de la Région, avec un nombre croissant de maladies chroniques non transmissibles et une population qui vieillit progressivement. Cette fragmentation, par elle-même ou en combinaison avec d'autres facteurs, rend

difficile l'accès à des services de qualité et elle entraîne une utilisation inefficiente des ressources disponibles, des hausses inutiles des coûts de production et de bas niveaux de satisfaction de l'utilisateur.

d) La distribution de l'infrastructure des services de santé, en particulier les hôpitaux, est principalement concentrée dans les grands centres urbains, ce qui a un impact négatif sur l'accès et exacerbe les inégalités en santé.

e) Pour renforcer l'information sur la santé, il sera nécessaire d'accroître la fiabilité et la communication des données à tous les niveaux et d'améliorer la capacité analytique des pays. De plus, il faudra stimuler la production et l'utilisation de données probantes pour une prise de décisions éclairée en matière de gestion de la santé et de gouvernance des systèmes de santé.

f) Alors que la majorité des pays ont amélioré la gouvernance de leurs systèmes de santé, tel que reflété dans des évaluations des fonctions essentielles de la santé publique (FESP), les mécanismes de dialogue national et de partenariat social avec une responsabilisation bien établie sont encore limités.

g) Des efforts renouvelés sont nécessaires pour inclure l'utilisation rationnelle et appropriée de médicaments et des technologies de la santé comme une composante intégrale de la couverture sanitaire universelle.

h) La distribution équitable des agents de santé en termes de besoins et de réforme du secteur de la santé pour appuyer la mise en œuvre des systèmes de santé fondés sur les SSP continue d'être un défi de taille. De grandes disparités persistent dans la composition du personnel de santé, avec une pénurie de personnel en soins de santé primaires. D'autre part, la capacité institutionnelle est limitée en matière de planification et de prévision des ressources humaines pour la santé afin de combler les pénuries actuelles et futures.

i) Les indicateurs de protection financière en santé ne sont pas systématiquement recueillis. Et surtout, il n'y a pas encore de méthodologie commune pour mesurer l'impact des sorties effectives d'argent dans les cas de pauvreté et d'exposition aux dépenses en cas de catastrophe.

Principales réalisations de la coopération technique du BSP

42. Au cours de la période 2008-2013, le BSP a continué de jouer son rôle dans la coopération technique dans le cadre des fonctions de base de l'Organisation:

A. Prestation de leadership sur des questions critiques pour la santé et établissement de partenariats là où l'action conjointe est nécessaire.

B. Définition du programme de recherche et stimulation de la création, la dissémination et l'application de connaissances précieuses.

C. Établissement de normes et principes et promotion et suivi de leur mise en œuvre.

D. Définition d'options stratégiques éthiques et fondées sur des données probantes.

E. Établissement de la coopération technique pour catalyser le changement et renforcer une capacité institutionnelle durable.

F. Suivi de la situation sanitaire et évaluation des tendances en santé.

43. La section suivante fournit un résumé des principales réalisations du BSP et des défis qui se sont présentés durant la mise en œuvre du Plan.

A. Prestation de leadership sur des questions critiques pour la santé et établissement de partenariats là où l'action conjointe est nécessaire

44. Le BSP a continué d'exercer son rôle de leader par ses activités de plaidoyer, de sensibilisation et de mobilisation des ressources pour traiter les priorités régionales collectives de santé publique telles qu'établies dans le Plan stratégique de l'OPS et le Programme d'action sanitaire pour les Amériques 2008-2017. Ce rôle incluait également le traitement des mandats mondiaux établis dans le Programme de travail général de l'OMS et les mandats liés à la santé et émanés du système des Nations Unies et du système interaméricain, tel que décrit ci-après:

a) Le BSP a établi des partenariats au sein du système des Nations Unies sur l'harmonisation des questions de santé, au niveau tant régional que national. Une attention particulière a été portée sur les efforts d'appui en vue de la réalisation des OMD, en particulier l'OMD 4 (réduction de la mortalité infantile), l'OMD 5 (amélioration de la santé maternelle), l'OMD 6 (lutte contre le VIH/sida, le paludisme et autres maladies) et l'OMD 7 (assurer la durabilité environnementale). Le BSP a été activement engagé avec des pays et des partenaires dans la Réunion plénière de haut niveau des Nations Unies sur les maladies non transmissibles, en mettant en évidence la priorité qu'il y a lieu d'accorder aux maladies non transmissibles au niveau infrarégional, régional et mondial. Cet engagement est illustré par la Conférence mondiale sur les déterminants sociaux de la santé (Rio+20).

b) De multiples accords ont été signés avec des organisations bilatérales et multilatérales et d'autres partenaires, y compris des agences des Nations Unies et du système interaméricain, pour faire avancer le Programme d'action sanitaire pour les Amériques. Le BSP a également plaidé avec succès pour l'inclusion de la santé dans les déclarations des sommets, notamment celle du Sixième Sommet des Amériques à Cartagena, en Colombie. En 2013, le BSP a été accepté comme un membre associé du Processus ibéroaméricain, ce qui contribuera à la visibilité accrue de la santé aux plus hauts niveaux.

c) Le nouveau Plan stratégique 2014-2019 de l'OPS et le PB 2014-2015 ont été élaborés à des niveaux élevés de collaboration et de consultation avec les États Membres. Le Plan et le PB ont tous deux été améliorés sur la base des

enseignements tirés de périodes de planification antérieures et de l'évaluation à mi-parcours du Programme d'action sanitaire pour les Amériques. D'autre part, le Plan stratégique est étroitement aligné sur le Programme général de travail de l'OMS.

d) En conformité avec les mandats régionaux et mondiaux, le BSP a continué de travailler avec les États Membres sur le renforcement d'une capacité nationale fondamentale pour le Règlement sanitaire international (RSI) et sur la mise en œuvre de la Convention-cadre de l'OMS pour la lutte antitabac.

e) La gouvernance, la transparence et le positionnement de l'OPS ont été renforcés par une participation accrue des États Membres à la préparation et au processus décisionnel pour des documents clés des organes directeurs. Au cours de la période 2008-2013, les organes directeurs de l'OPS ont approuvé des résolutions qui avalisaient 14 documents stratégiques et 35 stratégies et plans d'action sur des questions clés de santé publique ; ils ont également adopté d'autres décisions importantes sur des questions de santé publique. Un total de 36 stratégies de coopération avec les pays (SCP) et quatre stratégies de coopération infrarégionale au total ont été élaborées au cours de la période 2008-2013. En outre, le BSP a appuyé l'élaboration, la mise à jour et la mise en œuvre de politiques, stratégies et plans nationaux en matière de santé, ainsi que de programmes infrarégionaux de santé.

f) Le BSP a travaillé en étroite collaboration avec des homologues nationaux pour établir des mécanismes de coopération fonctionnels, tels que celui pour le VIH/sida, le paludisme et la tuberculose, dans un effort de mobilisation de l'engagement politique et de mobilisation des ressources pour assurer la pérennité des programmes, cultiver des partenariats et engager des intervenants clés.

g) Le BSP, y compris les centres collaborateurs, a mis l'accent sur l'appui aux pays pour promouvoir des actions dans des environnements spécifiques et auprès de populations vulnérables, et pour lancer des initiatives telles que la protection de la santé des travailleurs, la santé environnementale des enfants, la santé des consommateurs, l'élimination du travail des enfants, etc. Ce travail visait à optimiser l'utilisation des ressources au moyen d'actions intégrées par le secteur de la santé.

h) Une mobilisation rapide des ressources pour la santé et les partenariats était essentielle pour un appui immédiat et effectif pour les pays de la Région affectés par des phénomènes naturels, des épidémies et la pandémie de grippe H1N1 en 2009. Le rôle de l'Organisation en tant que chef de file du Groupe de responsabilité sectorielle Santé a été renforcé de par sa contribution au traitement des urgences et sa participation lors d'interventions dans d'autres régions de l'OMS, notamment lors du typhon Haiyan aux Philippines et de la crise humanitaire en Syrie. L'établissement du Centre des opérations d'urgence (EOC) en 2012 a renforcé le rôle de coordination du BSP dans les interventions dans les cas d'urgences et de catastrophes dans la Région et avec l'OMS.

B. Définition du programme de recherche et stimulation de la création, la dissémination et l'application de connaissances précieuses

45. Le BSP a continué de façonner le programme de recherche et de stimuler la création, la dissémination et l'application de précieuses connaissances par le biais d'une recherche opérationnelle, la préparation de rapports et de publications, y compris ce qui suit:

a) De multiple documents ont été élaborés dans plusieurs pays sur les thèmes suivants: *i)* les interventions efficaces par rapport aux coûts pour traiter les maladies non transmissibles, *ii)* les troubles mentaux, *iii)* les traumatismes subis dans des accidents de la route, la violence et le handicap, *iv)* l'analyse économique des maladies non transmissibles. De plus, des études ont également été produites sur l'alcool et les traumatismes dans 5 pays et sur l'alcool et la violence contre les femmes dans 10 pays. Plusieurs études sur la violence et une compilation de l'analyse des études sur la prévalence de l'utilisation de services et les lacunes de traitement pour les troubles mentaux ont également été produites.

b) *Action sanitaire d'urgence suite au tremblement de terre en Haïti—janvier 2010: enseignements à tirer pour la prochaine catastrophe soudaine et massive [Health Response to the Earthquake in Haiti—January 2010: Lessons to be Learned for the Next Massive Sudden-Onset Disaster]*.

c) *Trente années de Bulletin d'immunisation: l'histoire du PEV dans les Amériques*, un recueil de 2500 articles publié dans le *Bulletin d'immunisation* et mettant en valeur les meilleurs pratiques pour accroître la couverture vaccinale.

d) Une étude OMS/OPS sur les pratiques familiales clés pour faciliter la délégation des tâches et la formation d'équipes multisectorielles de fournisseurs de services de santé et de leaders communautaires.

e) *The Health of Indigenous Young People in Latin America: A Panorama*, un rapport régional publié conjointement par l'OPS et la CEPALC avec l'appui de l'AECID.

f) Vingt-six études sur la Santé dans toutes les politiques.

g) Un total de 30 documents ont été produits, y compris des études sur les meilleures pratiques d'intégration des questions de genre et d'ethnicité, des feuillets d'information sur l'égalité des sexes au regard de la santé et des études spécifiques sur l'égalité des sexes au regard de la santé.

h) Une étude sur un système d'information périnatale basé sur l'espacement des naissances, réalisée en Argentine (CREP/CLAP) (en voie d'impression).

i) Une étude effectuée dans 10 pays sur le Réseau de surveillance sentinelle pour évaluer l'élimination de la syphilis congénitale.

j) La trousse des hôpitaux intelligents (*Smart Hospital Toolkit*), développée pour guider la mise en œuvre des mesures d'atténuation du changement climatique dans

les établissements de santé existants, avec une analyse coûts-avantages d'une « adaptation des hôpitaux au changement climatique » qui montre la rentabilité d'instituer des mesures écologiques et de résistance aux catastrophes dans les hôpitaux.

k) Le BSP a également fourni aux pays la coopération technique nécessaire pour renforcer les capacités dans la recherche opérationnelle aux fins de créer de nouvelles connaissances relativement à des stratégies et interventions effectives pour la détection, le contrôle et l'élimination des maladies prioritaires. Une recherche a, en particulier, été effectuée dans divers domaines techniques, qui a mené à l'organisation d'interventions pour le contrôle des triatomines domiciliaires et non domiciliaires, l'appui aux programmes nationaux de TB et la normalisation de la réaction en chaîne de la polymérase comme biomarqueur de la maladie de Chagas.

C. Établissement de normes et principes et promotion du suivi de leur mise en œuvre

46. Le BSP a continué d'être à la pointe de l'élaboration de normes et standards et de promouvoir et vérifier leur mise en œuvre. Quelques exemples incluent:

a) des manuels pour appuyer la mise en œuvre des réseaux intégrés de services de santé, qui mettent l'accent sur la revitalisation de la coopération technique avec les hôpitaux dans le cadre des réseaux intégrés de services de santé au niveau mondial, régional et des pays.

b) l'élaboration d'un outil de calcul des coûts, d'un guide pratique et de lignes directrices de laboratoire pour la mise en œuvre du Plan d'action pour l'élimination de la transmission mère-enfant du VIH et de la syphilis congénitale.

c) un appui à l'élaboration de lignes directrices pour la survie et les soins en période néonatale et à leur mise en œuvre, ainsi que de manuels sur le contrôle des infections dans les services de santé.

d) des plans nationaux et des procédures opérationnelles standards de préparation pour les équipes de réponse rapide pour faciliter leur préparation à d'éventuelles flambées.

e) des plans de salubrité de l'eau, des lignes directrices de l'OMS relatives à l'eau potable et des lignes directrices de l'OMS relatives à la qualité de l'air.

f) des outils et des documents d'orientation pour l'incorporation de l'égalité des sexes dans les analyses, la programmation, le suivi ou la recherche en matière de santé.

g) des lignes directrices pour la détection, le traitement et la prévention des maladies non transmissibles (NCD) et les maladies transmises par vecteur en combinaison avec des possibilités de renforcement des capacités.

h) l'élaboration et la mise en place de l'Index de sécurité des hôpitaux dans tous les pays de la Région et dans d'autres régions de l'OMS.

D. Définition d'options stratégiques éthiques et fondées sur des données probantes

47. Le BSP a continué de promouvoir l'élaboration et la mise en œuvre de politiques éthiques et fondées sur des données probantes, notamment :

a) prestation d'une coopération technique aux États Membres pour renforcer les politiques, les systèmes de santé et les soins de santé primaires en vue d'améliorer la santé tout au long de la vie, y compris la santé sexuelle et génésique, la grossesse, l'accouchement, la période néonatale, l'enfance et l'adolescence, et le vieillissement.

b) collaboration avec la Commission interaméricaine des droits de l'homme et le Rapporteur spécial des Nations Unies sur le droit à la santé. Un examen de la législation de 11 pays a été opéré dans une perspective des droits de la personne.

c) promotion des politiques et actions multisectorielles pour traiter les maladies non transmissibles et leurs facteurs de risque, les déterminants de la santé et la stratégie de Santé dans toutes les politiques.

d) production de documents et d'outils pour appuyer l'élaboration de politiques fondées sur des données probantes dans le domaine de la violence contre les femmes.

e) élaboration d'une nouvelle politique de budget de l'OPS en 2012, en s'appuyant sur les enseignements tirés de la politique précédente pour mieux définir la présence essentielle de l'OPS dans les pays et guider l'allocation des ressources du budget ordinaire aux trois niveaux de l'Organisation (national, infrarégional, régional), avec une concentration marquée sur les pays.

E. Établissement de la coopération technique pour catalyser le changement et renforcer une capacité institutionnelle durable

48. Au cours de la période du Plan stratégique 2008-2013, le BSP a amélioré son efficience et son efficacité dans l'exécution de son mandat en tant qu'organisation souple et en apprentissage constant, qui appuie le renforcement des capacités dans les pays. Quelques exemples sont donnés ci-après:

a) Des progrès ont été réalisés dans des projets à l'échelle de l'Organisation, notamment le Système d'information pour la gestion du Bureau sanitaire panaméricain (PMIS), la gestion fondée sur les résultats (RBM), les Normes comptables internationales du secteur public (IPSAS) et la gestion du risque d'entreprise. Ces initiatives ont augmenté l'efficience et l'efficacité de l'ensemble de l'Organisation, et elles continueront de le faire.

b) Le BSP révise constamment ses processus et explore de nouvelles modalités pour la coopération technique. Par exemple, la nouvelle modalité pour la coopération technique avec les centres collaborateurs de l'OPS/OMS et les institutions

nationales de référence a amélioré la capacité de l'Organisation de répondre à ses États Membres. Il convient de noter également que les efforts continus de l'Organisation d'investir dans l'optimisation de l'usage de ses ressources, y compris l'utilisation de la technologie de l'information comme la téléconférence en ligne via Blackboard Collaborate, un système de téléphonie moderne, et la centralisation de l'infrastructure de l'information, ont aidé à améliorer l'efficience tout en contenant les frais d'exploitation. Des efforts additionnels dans ce domaine incluent la consolidation du domaine de l'OPS et du réseau privé de l'OPS.

c) Le BSP a continué d'appuyer les pays pour l'achat de vaccins pour leur programme de vaccination national par le biais du Fonds renouvelable de l'OPS pour l'achat de vaccins, avec un total de 35 pays participants au Fond à ce jour. En outre, 24 pays et territoires achètent actuellement des fournitures et médicaments essentiels par le biais du Fonds stratégique de l'OPS.

d) Le BSP a fait des avances importantes dans l'intégration de la perspective de genre dans le domaine de la santé. Le BSP a également appuyé une intensification des efforts de renforcement des capacités avec les pays, pleinement intégré dans le campus virtuel avec des cours abrégés dispensés en ligne en mode d'auto-apprentissage ou sous forme de cours particulier dans le domaine de la perspective de genre et de la santé dans un cadre de diversité et des droits de la personne.

e) Diverses initiatives de renforcement des capacités ont été mises en œuvre dans des secteurs publics clés pour renforcer la capacité des professionnels de la santé de traiter des questions de santé publique. Cette activité inclut la gamme de cours offerts par le biais de Campus virtuel de l'OPS pour la santé publique ainsi que de cours et séminaires régionaux, infrarégionaux et nationaux.

f) Le BSP a continué d'appuyer la mise en œuvre de la méthodologie de gestion productive pour les services de santé, tel que demandé par les États Membres. D'autre part, plus de 200 gestionnaires de services de santé ont été formés à cette méthodologie.

F. Suivi de la situation sanitaire et évaluation des tendances en santé

49. Le BSP a continué de travailler sur le suivi de la situation de la santé et l'évaluation des tendances en santé. Ce travail a été accompli dans le cadre de programmes continus et d'initiatives spécifiques comme décrit ci-après.

a) La plateforme d'information régionale de l'OPS a été installée, et des publications annuelles des indicateurs de base de l'OPS et les indicateurs de base de 2011 sur les maladies non transmissibles ont été produites.

b) La plateforme régionale d'accès et d'innovation pour la santé a été développée comme un instrument régional pour appuyer la mise en œuvre de la Stratégie mondiale sur la santé publique, l'innovation et la propriété intellectuelle.

c) Un appui continu été fourni pour améliorer les systèmes nationaux de surveillance, améliorer la capacité de réponse et faire rapport sur les indicateurs liés à la surveillance tant pour les maladies transmissibles que les maladies non transmissibles. Une coopération technique également été fournie aux pays pour le développement et le renforcement de systèmes de surveillance pour les facteurs de risque et la résistance antimicrobienne.

d) Un appui continu a été fourni aux pays pour continuer le renforcement des systèmes d'information sur la santé, avec des améliorations spécifiques de la qualité des données et de la ventilation par sexe et âge.

e) Le BSP a appuyé les États parties au Règlement sanitaire international dans l'établissement, le renforcement et le maintien d'une capacité de surveillance et de réponse dans le cadre de leur engagement aux termes du RSI.

f) Toutes les demandes reçues par les États Membres dans le cadre d'urgences ou d'épidémies ont été évaluées et ont reçu une réponse dans un délai de 24 heures, conformément au RSI, y compris le déploiement opportun d'experts du Réseau mondial d'alerte et de réponse en cas d'épidémie, ainsi que les membres d'équipes régionales et de pays. Des mesures d'intervention ont traité les flambées de dengue, de chikungunya, de peste, de choléra, d'infections nosocomiales néonatales et d'autres maladies infectieuses.

g) Le BSP a répondu à 100 % de tous événements de santé publique de préoccupation internationale, qui ont été vérifiés dans les 48 heures de leur détection par le biais d'une collaboration pluridisciplinaire entre les pays, le siège de l'OPS et les bureaux de pays de l'OPS. De janvier 2008 à décembre 2013, 932 événements ont été évalués, 325 d'entre eux ont requis une vérification par les États Membres.

h) Le BSP a appuyé l'évaluation à mi-parcours du Programme d'action sanitaire pour les Amériques.

Des défis pour le BSP

50. Quelques-uns des principaux défis sont mis en évidence ci-après. Les rapports respectifs sur les objectifs stratégiques (OS), qui se trouvent à l'Annexe A, incluent des détails sur les défis spécifiques qui se présentent dans les différents secteurs techniques et fonctions habilitantes.

a) Le BSP doit continuer à améliorer et à promouvoir des modèles de réussite pour une approche intégrée de la coopération technique afin de maximiser son impact sur la santé publique. Il est nécessaire de continuer à promouvoir et à exécuter le travail programmatique et d'explorer de nouvelles modalités de coopération technique pour élargir la portée de la coopération technique de l'OPS et assurer que l'Organisation reste en mesure de répondre aux priorités des États Membres.

b) Alors que des progrès importants ont été réalisés dans la mise en œuvre de la gestion fondée sur les résultats, il est nécessaire de traiter les questions clés

suivantes pour pleinement consolider cette gestion à tous les niveaux de l'Organisation: *i)* poursuite du renforcement des mécanismes de responsabilisation et d'évaluation indépendante, *ii)* amélioration de la documentation systématique et de l'application des leçons apprises, *iii)* renforcement du suivi et de l'évaluation conjoints des résultats par le BSP et les États Membres afin de mieux évaluer et documenter le progrès accompli en vue de réalisations au niveau de l'impact et des résultats.

c) L'absence d'un système d'information de gestion intégré au BSP compromet la capacité de continuer à améliorer l'efficience et à obtenir des informations de qualité et en temps opportun pour la gestion et la prise de décisions.

d) Veiller à la présence essentielle des pays dans un environnement de ressources en baisse et de charges d'exploitation à la hausse, y compris des ressources humaines appropriées pour réaliser des programmes de coopération technique dans le cadre de la SCP en dépit des dispositions de la politique de budget régional de 2012.

e) L'absence d'une stratégie de mobilisation générale intégrée des ressources et l'engagement limité de partenaires non traditionnels, y compris le secteur privé, sont des domaines qui exigent un examen plus approfondi afin d'assurer le positionnement stratégique de l'Organisation et son financement sain.

f) L'impact de la crise financière et le nombre croissant d'acteurs dans le domaine de la santé publique a mené à des difficultés dans la mobilisation des ressources pour appuyer les priorités du Plan stratégique. De plus, une tendance à la baisse dans l'allocation des contributions volontaires à la Région des Amériques a été observée au cours de la mise en œuvre du Plan.

g) Alors que certains partenaires ont reconnu la valeur d'une approche de programme pour les contributions volontaires, le BSP fait face à des défis constants concernant les fonds à objet déterminé. Il est important de continuer à renforcer l'approche de programme dans les négociations pour les contributions volontaires tout en continuant à concilier les divers intérêts entre les partenaires par le biais des priorités collectives qui ont été précisées dans le Plan stratégique.

V. PERFORMANCE PROGRAMMATIQUE

51. Cette section présente une analyse générale du statut des 16 OS, 90 RER et 256 cibles d'indicateurs de RER du Plan stratégique dans son ensemble. On trouvera plus de rapports d'étape détaillés pour tous les objectifs stratégiques (OS), leurs résultats escomptés au niveau régional (RER) et leurs indicateurs de RER respectifs à l'annexe A.

Évaluation des objectifs stratégiques (OS)

52. À la fin de la mise en œuvre du Plan stratégique 2008-2013, sept des OS avaient été pleinement atteints et neuf avaient été partiellement atteints. Il convient de noter que huit des OS qui avaient été partiellement atteints l'avait été dans dans une proportion de plus de 75 % de leurs cibles d'indicateurs (le niveau de performance acceptable établi dans le Plan stratégique 2008-2013) et une proportion de moins de 75 % a été constatée dans un cas seulement. L'évaluation des RER et des indicateurs de RER montre un progrès général constant en vue de l'atteinte des cibles qui avaient été fixées pour chaque OS au cours de la période de six ans du Plan. Le tableau 1 présente un résumé de l'évaluation des OS, y compris les RER et les indicateurs de RER atteints à la fin de 2013. L'annexe B fournit des détails sur les indicateurs de RER qui n'ont pas été atteints.

Tableau 1 : aperçu de l'évaluation des objectifs stratégiques, 2008-2013

Objectifs stratégiques	Statut de l'OS	Statut des RER	Statut des cibles des indicateurs de RER
OS1: Maladies transmissibles	73 % des cibles d'indicateurs atteintes	6 sur 9 pleinement atteints et 3 partiellement atteints	16 sur 22 atteintes et 6 non atteintes
OS2: VIH/sida, TB, paludisme	83 % des cibles d'indicateurs atteintes	5 sur 6 pleinement atteints et 1 partiellement atteint	20 sur 24 atteintes et 4 non atteintes
OS3: Maladies chroniques non transmissibles	96 % des cibles d'indicateurs atteintes	5 sur 6 pleinement atteints et 1 partiellement atteint	26 sur 27 atteintes et 1 non atteinte
OS4: Santé de la mère, de l'enfant, de l'adolescent et de la personne âgée	100 % des cibles d'indicateurs atteintes	8 sur 8 pleinement atteints	15 sur 15 atteintes
OS5: Urgences et catastrophes	100 % des cibles d'indicateurs atteintes	7 sur 7 pleinement atteints	17 sur 17 atteintes
OS6: Promotion de la santé et facteurs de risque	79 % des cibles d'indicateurs atteintes	3 sur 6 pleinement atteints et 3 partiellement atteints	11 sur 14 atteintes et 3 non atteintes
OS7: Déterminants sociaux et économiques de la santé	100 % des cibles d'indicateurs atteintes	6 sur 6 pleinement atteints	12 sur 12 atteintes
OS8: Environnement plus sain	100 % des cibles d'indicateurs atteintes	6 sur 6 pleinement atteints	13 sur 13 atteintes
OS9: Nutrition, sécurité sanitaire des aliments et sécurité des	93 % des cibles d'indicateurs	5 sur 6 pleinement atteints et 1	13 sur 14 atteintes et 1 non atteinte

Objectifs stratégiques	Statut de l'OS	Statut des RER	Statut des cibles des indicateurs de RER
approvisionnements alimentaires	atteintes	partiellement atteint	
OS10: Services de santé	86 % des cibles d'indicateurs atteintes	2 sur 3 pleinement atteints et 1 partiellement atteint	6 sur 7 atteintes et 1 non atteinte
OS11: Leadership et gouvernance dans les systèmes de santé	79 % des cibles d'indicateurs atteintes	2 sur 5 pleinement atteints et 3 partiellement atteints	11 sur 14 atteintes et 3 non atteintes
OS12: Produits et technologies médicaux	89 % des cibles d'indicateurs atteintes	2 sur 3 pleinement atteints et 1 partiellement atteint	8 sur 9 atteintes et 1 non atteinte
OS13: Ressources humaines pour la santé	92 % des cibles d'indicateurs atteintes	4 sur 5 pleinement atteints et 1 partiellement atteint	12 sur 13 atteintes et 1 non atteinte
OS14: Protection sociale et financement	100 % des cibles d'indicateurs atteintes	5 sur 5 pleinement atteints.	10 sur 10 atteintes
OS15: Leadership et gouvernance de l'OPS/OMS	100 % des cibles d'indicateurs atteintes	3 out of 3 pleinement atteints	15 sur 15 atteintes
OS16: Organisation souple et en apprentissage constant	100 % des cibles d'indicateurs atteintes	6 sur 6 pleinement atteints	29 sur 30 atteintes; 1 non applicable.
Résumé OS de l'OPS	7 pleinement atteints et 9 partiellement atteint (8 avec > 75 % cibles atteintes)	75 RER (83 %) pleinement atteints et 15 partiellement atteints	233 (91 %) indicateurs de RER atteints, 22 non atteints et 1 non applicable à la fin de 2013.

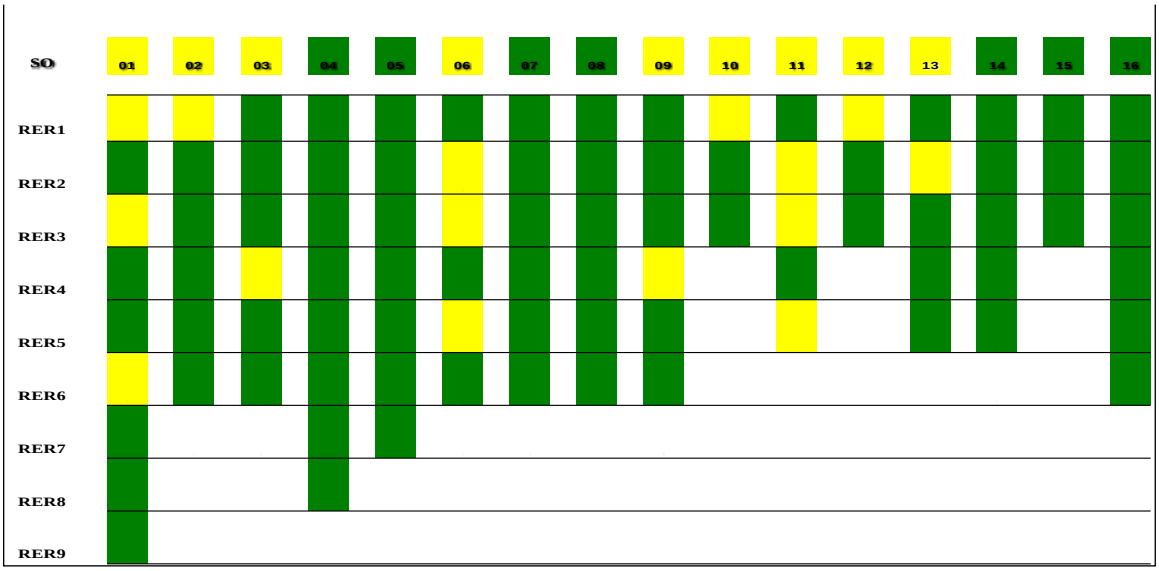
Pleinement atteint

Partiellement atteint

Évaluation des résultats escomptés au niveau régional (RER)

53. Tel que noté au Tableau 1, 75 (83 %) des 90 RER ont été pleinement atteints (vert) et 15 ont été partiellement atteints. La Figure 1 montre l'indice de couleur pour chaque RER, et le Tableau 2 montre les 15 RER qui ont été partiellement atteints.

Figure 1 : progrès réalisés en vue de l'atteinte des OS et des RER, 2008-2013



SO1: Maladies transmissibles
SO2: VIH/sida, TB, paludisme
SO3: Maladies chroniques non transmissibles
SO4: Santé de la mère, de l'enfant, de l'adolescent et de la personne âgée
SO5: Urgences et catastrophes
SO6: Promotion de la santé et facteurs de risque
SO7: Déterminants sociaux et économiques de la santé
SO8: Environnement plus sain
SO9: Nutrition, sécurité sanitaire des aliments et des approvisionnements alimentaires
SO10: Services de santé
SO11: Leadership et gouvernance dans les systèmes de santé
SO12: Produits et technologies médicaux
SO13: Ressources humaines pour la santé
SO14: Protection sociale et financement
SO15: Leadership et gouvernance de l'OPS/OMS
SO16: Organisation souple et en apprentissage constant

54. Comme le montre le tableau, la plupart des RER partiellement atteints ont trait aux politiques, plans et interventions pour intensifier et soutenir les réalisations. Ils requièrent un engagement politique continu de la part des États Membres, ainsi que des activités de plaidoyer de la part du BSP, pour mettre en valeur leur priorité au sein du programme national. Quelques-uns de ces RER incluent également de nouveaux engagements qui requièrent des efforts additionnels et des ressources de l'intérieur et au-delà du secteur de la santé (par exemple, des politiques publiques et des actions multisectorielles pour traiter les NCD et leurs facteurs de risque, les déterminants de la santé et le RSI, ainsi que des services de santé améliorés pour les groupes vulnérables). Une attention continue doit être portée à ces thèmes durant la mise en œuvre du nouveau Plan stratégique de l'OPS afin de traiter les défis sous-jacents qui freinent le progrès.

Tableau 2 : Résultats escomptés au niveau régional partiellement atteints, 2012-2013

Objectif stratégique	RER No.	RER
OS1: Maladies transmissibles	1.1	Accès équitable aux vaccins: défis à relever pour atteindre une couverture de 95 % au niveau infranational.
	1.3	Prévention, lutte et élimination des maladies négligées et des maladies transmissibles: cibles liées à la lèpre, à l'élimination de la rage humaine transmise par les chiens, au suivi de l'état de préparation pour les maladies zoonotiques émergentes et à l'index d'infestation domiciliaire n'ont pas été atteintes.
	1.6	Règlement sanitaire international (RSI) et alerte et riposte à l'épidémie: 6 pays ont répondu aux exigences et 29 ont demandé une extension.
OS2: VIS/sida, TB et paludisme	2.1	Prévention, traitement et soins pour VIH/sida et TB: la couverture TAR pour le VIH n'a pas été atteinte; difficultés relatives au succès du traitement TB et peu de soins prénatals et systèmes de surveillance pour la syphilis congénitale.
OS3: Maladies chroniques non transmissibles	3.4	Interventions pour des conditions chroniques non transmissibles: les cibles pour analyse des coûts et études sur la violence n'ont pas été atteintes.
OS6: Promotion de la santé et facteurs de risque	6.2	Surveillance des plus importants facteurs de risque: 27 pays sur 30 ont élaboré des systèmes nationaux de surveillance en utilisant l'Enquête mondiale réalisée en milieu scolaire sur la santé des élèves pour produire des rapports systématiques sur les facteurs de risque pour la santé qui affectent les jeunes.
	6.3	Prévention et réduction du tabagisme: 19 pays cibles sur 23 ont mis en œuvre des règlements sur l'emballage des produits du tabac et mis à jour au moins une composante de leur système de surveillance du tabagisme; 5 autres pays (sur 35) doivent atteindre la cible.
	6.5	Prévention et réduction des mauvaises habitudes alimentaires et de l'absence d'activité physique: des difficultés se sont présentées pour faire avancer des politiques nationales pour promouvoir des bonnes habitudes alimentaires et l'activité physique (seulement 9 pays sur 20 ont atteint cet indicateur).
OS9: Nutrition, sécurité sanitaire des aliments et des approvisionnements alimentaires	9.4	Plans et programmes de nutrition: 21 pays cibles sur 25 ont signalé des interventions en nutrition dans leurs programmes pour répondre au VIH/sida et à d'autres épidémies.
OS10: Services de santé	10.1	Politiques de santé interculturelles: seuls 5 pays ont signalé des progrès dans l'intégration de considérations interculturelles dans des politiques et des systèmes de santé basés sur les SSP.

Objectif stratégique	RER No.	RER
OS11: Systèmes de santé, leadership et gouvernance	11.2	Systèmes d'information en santé: 20 pays cibles sur 27 ont mis en œuvre l'initiative de l'OPS sur les données de base en santé.
	11.3	Accès, dissémination et utilisation de l'information, des connaissances et des preuves scientifiques sur la santé pour la prise de décision: le nombre cible de pays assurant le suivi des OMD relatifs à la santé n'a pas été atteint.
	11.5	OPS comme agent transmetteur de l'information et de la connaissance sur la santé publique: la plateforme d'information régionale est installée mais en attente de révision et d'ajustement pour la mise en œuvre, la coordination générale et le déploiement de la phase II.
OS12: Produits et technologies médicaux	12.1	Accès aux produits médicaux et technologies de la santé: cible irréaliste (17) fixée pour le nombre de pays qui devaient atteindre 100 % de dons du sang bénévoles non rémunérés; atteinte 12 sur 17.
OS13: Ressources humaines pour la santé	13.2	Indicateurs de base et système d'information pour les ressources humaines pour la santé: le nombre escompté de pays participant au Réseau des observatoires des ressources humaines pour la santé n'a pas été atteint (29 sur 36).

Note: Les titres de RER ont été abrégés par souci de commodité.

Statut des indicateurs de RER

55. L'évaluation des cibles d'indicateurs de RER montre qu'à la fin du Plan stratégique 2008-2013, 91 % des cibles d'indicateurs (233 sur 256) avaient été atteintes, 22 n'avaient pas été atteintes et une n'était pas applicable à la fin du Plan stratégique 2008-2013 (voir Figure 2). Il est important de noter que des 233 indicateurs qui ont été atteints, 54 % (127 indicateurs) dépassaient les cibles de 2013. Il convient également de noter que des progrès considérables ont été accomplis sur les 22 indicateurs qui n'ont pas été atteints (la méthodologie utilisée ici ne considère que ceux qui ont pleinement rencontré leur cible comme l'ayant atteinte; il n'est pas tenu compte des atteintes partielles). Les détails sur chaque indicateur de RER sont fournis dans les rapports d'OS de l'annexe A, y compris la liste des pays qui avaient atteint leurs cibles à la fin de 2013. Un résumé des indicateurs de RER qui n'avaient pas atteint leurs cibles pour 2013 est fourni à l'annexe B. Les principaux problèmes relatifs à la non atteinte des indicateurs incluaient :

a) la qualité de l'indicateur et les limitations concernant la disponibilité d'une information fiable permettant de mesurer le progrès de façon appropriée ;

b) des cibles irréalistes pour la période de planification, sans égard pour les situations particulières dans les pays et les défis auxquels ils font face dans des domaines qui requièrent une action multisectorielle.

56. L'atteinte des cibles d'indicateurs de RER reflète le travail des pays et territoires avec l'appui du BSP et des partenaires qui ont collaboré à la mise en œuvre du Plan au niveau national, infrarégional et régional. Étant donné que plus de 70 % des indicateurs de RER mesurent le progrès accompli dans les pays et territoires, la plupart des résultats du Plan n'auraient pas pu être obtenus sans l'engagement des pays et territoires.

57. Tel que montré dans la figure 2 et au tableau 3, l'Organisation a maintenu une performance programmatique relativement constante au cours des trois exercices biennaux de la mise en œuvre du Plan. Il convient de noter que le Plan a été modifié en 2009 pour améliorer la qualité des indicateurs. Ce changement a mené à une réduction des indicateurs de RER de 324 approuvés dans la version originale du Plan à 256 pour les deux derniers exercices biennaux. Il a également contribué à une mesure améliorée des indicateurs de RER dans les exercices biennaux 2010-2011 et 2012-2013.

Figure 2 : atteinte des cibles d'indicateurs de RER, 2008-2013

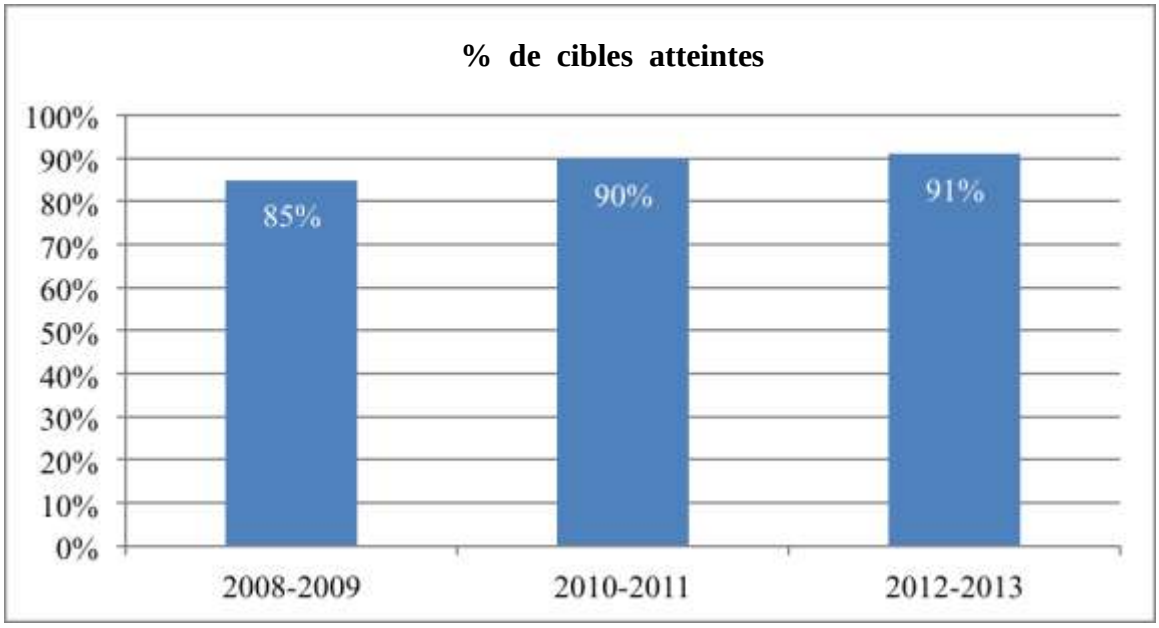


Tableau 3 : évaluation des cibles d'indicateurs de RER par exercice biennal, 2008-2013

Exercice biennal	Nombre total d'indicateurs	Atteint	Non atteint	Sans objet
2008-2009	324	275	43	6
2010-2011	256	231	25	0
2012-2013	256	233	22	1

VI. BUDGET ET MOBILISATION DES RESSOURCES

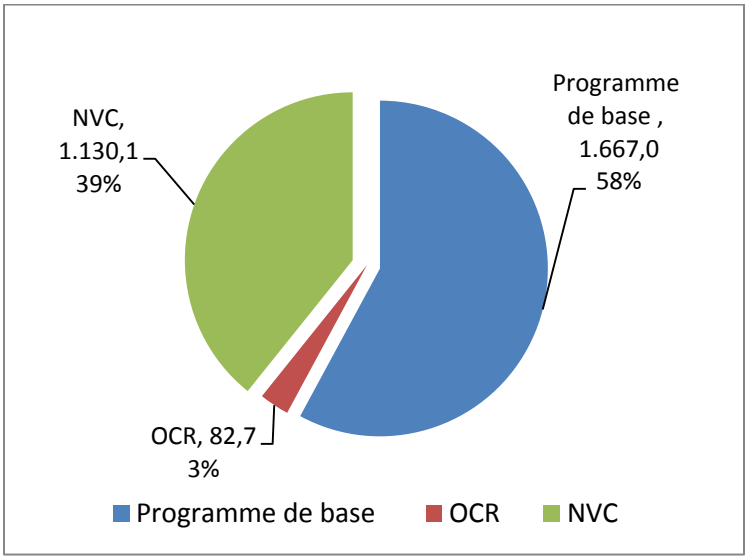
58. Cette section présente une analyse du budget approuvé et des ressources disponibles pendant la totalité de la période du Plan stratégique 2008-2013. Un résumé de l'analyse du Programme et budget pour 2012-2013 est fourni à l'annexe C.

Aperçu du budget: 2008-2013

59. Au cours de la période du Plan stratégique, le budget général approuvé de $2,3 milliards a été alloué à ses trois Programmes et budgets: programmes de base ($1,8 milliard), réponse aux flambées épidémiologiques et aux crises (OCR) ($44 millions), contributions volontaires nationales (NVC)[4] ($372,5 millions). Veuillez noter que la réponse aux flambées épidémiologiques et aux crises n'a pas été budgétées en 2008-2009 et n'a été reflétée qu'à partir du Programme et budget 2010-2011.

60. Les fonds disponibles pour les trois exercices biennaux couverts par le Plan stratégique 2008-2013 se montaient à $2,9 milliards distribués comme suit: programmes de base: $1,6 milliard, OCR: $82,7 millions, NVC $1,1 milliard. La figure 3 montre le pourcentage et la distribution du financement de chaque segment au cours de la période du Plan.

Figure 3 : financement total du Programme et budget par segment, 2008-2013 (millions de US$)



61. Le financement disponible pour les trois exercices biennaux était plus élevé que le budget approuvé dans les trois PB pour la mise en œuvre du Plan stratégique 2008-2013

[4] Les contributions volontaires nationales (NVC) ont été formellement identifiées comme des « projets internes financés par le gouvernement ».

pour la raison expliquée ci-dessus et parce que le volume des ressources mobilisées pour la réponse aux flambées épidémiologiques et aux crises était deux fois le niveau approuvé lors de l'exercice biennal 2010-2011, en grande partie en raison de l'échelle et du volume des ressources reçues pour la réponse en cas de catastrophe à la suite du séisme en Haïti.

62. L'exécution générale du budget pour tous les fonds disponibles était de 87 % ($2,5 milliards sur un total de $2.9 milliards). L'exécution par segment se présentait comme suit:

- 93 % pour les programmes de base ($1,5 milliard sur un total de $1,6 milliard);
- 97 % pour la réponse aux flambées épidémiologiques et aux crises ($80 millions sur un total de $82,7 millions);
- 63 % pour les contributions volontaires nationales (NVC) ($715 millions sur un total de $1,1 milliard). Le taux de mise en œuvre des NVC a été affecté par le volume élevé de fonds reçus vers la fin de l'exercice biennal 2012-2013 pour le projet de ressources humaines pour la santé de « Mais Médicos » au Brésil.

63. L'analyse de chaque segment de budget est présentée dans les sections suivantes.

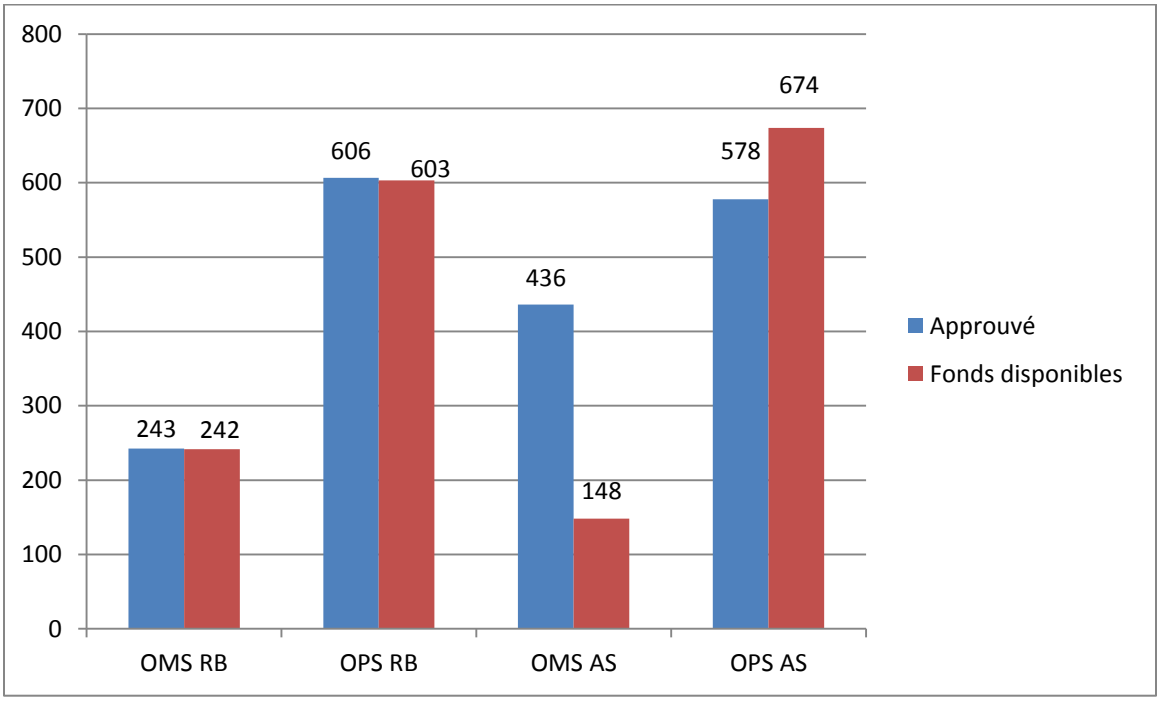
Segment des programmes de base

64. Le budget approuvé pour ce segment était de $1,8 milliard. Il y avait des fluctuations dans les programmes de base approuvés d'exercices biennaux en exercices biennaux, avec une augmentation de $626 millions en 2008-2009 à $642,9 millions en 2010-2011 et une baisse subséquente de $29,5 millions à $613,4 millions au cours de l'exercice biennal 2012-2013.

65. Le budget ordinaire approuvé était de $851 millions et le montant approuvé d'autres sources était de $1,013 million sur une période de six ans. La ventilation entre l'OPS et l'OMS est expliquée en détail dans la figure 4.

66. Comme le montre également la figure 4, la somme de $1,670 milliard était disponible pour la mise en œuvre du Plan stratégique, ce qui représentait 88 % du Programme et budget approuvé pour 2008-2013. Tout comme pour le Programme et budget approuvé pour les programmes de base, il y avait des fluctuations dans les fonds disponibles d'exercices biennaux en exercices biennaux, avec une augmentation de $559 millions en 2008-2009 à $583 millions en 2010-2011 mais une baisse générale (6 %) dans les fonds disponibles pour les programmes de base de 2008 ($559 millions) à 2013 ($525 millions).

Figure 4: aperçu du budget par source, 2008-2013 (millions de US$)



67. Le budget ordinaire constituait un peu plus de la moitié des fonds disponibles (51 % ou $844,8 millions) pour le Plan stratégique. Le budget ordinaire financé par l'OPS était de $603,1 millions et $241,7 millions sont venus de l'allocation de l'OMS au Bureau régional pour les Amériques (AMRO). De plus, les contributions volontaires totalisaient $822 millions, ou 49,3 % des fonds totaux disponibles. Plus spécifiquement, les contributions volontaires de l'OPS ont contribué 40 % des fonds disponibles ($673,7 millions) et les contributions volontaires de l'OMS couvraient les 9 % restants des fonds disponibles ($148,3 millions).

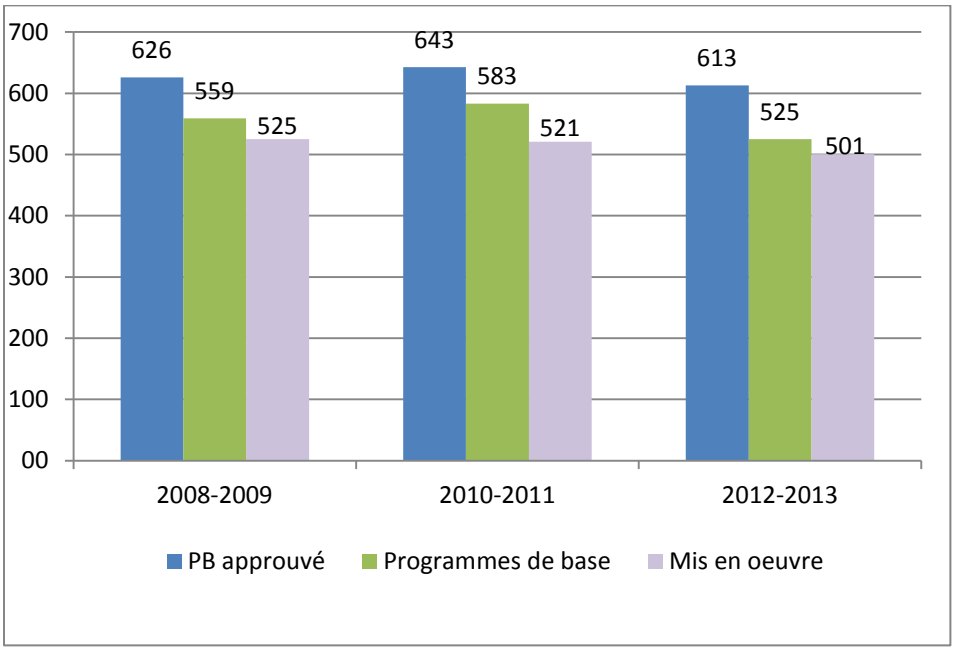
68. Tel qu'indiqué au tableau 4, la distribution des fonds était conforme à la Politique régionale du Programme et budget, avec une légère réduction étant appliquée au niveau infrarégional et régional. Cette réduction était due à une importance accrue de la focalisation sur le pays. Il convient de noter que la distribution des fonds disponibles par niveau organisationnel (en tant que pourcentage des fonds totaux disponibles pour l'exercice biennal) était conforme à la Politique régionale du Programme et budget.[5] Alors que cette politique ne s'applique qu'aux fonds du RB, elle a également guidé l'allocation des fonds des OS.

[5] Au cours de la période, la politique régionale du Budget Programme exigeait la migration suivante des allocations dans différents segments: niveau national, 40 %, niveau infrarégional, de 5 % à 7 %, niveau régional, de 55 % à 53 %.

Tableau 4 : aperçu du budget par niveau fonctionnel, 2008-2013 (millions de US$)

Niveau fonctionnel	Programme et budget approuvé	Fonds disponibles 2008-2013	Exécution	Fonds disponibles (comme % du PB)	Fonds disponibles (comme % des fonds totaux	Taux d'exécution (%)
National	728	761	693	105 %	46 %	91 %
Infrarégional	131	82	77	63 %	5 %	93 %
Régional	1 023	824	776	80 %	49 %	94 %
Total	**1 882**	**1 667**	**1 547**	**89 %**	**100 %**	**93 %**

Figure 5 : aperçu du budget : approuvé, financé et exécuté, 2008-2013 (millions de US$)



69. L'exécution totale du budget des programmes de base était de $1,5 milliard (93 % des 1,6 milliard disponibles pour le Plan stratégique). Les taux d'exécution ont été affectés par la réception tardive de fonds, en particulier des fonds reçus presque à la fin de l'exercice biennal. La figure 5 montre les fonds disponibles par exercice biennal comparé avec le PB approuvé et leur mise en œuvre.

Mobilisation des ressources

70. Au cours de la période de six ans du Plan stratégique de l'Organisation, les programmes et budgets biennaux ont varié pour refléter les ressources anticipées nécessaires pour obtenir les résultats planifiés. Alors que le financement du budget ordinaire pour ces programmes et budgets est demeuré relativement stable, il y a eu une

fluctuation dans les contributions volontaires reçues pour la mise en œuvre du programme dans son ensemble. De plus, la capacité de l'Organisation à combler le déficit de financement a reflété des défis importants dans la période finale de deux ans, alors que le déficit augmentait de 46 % en 2012-2013 par rapport à 2010-2011 (tableau 5).

Tableau 5 : état du déficit de financement par exercice biennal, 2008-2013 (en millions de US$)

Type de financement	PB 2008-2009		PB 2010-2011		PB 2012-2013	
	Début de l'exercice biennal	Fin de l'exercice biennal	Début de l'exercice biennal	Fin de l'exercice biennal	Début de l'exercice biennal	Fin de l'exercice biennal
Programme et budget approuvé	626,1	626,1	643,0	643,0	613,1	613,1
Budget ordinaire	279,1	278,1	287,1	286,7	285,1	279,6
Ressources mobilisées	0	280,7	0,0	295,9	0	245,1
Déficit de financement	347,0	66,3	355,9	59,9	328,3	88,0

71. L'augmentation du déficit de financement peut être attribué aux facteurs suivants :

a) Un déplacement du focus géographique et thématique de la part des partenaires de l'Organisation de coopération et de développement économiques (OCDE). Ce changement était particulièrement marqué dans les pays nordiques.

b) L'impact de la crise financière internationale sur le financement disponible de l'aide au développement. Cet impact était particulièrement marqué en Espagne, comme on peut le voir au tableau 6.

c) L'impact des réformes de l'OMS et les nouvelles relations d'engagement avec les partenaires au développement. Il y a eu une tendance accrue pour que les fonds qui avaient été précédemment négociés directement avec l'OPS soient acheminés par l'entremise de l'OMS, par exemple des fonds de la Gates Foundation et des pays nordiques.

d) Les efforts déployés par les partenaires au développement pour consolider la collaboration avec l'OPS, avec des partenaires passant de l'appui à plusieurs projets à une approche programmatique plus exhaustive. Alors que cette situation a fourni un meilleur alignement sur le Plan stratégique de l'Organisation, l'appui à certains programme de l'OPS a connu un déclin.

Tableau 6 : dépenses des contributions volontaires nationales par partenaires bilatéraux, 2008-2013 (en millions de US$)

Partenaire bilatéral	2008-2009	2010-2011	2012-2013
Brésil (externe seulement)*	10,3	12,0	9,0
Canada	24,5	35,1	46,1
Espagne	29,6	40,5	20,5
États-Unis	34,8	39,5	40,7
Norvège	2,2	3,14	1,2
Royaume-Uni	1,4	1,3	1,3
Suède	8,2	4,2	2,6
Tous les autres	4,1	6,8	5,3
Total	115,1	142,5	126,7

* Les dépenses reflètent principalement les contributions du gouvernement du Brésil pour appuyer PANAFTOSA et BIREME.

72. Le Plan stratégique 2008-2013 de l'OPS a marqué une ère nouvelle dans laquelle les États Membres ont établi leurs priorités de coopération technique dans le cadre de la gestion fondée sur les résultats, et ce pour la première fois. En ce qui concerne cette nouvelle modalité, lorsque les fonds étaient suffisamment souples pour ajuster le programme de l'Organisation, un effort constant a été fait pour accroître l'appui pour les objectifs stratégiques qui avaient la plus haute priorité. Les cinq priorités principales établies par les États Membres étaient l'OS4 (santé maternelle et infantile), l'OS1 (maladies transmissibles), l'OS2 (VIH/sida, TB et paludisme), l'OS3 (maladies non transmissibles chroniques) et l'OS7 (déterminants sociaux et économiques de la santé). Les contributions volontaires, de leur côté, visaient principalement:

a) L'OS4 (priorité 1): plusieurs des partenaires externes ont dû se conformer à leurs propres mandats institutionnels. Par exemple, le Canada a mis l'accent sur les programmes et projets d'appui qui s'alignaient sur son Initiative de Muskoka, qui met l'accent sur la réduction de la mortalité maternelle.

b) L'OS 7 (priorité 5): un appui a été reçu d'agences des Nations Unies telles que le PNUE, la CEPALC, l'OIT et le PNUD pour organiser des interventions intersectorielles aux niveaux national et régional afin de promouvoir un environnement plus sain et traiter les causes fondamentales des menaces environnementales pour la santé.

c) L'OS 1 (priorité 2): étant donné que ce domaine est une des fonctions traditionnelles de base de la santé publique, des contributions volontaires de l'USAID, des CDC et du Canada ont contribué à cette priorité.

d) L'OS 3 (priorité 4): ce secteur a été inclus avec succès comme une priorité majeure, et le Forum panaméricain d'action pour les maladies non transmissibles a

été créé dans le but d'établir des partenariats et des réseaux, et de mobiliser des ressources pour appuyer la coopération technique de l'OPS.

e) L'OS 2 (priorité 3): un appui a été reçu de plusieurs partenaires externes, y compris l'Union européenne, ONUSIDA et le Fonds mondial.

73. Il convient de reconnaître les contributions volontaires continues et importantes qui ont été reçues au cours de ces années des partenaires au développement suivants:

a) Bilatéral: Canada, par l'entremise du ministère des Affaires étrangères, du Commerce et du Développement (MAECD),[6] Santé Canada et le Centre de recherches pour le développement international (IDRC); Espagne, par l'entremise de l'Agence espagnole de coopération internationale au développement (AECID); États-Unis, par l'entremise des Centers for Disease Control and Prevention (CDC), le Département d'État, la Food and Drug Administration (FDA), ainsi que l'Agence américaine pour le développement international (USAID); la Suède, par l'entremise de l'Agence suédoise de coopération internationale au développement.

b) Multilatéral: la Commission européenne, le Programme des Nations Unies pour le développement et le Programme commun des Nations Unies sur le VIH/sida (ONUSIDA).

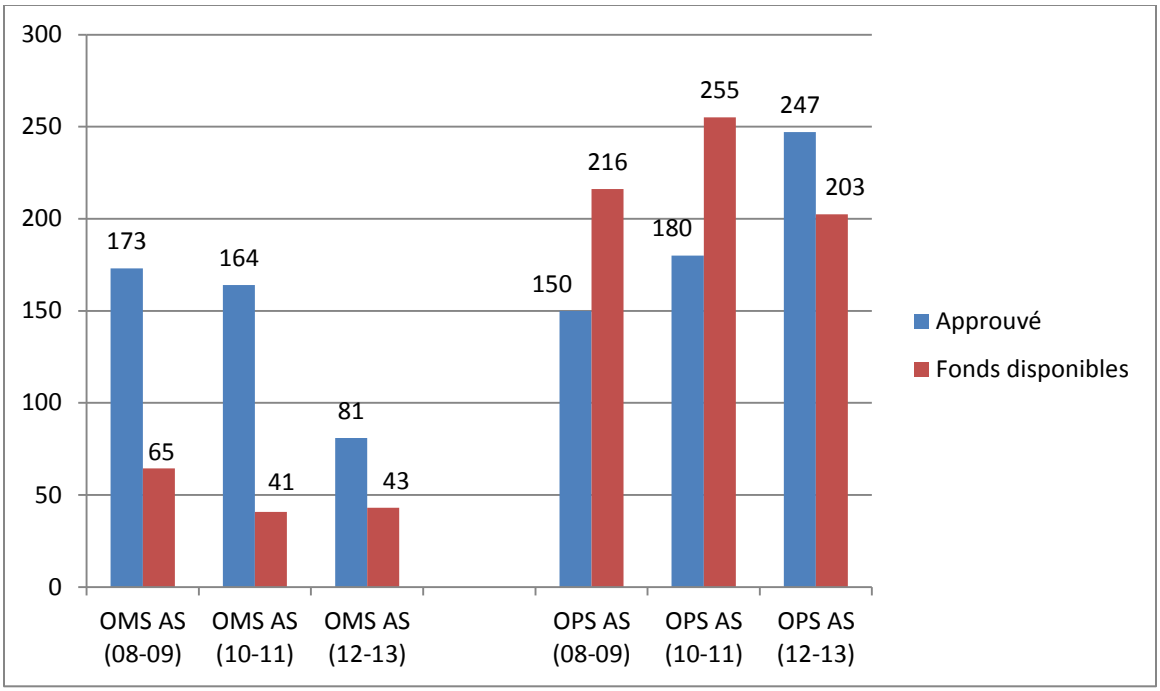
c) Autres: la Fondation panaméricaine pour la Santé et l'Éducation (PAHEF), la Rockefeller Foundation, l'Alliance mondiale pour les vaccins et la vaccination (GAVI), le Sabin Vaccine Institute et la Colgate Palmolive Company.

Financement par source, 2008-2013

74. Le financement par source est décrit à la figure 6. L'OPS continue de mobiliser des ressources à partir d'autres sources pour son Programme et budget. Il y a lieu de noter que les contributions volontaires (à l'exclusion des contributions nationales volontaires) mobilisées par l'OPS ont dépassé son budget approuvé pour ce segment dans l'exercice biennal 2008-2009. Dans les exercices biennaux 2010-2011 et 2012-2013, les fonds n'ont pas dépassé le montant approuvé. Le montant mobilisé en 2010-2011 ($296 millions) était encore 5 % plus élevé que pour l'exercice biennal précédent ($281 millions). En 2012-2013, le montant mobilisé ($246 millions) était 12 % inférieur au montant mobilisé en 2008-2009.

[6] À la suite d'une restructuration du ministère des Affaires étrangères en 2013, l'Agence canadienne de développement international (ACDI) a été intégrée dans le MAECD.

Figure 6 : financement par source : budget approuvé, financé et approuvé, 2008-2013 (en millions de US$)



75. En ce qui concerne les contributions volontaires mobilisées de l'OMS, il y a eu une baisse générale des affectations de 2008-2013 avec la baisse la plus marquée de $65 millions en 2008-2009 à $41 millions en 2010-2011. Dans tous les cas, les allocations des ressources de l'OMS représentaient moins de 53 % du budget approuvé d'autres sources (AS) qui devaient être financées par l'OMS. Cette baisse a eu un impact négatif sur la capacité de l'OPS à financer pleinement le Plan stratégique et elle a contribué au déficit de financement restant à la fin de l'exercice biennal 2012-2013.

Financement par objectif stratégique, 2008-2013

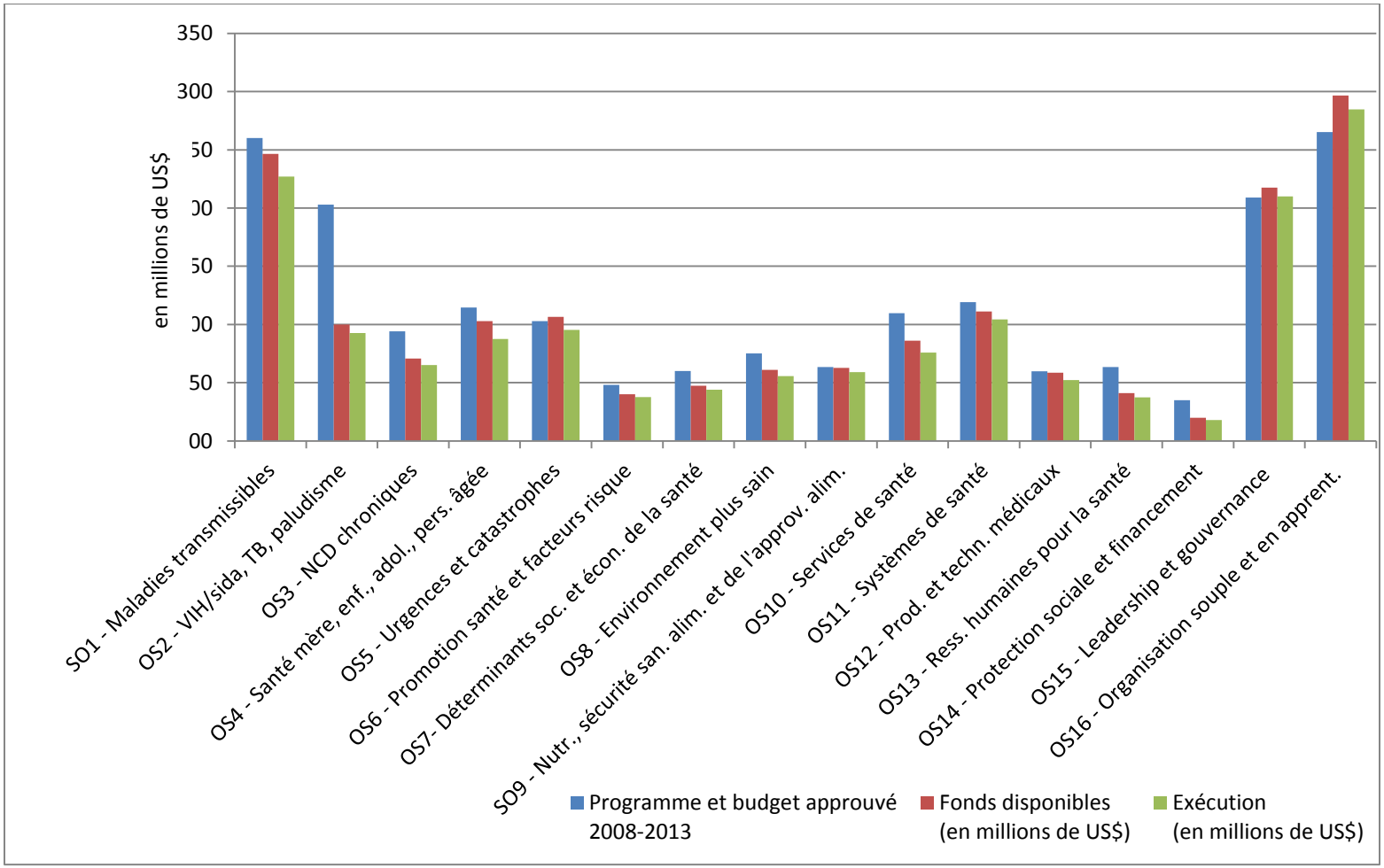
76. La Figure 7 montre le budget par objectif stratégique selon le Programme et budget de base approuvé, les fonds disponibles pour l'exercice biennal et les dépenses.

77. Des 16 OS, 13 ont obtenus plus de 75 % de leur niveau de financement escompté. Sur les 14 OS (OS1-14) de coopération technique essentielle, six avaient un financement de 90 % ou plus de leur budget approuvé. L'OS15 et l'OS16 (fonctions d'habilitation) avaient également un niveau de financement élevé. L'information budgétaire pour chacun des OS est fournie dans les rapports OS qui se trouvent à l'annexe A.

78. Tel que décrit à la figure 7, l'OS2 (VIH/sida, paludisme et TB), l'OS13 (ressources humaines pour la santé) et l'OS14 (financement de la santé et protection sociale) avaient les plus bas niveaux de financement (49 %, 64 % et 54 %, respectivement), par rapport à leurs budgets approuvés. Dans le cas de l'OS2, la

différence était due à la surestimation du budget au cours du processus de planification et au fait qu'une partie des fonds escomptés de certains partenaires ne se sont pas matérialisés. En ce qui concerne l'OS14, il est important de souligner qu'il y a un financement croisé d'activités des OS 11, 12, et 13, parce que ces cinq OS ont en commun un certain nombre d'aspects liés aux systèmes et services de santé. Tous les OS avaient un taux d'exécution budgétaire général de 90 % ou plus, à l'exception de l'OS10 (services de santé), qui avait un taux de 89 %.

Figure 7 : aperçu du budget par objectif stratégique, 2008-2013 (en millions de US$)



Financement par contributions volontaires nationales

79. Au cours de la période 2008-2013, $1,1 milliard en contributions volontaires nationales ont été mises à disposition au titre de ce segment pour la mise en œuvre de programmes nationaux de coopération technique. Les principaux contributeurs aux contributions volontaires nationales au cours de cette période sont indiqués ci-après.

Table 7 : financement des contributions volontaires nationales par pays, 2008-2013

État Membre	Financé (US$)			
	2008-2009	2010-2011	2012-2013	2008-2013
Argentine	2 954 521	5 000 279	5 237 736	13 888 228
Bahamas	15 562			
Bolivie		61 039	52 488	122 078
Brésil	222 912 542	302 601 166	347 366 154	830 834 602
Brésil (Mais Médicos)			183 052 333	183 052 333
Canada		39 255		
Colombie	5 052 717	18 981 509	25 794 202	54 467 960
El Salvador		0	28 244	28 244
Équateur	652 829	538 706	504 424	1 077 412
Guatemala	476 508	35 294	566	48 545
Guyana	16 773			
Honduras		312 596	1 022 616	1 396 351
Mexique	1 859 976	677 910	585 336	1 933 220
Nicaragua				0
Paraguay	48,476			
Pérou	1 211 763	1 307 504	1 384 353	3 355 071
Suriname	63 467	109 980	21 334	219 056
Trinité-et-Tobago			18 688	18 688
Uruguay	12 164		64 138	64 138
Total[7]	**235 277 298**	**329 665 238**	**565 132 612**	**1 130 075 148**

80. Le montant des contributions volontaires nationales a augmenté d'environ 70 % comparé à l'exercice biennal précédent (de $329,6 millions en 2010-2011 à $565,5 millions en 2012-2013). Le Brésil continue d'être le principal utilisateur de cette

[7] Veuillez noter que les chiffres des contributions volontaires nationales dans les exercices biennaux 2008-2009 et 2010-2011 reflètent les ajustements pour report à la fin de l'exercice biennal précédent. D'où le fait que les chiffres précédemment rapportés sont plus élevés que ceux qui figurent ici.

modalité de financement pour la coopération technique, qui représente plus de 90 % des fonds totaux de contributions volontaires nationales.

81. Il est important de noter que les contributions volontaires nationales sont une modalité pour le financement de la coopération technique dans un pays donné en vue d'intensifier les interventions identifiées dans la stratégie de coopération avec les pays (SCP). En tant que telles, les contributions volontaires nationales sont utilisées pour traiter les priorités identifiées dans la SCP du pays concerné et sont mises en œuvre dans le cadre des plans de travail biennaux comme partie du programme général de coopération technique de l'OPS avec et pour chaque pays particulier. Par conséquent, ces fonds contribuent directement à l'atteinte des cibles d'indicateurs de RER dans ces pays. En plus des contributions directes qui permettent de faire avancer les priorités de santé publique dans les pays qui utilisent cette modalité, les fonds ont également facilité l'échange de collaboration entre les pays, permettant ainsi de traiter des questions clés de santé publique que les pays ont en commun (par exemple, l'interruption de la transmission par vecteur de la maladie de Chagas en Amérique du Sud).

Analyse de l'affectation des ressources par rapport à la priorisation des objectifs stratégiques

82. Le Plan stratégique classe les OS par priorité programmatique (à l'exclusion des OS liés aux fonctions habilitantes : les OS15 et OS16) afin de guider la mobilisation et l'affectation des ressources au cours de la mise en œuvre du plan.

83. Le tableau 8 montre les OS classés selon leur priorité programmatique, de 1 (priorité la plus haute) à 14 (priorité la plus basse), tels qu'approuvés dans le Plan stratégique. Il montre également les fonds disponibles pour chaque OS pour les trois exercices biennaux 2008-2009, 2010-2011 et 2012-2013. La différence de pourcentage entre 2008-2009 et 2012-2013 montre un déplacement positif dans l'affectation des ressources dans trois des cinq OS prioritaires: OS4 (santé de la mère, de l'enfant, de l'adolescent et de la personne âgée), OS1 (maladies transmissibles) et OS3 (maladies non transmissibles). Il convient de noter que l'alignement des ressources sur les priorités programmatiques est un processus complexe en raison d'une flexibilité limitée dans l'affectation de la plupart des ressources dont dispose l'Organisation au cours d'un exercice biennal. Par exemple, plus de 70 % des fonds du budget ordinaire sont liés à des postes de durée déterminée (FTP), qui ne peuvent pas facilement transférés ou distribués à d'autres OS, étant donné l'association technique des postes avec leurs OS correspondants. De même, la majorité des contributions volontaires reçues par l'Organisation continuent d'être affectées à des fins particulières, ce qui restreint la capacité d'affecter les ressources conformément au classement prioritaire des OS tel qu'approuvé dans le Plan stratégique. Alors que l'Organisation continue de faire des efforts pour améliorer l'alignement entre les priorités programmatiques et l'affectation des ressources, il s'agit d'un processus progressif qui exigera une attention continue dans les futurs plans et programmes et budgets.

Tableau 8 : classement des priorités programmatiques par rapport à l'affectation des ressources, 2008-2013

Objectif stratégique	Classement des priorités	Fonds disponibles pour l'exercice biennal (en millions de US$)			% Différence :
		2008-2009	2010-2011	2012-2013	2008-2009 à 2012-2013
OS04: Santé de la mère, de l'enfant de l'adolescent et de la personne âgée	1	24,8	40,5	43,5	76 %
OS 01: Maladies transmissibles	2	75,1	90,6	81,6	8 %
OS 02: VIH/sida, TB et paludisme	3	34,9	33,9	30,3	-13 %
OS 03: Maladies chroniques non transmissibles	4	21	23,7	25,6	22 %
OS 07: Déterminants sociaux et économiques de la santé	5	17,5	17	13,5	-23 %
OS 13: Ressources humaines pour la santé	6	14,8	15,1	10,5	-29 %
OS 10: Services de santé	7	34,4	20,7	30,1	-12 %
OS 08: Environnement plus sain	8	19,1	22,7	19,5	2 %
OS 06: Promotion de la santé et facteurs de risque	9	14,2	13,6	12,3	-13 %
OS 14: Protection sociale et financement	10	4,8	6,2	7,9	65 %
OS 11: Leadership et gouvernance dans les systèmes de santé	11	31,1	39,7	37,9	22 %
OS O12: Produits et technologies médicaux	12	19,2	21,1	18,0	-6 %
OS 05: Urgences et catastrophes	13	49,3	32,9	23,4	-52 %
OS 09: Nutrition, sécurité sanitaire des aliments et sécurité des approvisionnements alimentaires	14	15,8	28,1	18,4	16 %

VII. CONCLUSIONS ET RECOMMANDATIONS

84. L'Organisation a accompli des progrès significatifs dans la mise en œuvre de la gestion fondée sur les résultats et utilisé l'expérience acquise et les leçons apprises pour améliorer sa planification, sa budgétisation et ses processus de contrôle et d'évaluation de la performance. Ces réalisations ont été rendues possibles grâce à la collaboration avec les États Membres, l'engagement de la haute direction (EXM) du BSP, la participation du personnel à tous les niveaux du BSP et l'élaboration de processus et d'outils pour faciliter sa mise en œuvre. Les leçons apprises et les bonnes pratiques identifiées au cours de la période 2008-2013 ont été appliquées à l'élaboration de la nouvelle Politique budgétaire de l'OPS pour 2014-2019, le nouveau Plan stratégique de l'OPS 2014-2019 et le Programme et budget 2014-2015, ainsi que le processus de planification opérationnelle pour 2014-2015, ce qui a permis d'accroître l'efficience et l'efficacité de la coopération technique de l'OPS.

85. Il y a encore des lacunes importantes dans les composantes d'évaluation indépendante et d'apprentissage pour mettre pleinement en œuvre la gestion fondée sur les résultats à l'OPS. Ces composantes nécessiteront encore plus d'attention au cours des prochaines périodes biennales pour que l'Organisation puisse consolider l'application de la gestion fondée sur les résultats.

86. Les évaluations des Programmes et budgets respectifs (2008-2009, 2010-2011 et 2012-2013) montrent que l'Organisation a maintenu un progrès constant en vue de la réalisation des cibles du Plan stratégique pour 2013. Une réduction importante des fonds disponibles a été notée au cours du dernier exercice biennal, principalement en raison d'une diminution du niveau des contributions volontaires (tant de l'OPS que de l'OMS).

87. Le taux élevé de réalisation programmatique au cours du dernier exercice biennal du Plan stratégique 2008-2013 était dû au dynamisme émané d'exercices biennaux antérieurs, aux efforts des pays pour atteindre les OMD et d'autres priorités régionales et nationales en matière de santé publique, ainsi qu'aux gains d'efficacité mis en place par le BSP pour améliorer le niveau de coopération technique de l'OPS. Cependant, il y a lieu de prendre en considération le besoin d'assurer un financement sain de l'Organisation pour qu'elles disposent des ressources nécessaires pour répondre effectivement et efficacement aux mandats et priorités des États Membres.

88. Le BSP doit continuer à améliorer et à promouvoir des modèles couronnés de succès pour une approche intégrée de la coopération technique afin de maximiser son impact sur la santé publique. Il est nécessaire d'explorer de nouvelles modalités de coopération technique pour étendre la portée de la coopération technique de l'OPS et assurer que l'Organisation reste attentive aux priorités des États Membres.

89. La mauvaise qualité de certains indicateurs, l'absence de définitions standards et le manque de cohérence entre certains indicateurs de RER et les indicateurs d'OS au niveau de l'impact ont affecté la cohérence et limité l'évaluation de sorte qu'il était difficile de montrer adéquatement le progrès fait en vue de l'obtention des résultats au niveau des effets et de l'impact. Les indicateurs doivent être bien définis, avec une définition précise des référence et des cibles pour évaluer l'atteintes des objectifs. De plus, les indicateurs et objectifs doivent être réalistes et tenir compte des risques et hypothèses y afférents.

90. Les principaux facteurs qui ont contribué à la non réalisation des indicateurs ont inclus : *a*) la qualité de l'indicateur et les limitations relativement à une information fiable qui aurait permis de mesurer de façon appropriée les progrès réalisés par les pays et *b*) des objectifs irréalisables pour la période de planification, sans prendre en considération les situations particulières dans les pays et les défis auxquels ils font face dans des secteurs qui exigent une action multisectorielle. D'autre part, l'Organisation doit utiliser une approche équilibrée afin d'assurer que les cibles puissent être raisonnablement atteintes tout en demeurant assez élevées pour motiver des actions axées sur les changements nécessaires concernant le niveau des résultats et de l'impact au cours de la période de planification.

91. Alors que des progrès notables ont été accomplis en ce qui concerne la qualité de l'information et de la reddition des comptes, il existe des domaines clés (tels que la santé maternelle, les maladies chroniques, la santé mentale et l'accès aux services de santé) pour lesquels les données à jour validées sont limitées, ou même absentes, pour mesurer adéquatement les progrès accomplis vers la réalisation des indicateurs d'impact. Cette limitation s'est avérée un défi pour définir les références des indicateurs et a donc affecté le processus de contrôle et d'évaluation.

92. Le processus de contrôle et d'évaluation de la performance a été bien établi au BSP, avec la participation de la direction et du personnel de l'ensemble de l'Organisation. Étant donnée la responsabilité conjointe des États Membres et du BSP pour l'obtention des résultats du Plan, le contrôle et l'évaluation de ses indicateurs devraient être effectués conjointement.

93. Une tendance croissante est notée dans le montant de fonds de contributions volontaires reçus au cours des deux derniers exercices biennaux (de $235 à $565 millions). Ces fonds ont contribué aux progrès accomplis dans l'atteinte des objectifs de santé publique dans les pays qui utilisent cette modalité pour financer la coopération technique de l'OPS. Il est nécessaire de procéder à une autre analyse de cette modalité de financement et de l'incorporer dans le nouveau Plan stratégique de l'OPS et ses programmes et budgets correspondants.

94. Les enseignements tirés de chaque OS dans le présent rapport devraient être analysés afin d'identifier les réussites et les échecs, pour ainsi permettre à l'Organisation de mettre à profit ces enseignements en reproduisant les interventions réussies et en évitant la répétition de fautes évitables dans la mise en œuvre du nouveau Plan stratégique de l'OPS pour 2014-2019.

Mesure à prendre par le Conseil directeur

95. Le Conseil directeur est prié de prendre note du Rapport final sur le Plan stratégique de l'OPS 2008-2013 et évaluation en fin de période biennale du programme et budget 2012-2013.

Annexes (en anglais)

VIII. ANNEXES

Annex A: Strategic Objective (SO) Reports

SO1: To reduce the health, social, and economic burden of communicable diseases							Partially Achieved[1] (73% of indicator targets achieved)		
RER Status[2]	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9

SO1 Budget Overview

Approved Budget (PB 08-13)	**Funds Available (in US$ millions)**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
260.1	71.4	175.9	247.3	92%	95%

SO1 Programmatic Assessment

1. Over the course of the Strategic Plan 2008-2013, PAHO provided technical cooperation to the Member States to reduce the burden caused by communicable diseases in the Region. Region-wide expected results were established to guide the Secretariat and the countries in their efforts to increase access to life-saving vaccines; strengthen immunization services; maintain measles, rubella and congenital rubella syndrome (CRS) elimination and the certification of polio eradication; control and/or eliminate various neglected infectious diseases and zoonotic diseases; strengthen surveillance and response efforts; build country capacity in operational research; establish and maintain core capacities under the IHR; address epidemic- and pandemic-prone diseases; and improve alert and response activities, including timely response to emergencies.

2. Although the strategic objective was assessed as partially achieved, significant advances have been made in the fight against communicable diseases in the Region. Ongoing efforts supported the countries and enabled them to guarantee sustainability in immunization programs, boost vaccination coverage by reaching vulnerable populations with quality vaccines, and strengthen surveillance and monitor progress. The Region continues to be at the forefront of disease elimination and eradication efforts, as exemplified by the ability of countries to maintain their achievements in measles, rubella, and CRS elimination and the eradication of polio. Significant advances were also made by countries in the elimination of leprosy, the elimination of human rabies transmitted by dogs, and the interruption of the vector-borne transmission of Chagas' disease. Country-specific advances have been documented in the elimination of neglected infectious diseases (i.e., trachoma, filariasis, schistosomiasis, and onchocerciasis), including verification of the elimination of onchocerciasis in Colombia. PAHO provided technical cooperation to selected countries to strengthen their capacity in operational research in order to generate new knowledge regarding effective strategies and interventions in the detection, control, and elimination of priority diseases.

3. As part of their commitment under the International Health Regulations (IHR), all the States Parties[3] are required to establish, strengthen, and maintain surveillance and response capacity. This competency

[1] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[2] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

was achieved by 87% of the States Parties, which reported a score of 60% above the minimum standard set at the global level for surveillance capacity. In addition, the majority of countries have advanced in the routine implementation of surveillance interventions to address antimicrobial resistance (AMR), including health care-associated infections. With the support of PAHO, the countries continue to strive for the attainment of core capacities and the Region has experienced renewed interest in the IHR.

4. PAHO has worked in close collaboration with countries to develop national preparedness plans and standard operating procedures for rapid response teams in preparation for potential outbreaks. The wealth of experience obtained through these efforts provided a strong foundation that informed other regional initiatives, such as the development of cholera response plans. Alert and response efforts have also strengthened dramatically in the Region over the last several years through multidisciplinary collaborative work by the regional Alert and Response team, experts across PAHO technical areas, and PAHO Country Offices. As a result, 100% of all public health events of international concern were verified within 48 hours of their detection. In addition, effective operations have been established to ensure timely response to emergencies in the Region.

SO1 Main Achievements

a) The PAHO ProVac TRIVAC Model estimated that between 2002 and 2012 there was a 53% reduction in childhood deaths due to the diseases most commonly associated with childhood death, including rotavirus, pneumococcus, meningococcus, and *Haemophilus influenza* type b.

b) Member States have recognized vaccines as a public good and continue to prioritize immunization programs, as demonstrated by the allocation of national budgets to vaccine procurement and capacity-building for health workers, as well as decisions to introduce new vaccines into National Immunization Programs (NIPs). Currently, 87% of the birth cohort in the Region live in countries that use the rotavirus vaccine in their NIPs; 90% of the birth cohort live in countries that use the pneumococcal vaccine; and human papillomavirus (HPV) vaccine is now available to more than 80% of adolescent girls in the Americas.

c) All the countries and territories have maintained measles, rubella, and CRS elimination, as well as certification of polio eradication by achieving high vaccination coverage, ensuring quality surveillance, and detecting and responding to outbreaks in a timely manner.

d) All requests received by Member States during emergencies or epidemics were assessed and answered within a 24-hour period, in compliance with the IHR, and followed up with timely deployment of experts from the Global Outbreak Alert and Response Network as well as regional and country team members. Response actions addressed outbreaks of dengue, Chikungunya fever, plague, cholera, neonatal nosocomial infections, and other infectious diseases.

e) Over the past three years, significant progress has been noted for virtually all IHR core capacities across countries in the Region, with improvements of 15% or more observed for the following capacities: preparedness, legislation and policy, response, laboratory, zoonotic events, and surveillance. Achieving and sustaining IHR core capacities is a complex process and requires unrelenting commitment by the States Parties.

f) Since 2008, the proportion of initial event information received via IHR National Focal Points (NFPs) has grown from 34% to 97%, which clearly demonstrates the high level of commitment and functionality of the network. By the end of 2013, 100% of all public health events of international concern were verified within 48 hours of their detection through multidisciplinary collaboration between the NFPs, the PAHO Regional Office, and PAHO Country Offices. From January 2008 to December 2013, 932 events were assessed, 325 of which required verification by Member States.

[3] State Party means a WHO Member State that has not expressly rejected the Regulations in accordance with Article 61 or a State that is not a Member of WHO that has notified the Director-General of WHO of its acceptance of the Regulations in accordance with Article 64.

g) By the end of 2013, all the countries and territories were detecting and notifying cases of dengue, with weekly reports of severe dengue and deaths due to the disease disaggregated by age and sex at the department/province level (since 2012). The case fatality rate decreased from 0.07% in 2010 to 0.05% 2013.

h) The PAHO Directing Council approved Resolution CD48.R12 (2008), which established the goal of elimination of onchocerciasis in the Americas by 2012. In 2009, the Directing Council also approved Resolution CD49.R19, which set 2015 as the year to achieve the goals of control and elimination of neglected infectious diseases (NIDs) in the Americas, including onchocerciasis. In alignment with these resolutions, Colombia was the first country in the world to receive WHO verification of onchocerciasis elimination and Ecuador has submitted a request for verification as well. With regard to trachoma, Mexico is close to achieving elimination.

i) A total of 18 countries successfully eliminated leprosy as a public health concern at the national and subnational level; 17 countries achieved elimination of human rabies transmitted by dogs; and 17 countries interrupted vector-borne transmission of Chagas' disease by reducing household infestation in the defined area to lower than 1%.

j) The countries of the Americas continued to strengthen the health situation related to foot-and-mouth disease (FMD) and were able to overcome an emergency in Paraguay. The Region has not experienced another FMD outbreak for 33 months.

SO1 Main Challenges

a) Significant differences in immunization coverage persist within the countries and it is difficult to demonstrate the impact of vaccination interventions that target low-coverage municipalities with pockets of susceptible individuals. It is particularly challenging to address the various determinants of low coverage, such as geography, income levels, and other socioeconomic factors.

b) In light of the circulation of measles and rubella viruses in other regions of the world and the high risk of these viruses being reintroduced in the Americas, the 28th Pan American Sanitary Conference approved Resolution CSP28.R14 (2012) calling for the implementation of an emergency plan of action to sustain the elimination gains. The plan emphasized the need to address the continued challenges of strengthening country surveillance systems to ensure timely notification of suspected cases of measles and rubella, as well as to achieve sustained and homogeneous vaccination coverage for measles and rubella at the municipal level.

c) Several challenges require the attention of Ministries of Health in order to ensure that NID control and elimination remains high on the public health and political agendas of priority Latin American and Caribbean (LAC) countries, with emphasis on the following actions: (1) increase deworming coverage to control soil-transmitted helminthiasis (STH) in 30 endemic countries of the Region; (2) reinforce efforts to eliminate lymphatic filariasis (LF) in Brazil, the Dominican Republic, Haiti, and Guyana; (3) strengthen efforts to eliminate blinding trachoma in Brazil, Colombia, and Guatemala; (4) reinforce efforts to eliminate schistosomiasis in Brazil and Venezuela; (5) coordinate binational efforts in the Yanomami area to support the elimination of onchocerciasis; (6) reach the goal of leprosy elimination first at the subnational level in endemic countries; and (7) integrate actions to address the NID-related social determinants of health, particularly safe water, basic sanitation, and hygiene education.

d) Despite the increasing relevance of antimicrobial resistance (AMR) in the public health arena, support in the Americas has been steadily decreasing. This situation jeopardizes the achievements gained thus far in the Region and will hinder AMR surveillance, laboratory capacity-building, and containment efforts.

e) The response to the 2009 H1N1 influenza pandemic highlighted several challenges for countries, including: (1) the lack of real-time linked clinical, epidemiological, and virological data on severe cases; (2) the need for adequate early warning systems and alert and response capacity; (3) the need for proficient laboratories; and (4) capacity-building for health systems to ensure patient safety and quality of care.

f) With regard to the IHR, continued challenges include: (1) institutionalization of IHR core capacities so they are relevant to each specific country while avoiding a "one size fits all" scenario; (2) strengthening of monitoring and evaluation efforts in connection with IHR implementation to ensure mutual accountability; and (3) use of the IHR as an effective tool for fostering intersectoral coordination mechanisms.

g) Limited resources are impeding country efforts to prevent and control epidemic-prone viral diseases—for example, Bolivian hemorrhagic fever, hantavirus, equine encephalitis, and Chikungunya fever and mount a coordinated response to vector-borne diseases.

h) With regard to zoonotic diseases and food safety, the efficient management of public health risks was challenged by the ongoing need to establish or strengthen mechanisms and permanent platforms of intersectoral communication and collaboration between the health, agriculture, and environment sectors.

SO1 Lessons Learned

a) The recent introduction of new vaccines in the Region has raised key issues that are important for immunization programs: (1) communication and crisis prevention/management is critical to maintaining the integrity of information management programs; (2) high-functioning information and surveillance systems are important for capturing timely and accurate coverage data as well as the presence of disease circulation in the established territory; and (3) it is beneficial to integrate vaccination services with other health programs that target key populations.

b) The integration of NID activities into other public health programs is necessary in order to achieve targets. Successful examples include: (1) implementation of an innovative integrated campaign in Brazil (2013) to reach school-age children with deworming for STH and screening and treatment for leprosy and trachoma, in which 2.8 million school-age children were dewormed, almost 300 new cases of leprosy were identified in children under 15 years old, and approximately 2,000 children were diagnosed and treated for trachoma infection; and (2) the experience of Belize, Honduras, Mexico, and Nicaragua, which integrated deworming for STH into the activities of Vaccination Week of the Americas.

c) The epidemiological, economic, and political context around the FMD outbreak in Paraguay demonstrates the continued risk of viral circulation in the continent and emphasizes the need to strengthen the national programs.

d) Country experiences in the development of national preparedness plans and standard operating procedures for rapid response to pandemic influenza, in capacity-building to detect epidemic-prone viral pathogens, and in the development, implementation, and evaluation of the Integrated Management Strategy for Dengue provided a strong foundation for other regional initiatives, such as the development of cholera response plans and rapid and coordinated response to the introduction of Chikungunya fever in the Region.

Progress towards Impact Results

5. The evaluation of strategic objective impact indicators showed an estimated 53% reduction in childhood deaths due to the vaccine-preventable diseases (VPDs) most commonly associated with child mortality (those produced by rotavirus, pneumococcus, meningococcus, and *Haemophilus influenzae* type b). All the countries and territories in the Region successfully maintained their certification of poliomyelitis eradication, as well as the elimination of measles, rubella, and CRS. Although only six countries declared that they maintained the minimum core capacity requirements established in the IHR by June 2012, there was revived commitment and ownership of the Regulations by national authorities that culminated in the unanimous adoption of Decision CD52(D5) by the 52th PAHO Directing Council. With regard to neglected infectious diseases, Colombia became the first country in the world to receive WHO verification of onchocerciasis elimination; there was a decline in case fatality due to dengue; and notable advances were made in the fight against Chagas' disease.

SO1 Indicator 1: Reduction of the mortality rate in children under 5 years old due to vaccine-preventable diseases in the Region
Baseline: 47 per 100,000 children under 5 years old in 2002
Target: 31 per 100,000 by 2013

Given the lack of substantiated data available at the time the indicator was proposed, the PAHO ProVac TRIVAC Model[4] was used to provide an estimation. Between 2002 and 2012, a static cohort childhood disease impact TRIVAC model estimated a 53% reduction in childhood deaths due to the diseases most commonly associated with child mortality, including those produced by rotavirus, pneumococcus, meningococcus, and *Haemophilus influenzae* type b. As a result of increasing coverage of vaccines for these diseases in the Region, the model estimates that childhood mortality due to these three VPDs has dropped to 35.2 per 100,000 children < 5 years old.

SO1 Indicator 2: Number of countries maintaining certification of poliomyelitis eradication in the Region
Baseline: 38 countries in 2006
Target: 38 countries by 2013

38 countries/territories achieved this indicator: 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, USA, URU, and VEN.

All the countries and territories successfully maintained their certification of poliomyelitis eradication status in the Region. PAHO supported countries in maintaining quality surveillance by implementing acute flaccid paralysis (AFP) case-based surveillance, ensuring adherence to surveillance quality indicators, and strengthening the regional laboratory network through accreditation processes. The countries have also strived for high vaccination coverage against polio in all municipalities, which included the implementation of vaccination campaigns. An important milestone was reached during this period when the Region concluded the first phase of laboratory containment of poliovirus.

SO1 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

38 countries/territories achieved this indicator: 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, and VEN.

Measles was eliminated from the Americas in 2002 and rubella and CRS were eliminated in 2002 and 2009, respectively. These regional achievements resulted from the implementation of PAHO-recommended strategies on surveillance, which included integrated measles and rubella surveillance, switching to a case-based surveillance report, and viral detection/isolation for genotyping identification, as well as the implementation of recommended vaccination strategies such as mass vaccination campaigns, targeting of men and women under 40 years old, and the introduction of a vaccine containing measles-mumps-rubella (MMR) in the routine program, while ensuring vaccination coverage at >95%.

In reference to the elimination of neonatal tetanus, only Haiti has not achieved the target; the country continues to face the challenge of strengthening the routine Expanded Program on Immunization (EPI) program at all levels. PAHO is providing technical cooperation to implement and evaluate a plan to eliminate neonatal tetanus in the country.

[4] The ProVac TRIVAC model has been reviewed by WHO Expert Panels (QUIVER) and published. Data inputs are drawn from the best available internationally recognized sources.

SO1 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
Baseline: 0 countries in 2007
Target: 35 countries by 2013

6 countries achieved this indicator: BRA, CAN, CHI, COL, COR, and USA.

A total of 6 countries declared that they attained and maintained the minimum core capacities established in the IHR by June 2012, while the remaining 29 out of the 35 States Parties in the Region requested and obtained a two-year extension to establish core capacities. The States Parties decision reflects a responsible and transparent approach to the ongoing public health preparedness process, requiring a dynamic intersectoral approach while maintaining a certain degree of flexibility. It was anticipated that a significant number of the States Parties would seek an additional two-year extension until 15 June 2016. The main challenges faced by the States Parties in attaining core capacities have to do with adequately addressing chemical emergencies, radio nuclear emergencies, and points of entry issues.

SO1 Indicator 5: Reduction in the lethality rate from dengue (dengue hemorrhagic fever/dengue shock syndrome) in the Region
Baseline: 1.3% in 2006
Target: 1.0% by 2013

Reduction in the lethality rate from dengue to 0.05%

The clinical classification of dengue was updated in 2010, and it no longer includes a reference to dengue hemorrhagic fever/dengue shock syndrome. This significant change was not anticipated at the time the indicator was established, which has complicated the comparison of data over the period of the Strategic Plan. However, after initiation of the process to adapt national guides to align with the new clinical dengue classification and updated PAHO/WHO dengue guidelines in 2010, the case-fatality rate from dengue declined from 0.07% in 2010 to 0.05% in 2013. As of epidemiological week 52/2013, a total of 2,376,869 dengue cases had been reported by the countries, with an incidence of 435.5 per 100,000 inhabitants, and 1.6% the reported cases were severe. Persisting challenges include developing and implementing an integrated dengue surveillance system, strengthening health worker capacity at the primary care level to detect outbreaks and subsequently prevent serious dengue cases and death, and build regional capacity in integrated vector management. The fight against dengue must include the sensitization and sustained engagement of householders, communities and other sectors, as well as intersectoral action

SO1 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

17 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, ELS, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, and URU.

The regional goal was surpassed: a total of 17 countries certified the interruption of transmission by the principal vector in the entire territory or in subunits of its territory. This achievement resulted from implementation of the Subregional Initiatives for Prevention and Control and Medical Care of Chagas' Disease, which are subregional South-South cooperation schemes that facilitate adequate vector control measures, universal screening of donors at blood banks, and improved medical care in terms of both quality and coverage.

SO1 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

1 country achieved this indicator: COL.

Colombia was the first country in the world to receive WHO verification of onchocerciasis elimination, following a mission of the International Verification Team (IVT) in November 2012, with receipt of the WHO official letter confirming elimination in April 2013. This achievement will serve as a lesson for other countries to move forward in NID elimination actions. Ecuador submitted request for verification of onchocerciasis elimination in 2013, and an IVT is expected to visit the country during the first half of 2014 to verify the achievement of elimination. Guatemala and Mexico will complete their three years of post-treatment epidemiological surveillance in all their foci at the end of 2014 and, depending on the results of epidemiological assessments, they could then request verification of elimination from PAHO/WHO. The focus of cases in Yanomami communities located in an area shared by Brazil (Amazon focus) and Venezuela (Southern focus) is the final major challenge to eliminating onchocerciasis from the entire Region. This focus presents particular difficulties: (*i*) a population and geographical area split by a political border; (*ii*) difficult physical access in both countries (jungle area); and (*iii*) the nomadic lifestyle of the affected peoples. The challenge to reach this endemic area involves high logistic and operational costs, which makes it difficult to provide comprehensive care to the communities and achieve the required treatment coverage.

Assessment of the Region-wide Expected Results

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	Partially Achieved

RER Assessment Summary (3 out of 4 RER indicator targets achieved; 1 not achieved)

6. PAHO continues to provide technical cooperation to the Member States in collaboration with strategic partners to ensure equitable access to quality vaccines and to integrate vaccination services with other public health measures. Ongoing efforts to guarantee program sustainability include facilitating decision-making processes with countries to ensure the allocation of resources to national programs for vaccine procurement, building national capacity among health workers, ensuring appropriate infrastructure, identifying opportunities for integrating services that benefit families and communities, etc. Priority activities to boost vaccination coverage include the implementation of national plans of action with tailored interventions to reach vulnerable populations with limited access to vaccines and to overcome challenges identified by the respective countries. The Region has made great strides in the establishment of sentinel sites for pneumococcal and/or rotavirus to strengthen national surveillance systems. As of 31 December 2013, 35 countries and territories were participating in the PAHO Revolving Fund for Vaccine Procurement to prevent shortages and improve access to quality vaccines at competitive prices.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.1.1	Number of countries achieving more than 95% vaccination coverage at the national level (DPT3 as a tracer)	17	25	Yes
Comments: 25 countries/territories achieved this indicator: ABM, ANI, BAH, BLZ, BRA, CAN, CUB, DOM, ECU, GRA, GUT, GUY, JAM, MEX, NCA, NEA, NIC, PER, SCN, SAL, SAV, TCA, TRT, USA, and URU. All the countries in the Region regard their national immunization programs as a priority and have				

fostered partnerships to support programs; allocated domestic budgets for program financing, which goes beyond vaccine procurement and also supports training of health workers; and implemented additional activities to achieve and sustain high coverage. PAHO technical cooperation with the countries promotes the sharing of best practices for achieving high immunization coverage. Vaccination coverage figures for all the countries are available in the *Immunization in the Americas* brochure at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=3573&Itemid=2573&lang=en

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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)	38%	32%	No

Comments:
Despite the ongoing efforts of countries to reach small pockets of unvaccinated individuals with limited access to vaccination services, this indicator target was not achieved: 50% of municipalities were still reporting DPT3 coverage of <95% according to 2012 data. Persistent problems associated with measuring and achieving the indicator included: (*i*) denominator issues, including number changes; (*ii*) population movements between and within countries; (*iii*) data quality issues; and (*iv*) timeliness of data reporting. The countries that continue to report the highest number of municipalities with low coverage are BOL, PAR, and VEN. Intense efforts continue in these countries to boost vaccination coverage in vulnerable areas, as well as to overcome other identified challenges across the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.1.3	Number of countries that have included pneumococcal and/or rotavirus sentinel surveillance in their national epidemiological system	0	15	Yes

Comments:
20 countries/territories achieved this indicator: ABM, BOL, BRA, CHI, COL, DOM, DOR, ECU, ELS, GUT, GUY, HAI, HON, NIC, PAN, PAR, PER, SAV, SUR, and VEN.

PAHO provided countries with technical cooperation to establish functioning sentinel surveillance within the national systems. Over the last several years, 20 countries/territories have established rotavirus surveillance, while 11 countries of the Region have successfully established pneumococcal surveillance (BOL, BRA, ECU, ELS, GUT, HON, NIC, PAN, PAR, PER, and VEN).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	34/38	Yes

Comments:
35 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HON, JAM, NCA, NEA, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TCA, TRT, URU, and VEN.

By the end of 2013, a total of 35 countries and territories were participating in the PAHO Revolving Fund for Vaccine Procurement (RF). There have been ongoing discussions with Mexico regarding the Revolving Fund procedures and potential benefits to the country.

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	Fully Achieved

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

7. The Region of the Americas continues to be at the forefront of disease elimination and eradication efforts, as exemplified by the countries' ability to maintain the achievements in measles, rubella, and congenital rubella syndrome (CRS) elimination and the eradication of polio. A Plan of Action for Maintaining Measles, Rubella, and CRS Elimination was approved by the 28th Pan American Sanitary Conference (September 2012) to provide the steps required to maintain these achievements and ensure high coverage to protect susceptible populations and prevent potential outbreaks, as well as guidance for maintaining high quality surveillance as measured through recommended indicators. A Plan of Action to Maintain the Americas Free of Polio was also developed and implemented during the period to support countries in the transition from the pre- to post-eradication eras and enhance community protection and surveillance. Ongoing technical cooperation with Haiti sought to overcome the continuing challenge of strengthening routine EPI program at all levels in the country. The Region is near to verifying measles, rubella, and CRS elimination and will prioritize support to countries in the implementation of the Polio Eradication and Endgame Strategic Plan 2013-2018.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.2.1	Number of countries with surveillance activities and vaccination to maintain the polio eradication	38/38	38/38	Yes
Comments: 38 countries/territories achieved this indicator 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, USA, URU, and VEN. According to 2012 data, regional polio vaccine coverage was 93%. With regard to surveillance, key acute flaccid paralysis (AFP) indicators were achieved, including an AFP notification rate of 1.23 cases per 100,000 population under 15 years of age, as well as the collection of an adequate sample from 80% of reported AFP cases. PAHO continues to engage in technical cooperation with countries to ensure that quality surveillance is in place and high vaccination coverage is achieved in order to prevent, detect, and respond to potential outbreaks. PAHO will also support countries in their efforts to address the eradication of polio, in alignment with the Polio Eradication and Endgame Strategic Plan 2013-2018.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.2.2	Number of countries that have implemented interventions to achieve rubella and congenital rubella syndrome (CRS) elimination	35/38	38/38	Yes
Comments: 38 countries/territories achieved this indicator: 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, SAL, SAV, SCN, SUR, TRT, URU, USA, and VEN. The few reported rubella cases have been associated with importations and PAHO continues its work with countries to strengthen surveillance and ensure rapid detection and response to reported cases.			

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	Partially Achieved

RER Assessment Summary (1 out of 5 RER indicator targets achieved; 4 not achieved)

8. Although the region-wide expected results were only partially achieved by the end of the Strategic Plan period, significant advances were made by countries in the Region in terms of providing all populations with access to interventions for the prevention, control, and elimination of priority diseases. Technical cooperation was provided for leprosy- endemic countries to update their national guidelines on detection, treatment, and prevention in order to provide adequate access to health services for an average of 35,000 new cases each year (36,178 new cases reported in 2012). A total of 18 countries successfully eliminated leprosy as a public health concern at the national and subnational level, while several other countries documented great progress. With regard to the elimination of human rabies transmitted by dogs, the Region was only one country away from achieving the established goal (17 out of 18 countries achieved elimination) and a clear path has been set for addressing the complex challenges that have been identified. For zoonotic diseases, despite improvements in surveillance and preparedness efforts, challenges remain when it comes to securing the required resources to build country capacity, ensuring the availability of laboratory supplies, and improving intersectoral coordination. Considerable advances have been made in the fight against Chagas' disease, yet political commitment and the allocation of country resources continue to pose challenges. Finally, country-specific advances have been documented in terms of increasing access to measures for the elimination of neglected infectious diseases (e.g., in 2012, 8.4 million people were treated for lymphatic filariasis (LF), mainly in Haiti; by the end of 2013, close to 185,000 out of a population 538,517 were no longer at risk for onchocerciasis; and 25.6 million children under 15 years old were treated for intestinal worms in 2012). Notably, Colombia was the first country in the world to eliminate onchocerciasis as verified by WHO – this is indeed an impressive achievement for the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.3.1	Number of countries that have eliminated leprosy at national and subnational levels as a public health concern	16/24	24/24	No
Comments: 18 countries achieved this indicator: COL, COR, CUB, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PER, SAL, SUR, TRT, and URU. Although the indicator target was not achieved, a total of 18 countries have successfully eliminated leprosy as a public health concern at both the national and subnational levels, while several other countries have made significant progress. BRA is advancing towards elimination but still reports a prevalence of <1:10,000 population at the national level. Five countries, ARG, BOL, DOR, PAR, and VEN, eliminated leprosy at the national level, but elimination at the first subnational level is still pending. Adequate financial and human resources must be provided at the regional and country level to support the activities needed in order to maintain progress to date and continue to advance towards achieving the goal of leprosy elimination.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.3.2	Number of countries that have eliminated human rabies transmitted by dogs	11	18	No
Comments: 17 countries achieved this indicator: ARG, BLZ, CHI, COL, COR, CUB, ECU, ELS, GUY, HON, MEX, NIC, PAN, PAR, SUR, URU, and VEN. A total of 17 countries have eliminated human rabies transmitted by dogs, as evidenced by the absence of reported cases in the regional database (SIRVERA). However, neither GUT nor PER were able to achieve the indicator, mostly because of a disruption in canine vaccination and lack of awareness among health officials of the need for post-exposure prophylaxis (PEP) following a dog bite. PAHO, in collaboration with the Ministries of Health, continued to carry out ongoing technical field missions in affected countries aimed at strengthening their rabies programs. At the last REDIPRA14 in 2013, PAHO				

was requested to review the definition of dog-transmitted rabies elimination, which will be field-tested and implemented in 2014. In addition, there is need for high-level political advocacy with the Ministries of Health to ensure the political commitment to sustain programs for the elimination of human rabies transmitted by dogs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.3.3	Number of countries that maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases	11	23	No

Comments:
11 countries achieved this indicator: ARG, BRA, CHI, COL, COR, GUT, MEX, PAN, PAR, PER, and URU.

A total of 11 countries maintained and/or improved their surveillance efforts and preparedness for emerging or re-emerging zoonotic diseases at varying degrees over the period, primarily in the area of laboratory diagnosis and response capacity in the field. This progress has been achieved through various strategies, such as the sharing of best practices between countries, which allowed countries with large experience to enhance the capacity of others to address outbreaks through the use of Technical Cooperation among Counties (TCC), along with the direct technical cooperation of the Organization to improve the surveillance and rapid response capacity for influenza (i.e., through subregional meetings), rabies, equine encephalitis (in COL, GUT, PAN, and VEN), yellow fever, and spongiform encephalopathy.

However, significant challenges need to be overcome in order to increase country capacity in surveillance, early detection, and rapid response to events of public health importance due to zoonotic diseases, including the implementation of tailored interventions. These challenges and needs include: (*a*) improved coordination between the health and agriculture sectors; (*b*) strengthened human and financial resources and capacity-building; and (*c*) increased availability of diagnostic reagents and kits and standardized tests to facilitate the rapid detection of outbreaks.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Y/N
1.3.4	Number of countries with Domiciliary Infestation Index for their main triatomine vectors lower than 1%	3/21	18/21	No

Comments:
17 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, ELS, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, and URU.

Achievement of the indicator by 17 countries underscores the considerable advances made in the fight against Chagas' disease, even though the regional indicator target was not achieved. Countries have exerted tremendous efforts to interrupt vector-borne transmission by reducing household infestation in the area, across the country, and/or in endemic territorial subunits. Persisting challenges include the need for greater political commitment, limitations of the national budgets, and institutional changes in the health sector.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.3.5	Number of countries which have adopted programs or strategies for the surveillance, prevention, control, or elimination of the neglected diseases	0	11	Yes

Comments:
18 countries achieved this indicator: BLZ, BOL, BRA, COL, DOR, ECU, ELS, GUT, GUY, HAI, HON, MEX, PAN, PAR, PER, SAL, SUR, and VEN.

At the end of 2013, 18 countries in the Region have demonstrated significant progress in the adaptation of programs or strategies towards the goals of controlling and eliminating neglected infectious diseases (NID): BOL prepared a draft national Plan of Action (PoA) for soil-transmitted helminthiasis (STH) and is implementing integrated subnational activities (STH and fascioliasis); BRA launched a national PoA for 6 NIDs and a campaign for identification and treatment of STH, trachoma, and leprosy in schoolchildren; COL launched a national PoA for onchocerciasis (ONCHO), STH, and blinding trachoma and received WHO verification of elimination of ONCHO; DOR maintained STH deworming and surveillance of LF and implemented an integrated survey for SCH+STH; ELS drafted a national PoA for 9 NIDs; GUT launched a national PoA for 6 NIDs; GUY maintained integrated control interventions for STH and LF; HAI maintained high treatment coverage for LF and STH; HON completed six subnational PoAs and expanded STH deworming; MEX maintained national deworming campaigns for STH and was close to eliminating trachoma; SUR prepared a draft PoA for NIDs and was retired from the WHO list of LF-endemic countries in 2011. As part of regional progress in this indicator, seven additional countries (BLZ, ECU, PAN, PAR, PER, SAL and VEN) drafted PoAs for STH. In general, 15 countries now have multidisease or integrated interprogrammatic programs, plans, projects, or strategies for NIDs. Between 2009 and 2013 the number of countries using a multidisease approach rose from 5 to 15, while the number of countries using a single-disease approach dropped from 18 to 8.

RER 1.4 Member States supported through technical cooperation to enhance their capacity to carry out communicable disease surveillance and response as part of a comprehensive surveillance and health information system	Fully Achieved

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

9. PAHO provided technical cooperation to countries to enhance their surveillance systems, improve response capacity, and report on surveillance-related indicators by: (*a*) supporting States Parties in establishing, strengthening, and maintaining surveillance and response capacity as part of their commitment under the IHR, which was achieved by 87% of States Parties, reporting a score at least 60% above the minimum standard set at the global level for surveillance capacity; (*b*) facilitating the routine implementation of AMR surveillance interventions, including health care-associated infections, as demonstrated by country achievements in the development of national surveillance of these infections and control plans, outbreak investigations of health care-associated infections, establishment of antimicrobial resistance surveillance networks, etc.; and (*c*) assisting countries and territories of the Region in providing timely information on immunization coverage and surveillance efforts, including state/province-level data, to help guide interventions. These collective efforts contributed to strengthening comprehensive surveillance and health information systems in the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.4.1	Number of countries with a surveillance system for all communicable diseases of public health importance for the country	14	20	Yes

Comments:
27 countries achieved this indicator: ANI, ARG, BAR, BLZ, BOL, CAN, CHI, COL, COR, CUB, DOM, DOR, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PER, SAL, SAV, TNT, USA, and VEN.

According to the IHR State Party Annual Report to the 66th World Health Assembly (WHA), 27 of the 31 States Parties (87%) in the Region that submitted a report had a score above 60% of the minimum standard set at the global level for surveillance capacity. Since the generalized adoption of a standard format for reporting to the Assembly (64th WHA, May 2011), substantial improvements were observed in the average regional score for surveillance capacity, from 59% in 2011 to 82% in 2013 (66th WHA). A total of 25 of the 29 States Parties (86%) that requested and obtained the 2012-2014 Extension indicated that action was still required to improve their surveillance systems.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	15/38	20/38	Yes

Comments:
22 countries/territories achieved this indicator: ABM, ANI, BAH, BAR, BLZ, BRA, CAN, CUB, DOM, ELS, GRA, GUY, HON, JAM, NIC, SAL, SCN, SUR, TCA, TRT, URU, and USA.

A total of 22 countries and territories successfully submitted their respective WHO/UNICEF joint reporting forms (JRF) on immunization surveillance and monitoring by the established deadline of 15 April 2013. An additional 15 countries submitted their JRF after the deadline, but nevertheless the data were included in *Immunization in the Americas, 2013 Summary*. Of the 37 countries that provided JRFs, 17 included immunization coverage by state/province. PAHO maintains an ongoing dialogue with all countries to ensure that timely and accurate information is provided.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.4.3	Number of countries routinely implementing antimicrobial resistance (AMR) surveillance and interventions for AMR containment, including health care-associated infections	17/35	27/35	Yes

Comments:
27 countries achieved this indicator: ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, USA, and VEN.

A total of 27 countries in the Region are routinely implementing AMR surveillance and interventions for AMR containment, including health care-associated infections. Notable progress has been achieved in several countries: (1) ECU reshaped and strengthened AMR surveillance nationally and also developed a national plan for surveillance and control of health care-associated infections; (2) in CHI, collaboration between the Public Health Institute and the Ministry of Health allowed for the successful investigation of a nosocomial outbreak caused by *Saroclaudium kiliense*; (3) in ARG, as an example of South-South cooperation, the country provided an External Quality Assurance program for Latin America and supported phenotypic and genotypic identification of unusual or emerging resistance mechanisms; (4)

GUT and NIC increased their capacity to detect emerging resistance mechanisms, including carbapenemases; (5) SUR initiated development of a Caribbean resistance surveillance network involving the participation of private institutions and academia; (6) BAR, BLZ, and PAN increased capacity to respond to outbreaks of health care-associated infections caused by multidrug-resistant organisms; and (7) COL developed a national surveillance network for health care-associated infections and is piloting AMR integrated surveillance in the public health, animal health and food sectors.

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	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

10. Significant progress has been made in the Region in strengthening research capacity within the countries and in generating new knowledge to shape strategies and interventions in the prevention and control of priority communicable diseases. The related indicator was surpassed as more than 5 countries carried out basic and operational research in various technical areas, including the development of interventions for the control of domiciliated and nondomiciliated triatomines, support for national TB programs, and standardization of real-time polymerase chain reaction as a biomarker of Chagas' disease. In addition, some of the countries benefited from capacity-building in the areas of epidemiology, data analysis, scientific writing, and grant development. Technical cooperation was also provided to ARG, BRA, and PAR on the development of a proposal to expand leishmaniasis research. The challenges of limited human and financial resources persist.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.5.1	Number of countries that have implemented operational research in accordance with the research priorities in communicable diseases	0/33	5/33	Yes

Comments:
12 countries achieved this indicator: ARG, BOL, BRA, CHI, COL, ECU, GUT, MEX, PAR, PER, URU, and VEN.

Countries have implemented operational research in accordance with the defined research priorities in communicable diseases in their respective countries. Specific examples include the development of interventions for the control of domiciliated and nondomiciliated triatomines (ARG, BOL, GUT, MEX, and PAR) and dengue control (BRA, COL, and URU); support for the national TB program in ECU; and training in the application of real-time polymerase chain reaction (RT-PCR) methods for Chagas' disease for laboratories across 11 Latin American countries (ARG, BOL, BRA, CHI, COL, ECU, MEX, PAR, PER, URU, and VEN). Technical cooperation has resulted in strengthened operational research capacity in the areas of epidemiology and data analysis (ECU and GUT), scientific writing (BOL, COL, ECU, GUT, MEX, PAR, and PER), and protocol development (ECU and HON).

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	Partially Achieved

RER Assessment Summary (1 of 2 RER indicator targets achieved; 1 not achieved)

11. A total of 29 of the 35 States Parties in the Region have requested and obtained a two-year extension to establish core capacities, while the remaining 6 confirmed that the capacities were in place and could be maintained. This decision of the States Parties reflects a responsible and transparent approach to the

ongoing public health preparedness process, and it requires a strong intersectoral approach while maintaining a certain degree of flexibility. It is anticipated that a significant number of the States Parties would seek an additional two-year extension until 15 June 2016. However, the momentum generated by the milestones set by the IHR has revived the commitment and ownership of the Regulations by national authorities, which culminated in the unanimous adoption of Decision CD52 (D5) by the PAHO 52nd Directing Council. Collaborative efforts at the international level to guide national preparedness for chemical- and radiation- hazards were remarkable.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	25	No

Comments:
6 countries achieved this indicator: BRA, CAN, CHI, COL, COR, and USA.

Technical cooperation provided by the Secretariat to States Parties facilitated the decision-making process to determine whether or not core capacities had been achieved and therefore decide whether a request for extension to 2012-2014 should be submitted. This process resulted in 6 States Parties confirming that the capacities were in place and could be maintained while 29 of the 35 States Parties submitted requests, supplemented with an action plan. Over the last three years, significant progress was noted in virtually all the core capacities across the subregions, with improvements of 15% or more observed for the following capacities: preparedness, legislation and policy, response, laboratory, zoonotic events, and surveillance. In addition, 31 of the 35 States Parties (89%) indicated their designated ports (64 in total); 34 of the 35 States Parties (97%) indicated their designated airports (77 in total); and 9 States Parties provided a list of their designated ground crossings (22 in total). The critical weaknesses identified that impeded attainment of the core capacities were those involving the management of chemical and radiation-related hazards

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.6.2	Number of countries that maintain training programs focusing on the strengthening of outbreak response capacities	16	23	Yes

Comments:
26 countries achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BRA, CAN, COL, COR, DOM, DOR, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, SAL, SAV, SCN, SUR, TRT, and USA.

A total of 26 countries maintained training programs to strengthen outbreak response capacity in their respective countries, as demonstrated by the existence of field epidemiology training or equivalent programs, as well as by establishment of the Caribbean subregional program. However, according to the IHR Annual Report to the 66th World Health Assembly (May 2013), which reflected submissions from 31 of the 35 States Parties, regional average human resources capacity was only 57% of the global minimum standard. In terms of the 13 core capacities, human resources had the fourth lowest score.

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)	Fully Achieved

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

12. PAHO support in the detection, containment, and response to pandemic influenza, epidemic-prone viral pathogens, and dengue outbreaks led to enriching country experiences that provided a strong

foundation for countries to implement more recent regional initiatives, such as cholera response plans. For example, the successful response to pandemic influenza resulted in the development of standard operating procedures for rapid response teams and surveillance tools for the countries. Close and strategic collaboration with the Caribbean Public Health Agency has been fundamental to this work in the Caribbean. Resource mobilization to continue country support in the prevention and control of epidemic-prone viral diseases, such as Bolivian hemorrhagic fever (BHF), Hantavirus, equine encephalitis, Chikungunya fever, among others, is urgent.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.7.1	Number of countries that have national preparedness plans and standard operating procedures in place for rapid response teams against pandemic influenza	17/35	35/35	Yes
Comments: 35 countries achieved this indicator: 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, TRT, SAL, SAV, SCN, SUR, URU, USA, and VEN. All the countries of the Region have developed national preparedness plans and standard operating procedures for rapid response teams in the event of pandemic influenza. In the Eastern Caribbean countries (ECC), national influenza plans have been used as an example of multi-hazard preparedness to build cholera response plans.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.7.2	Number of countries with basic capacity to detect epidemic-prone viral pathogens according to the PAHO/WHO epidemiological surveillance guidelines	2	12	Yes
Comments: 12 countries achieved this indicator: ARG, BOL, BRA, COL, ECU, GUY, PAN, PAR, PER, SUR, TRT, and VEN. A total of 12 countries in the Region successfully developed and strengthened country capacity to detect epidemic-prone diseases as a result of solid preparatory work over the last several years, in particular with regard to yellow fever; joint efforts with technical partners such as CDC and WHO Collaborating Centers; and close collaboration with the Caribbean Public Health Agency.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.7.3	Number of countries implementing interventions and strategies for dengue control according to PAHO/WHO guidelines	14	23	Yes
Comments: 23 countries achieved this indicator: ARG, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, PUR, TRT, URU, and VEN. A total of 23 countries in the Region have been implementing updated interventions for dengue control, which are aligned with the new WHO dengue guidelines. New treatment guidelines for dengue patients were also adapted, developed, and distributed to countries throughout the Region in combination with training opportunities provided over the last several years. In addition, 4 subregional strategies for dengue control were developed for the English-speaking Caribbean, Central America, the Andean Region, and the Southern Cone, as well as a strategy specific for the Dutch-speaking territories.				

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	Fully Achieved

RER Assessment Summary (1 of 1 RER indicator target achieved)

13. By the end of 2013, 100% of all public health events of international concern were verified within 48 hours of their detection. This achievement was the result of multidisciplinary collaborative work between the Alert and Response (ARO) team, experts across PAHO technical areas, and PAHO Country Offices. Between January 2008 and December 2013, a total of 932 events were assessed, 325 of which required verification from Member States. Since 2008, the proportion of initial event information received via International Health Regulations (IHR) National Focal Points (NFPs) has grown from 34% to 97%. PAHO/WHO surveillance conducted at the regional and country office levels accounts for detection of the remaining events. A 24/7 duty officer system was maintained during this period to cover all IHR-related communication. The PAHO web page on alert and response was updated to keep Member States informed. The 24/7 availability of Member States was tested through biannual communication tests, with results provided for corrective action to be taken as needed. Examples of events reported in the Americas during this period include an influenza pandemic in Mexico; a cholera outbreak in Hispaniola, Cuba, and Mexico; an outbreak of Chikungunya fever in the Caribbean; Bolivian hemorrhagic fever in Bolivia; pneumonic plague in Peru; methanol poisoning in Ecuador; intoxication with contaminated dextromethorphan in Paraguay; an outbreak of Oropouche virus disease in Peru; an extensively drug-resistant (XDR) case of tuberculosis with extensive travel detected in the United States of America; and nonviral hepatitis potentially associated with OxiElite dietary supplement products. Requests for support were received and provided by the Organization in connection with several of the aforementioned events.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.8.1	Percentage of public health events of international importance verified in the time recommended by the International Health Regulations	85%	98%	Yes
Comments: By the end of 2013, 100% of all public health events of international concern had been verified within 48 hours of their detection through PAHO/WHO surveillance activities. Between January 2008 to December 2013, 932 events were assessed and Member States were alerted about risks posed by substantiated events through 135 Epidemiological Alerts and 262 Event Information Site postings.				

RER 1.9 Effective operations and response by Member States and international community to declared emergency situations due to epidemic- and pandemic-prone diseases	Fully Achieved

RER Assessment Summary (1 of 1 RER indicator target achieved)

14. PAHO has consistently responded in a timely manner to all requests received from Member States during emergency situations, a record that underscores the effective operations that are in place. Activation of the Global Outbreak Alert and Response Network has proven time and again to be a critical mechanism for the rapid deployment of experts to respond to regional outbreaks, working in collaboration with regional and country-level team members. Examples of this collaboration include the responses to a BHF outbreak in BOL, dengue outbreaks in DOR and HON, the outbreak of Chikungunya fever in the Caribbean, and a plague outbreak in Peru.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
1.9.1	Percentage of PASB International Health Regulations-compliant responses based on requests for support from Member States during emergencies or epidemics	90%	100%	Yes
Comments: All requests received by Member States during emergencies or epidemics were assessed and answered within a 24-hour period, in compliance with the IHR, and responded to with the deployment of appropriate experts. Examples of these actions include the deployment of Global Outbreak Alert and Response Network, regional, or country-level team members to rapidly respond to dengue outbreaks in DOR and HON, infectious outbreaks in BAR and BLZ, the outbreak of Chikungunya fever in the Caribbean, and plague in PER.				

SO2: To combat HIV/AIDS, tuberculosis, and malaria					Partially Achieved[5] (83% of indicator targets achieved)	
RER Status[6]	2.1	2.2	2.3	2.4	2.5	2.6

SO2 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
202.9	23.7	75.4	99.1	93%	49%

SO2 Programmatic Assessment

15. Over the six-year period of the PAHO Strategic Plan 2008-2013, PAHO provided the Member States with technical cooperation to combat HIV/AIDS, tuberculosis (TB), and malaria—diseases that cause a significant health, social, and economic burden in the Region of the Americas. Effective strategies and interventions were developed and implemented to enhance the prevention, detection, treatment, and control of HIV, TB, and malaria. As a result, the incidence of HIV infections in the Region was reduced from an estimated 16.9 per 100,000 inhabitants in 2006, to 15.0 new infections per 100,000 in 2012. Between 2008 and 2013, the estimated incidence of TB was reduced from 39 to 29 cases per 100,000 population, and the incidence of malaria was reduced by 49%. Innovative measures were designed and implemented to increase access to interventions among vulnerable populations for all three diseases, and countries were supported on the incorporation of gender and human rights approaches into plans, policies, and services. Increased participation in the PAHO Strategic Fund contributed to improved and more equitable access to quality essential medicines and health commodities. The regional capacity for generation and use of strategic information on HIV, TB, and malaria was strengthened, as was effective monitoring of the evolution of drug resistance.

16. Through adoption of Resolution CD50.R12 in 2010, the Region consolidated and further strengthened its commitment to eliminate congenital syphilis and mother-to-child transmission (MCTC) of HIV. As a result of regional and country efforts, regional estimated HIV testing coverage among pregnant women in Latin America and the Caribbean increased from 29% in 2005 to 63% in 2012, and the number of children

[5] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[6] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

newly infected with HIV fell by 24% in Latin America and 32% in the Caribbean between 2009 and 2011. At least 13 countries (ABM [Anguilla], ANI, BAR, BLZ, CAN, CHI, CUB, GUY, JAM, NCA [Bermuda], SAL, SAV, and USA) may have achieved the congenital syphilis elimination target. Ongoing capacity-building and development of tools such as blueprints for services for transgender and men who have sex with men (MSM) populations contributed to improved services, even though major barriers persist for access of these key populations to HIV/STI services. Continued country efforts, capacity-building, and regional analysis of treatment and care programs contributed to expansion of treatment program coverage, and in fact HIV treatment coverage increased to 75% (66%-87%) for Latin America and the Caribbean in 2012.

17. With regard to malaria, countries have harmonized their national strategies with the recommended guidelines and continue to implement the updated Malaria Strategy and Plan of Action 2011-2015, components of the Roll Back Malaria action plan, and other technical PAHO guidelines that have been developed for the Americas. Of the 21 malaria-endemic countries in the Region, 13 have already reached the Millennium Development Goal (MDG) 6 of 75% reduction in malaria morbidity by the year 2015 vis-à-vis the year 2000. Another 5 countries are on the way to meeting the MDG goal in the coming years. In 2012, countries reported 469,378 malaria cases and 108 deaths, reflecting a 60% decrease in cases and a 72% decrease in deaths since 2000. Recorded malaria cases continued to decline in 17 of the 21 malaria-endemic countries. National TB programs have strengthened surveillance, resulting in increased detection rates of TB cases, and they will continue efforts to overcome challenges related to quality DOTS, control efforts at the country level, and the use of new treatment tools when they become available. In addition, there has been increased collaboration between HIV and TB programs in the Region. Furthermore, support has been provided to develop national plans for expansion of the programmatic management of multidrug-resistant TB (MDR-TB) in priority countries. Similarly, a new intersectoral and interprogramatic approach was launched at the end of the reporting period to address TB prevention and control in large cities, where most undiagnosed TB cases are located, within the context of social determinants of health and universal health coverage (UHC).

18. Country participation in the PAHO Strategic Fund for the procurement of essential medicines for the three diseases has increased over this period in an effort to avoid stock-outs and prevent gaps in treatment. Forty countries implemented blood safety measures and carried out HIV screening for 100% of donated blood units.

19. Strengthening HIV, malaria, and TB surveillance was a priority over the last several years. As a result, countries achieved and/or surpassed the diseases' specific indicators regarding the availability of timely surveillance data and disaggregation by sex and age. In addition, efforts to strengthen and expand routine surveillance for antiretroviral, antimalarial, and antitubercular drug resistance also improved in selected countries, although ongoing work is required in order to achieve timely detection of all cases.

20. The implementation of effective interventions and strategies for HIV/AIDS, malaria, and TB has generated important lessons for countries within and outside of the Region. PAHO will continue to work to identify research gaps with a view to shaping future endeavors. Finally, PAHO technical cooperation supported country efforts to foster political commitment, conduct advocacy activities, mobilize resources for programs, and nurture existing partnerships while establishing new alliances with other key partners.

SO2 Main Achievements

a) In 2012, 75% (66%-87%) of all HIV/AIDS patients who met the WHO criteria for treatment under the 2010 guidelines received antiretroviral treatment. In 2010, the Region consolidated its commitment to eliminate congenital syphilis and reduce MTCT of HIV through adoption of a resolution for dual elimination (CD50.R12), and by the end of 2013, 19 countries were down to less than 5% MTCT of HIV, and 13 countries and territories of the Region reported achievement of the regional target for elimination of congenital syphilis.

b) All countries of the Region report timely TB data disaggregated by sex and age. The TB-related MDGs were reached by 2005 and there has been a steady decline in incidence, prevalence, and mortality. During the period 1990-2012, mortality decreased by 61% and prevalence by 62%. All the countries and territories have implemented TB/HIV collaborative activities. The proportion of TB patients tested for HIV increased from 43% in 2007 to 57% in 2012, with some of the countries, including the Caribbean countries, ELS, PAN and URU, testing more than 90% of their TB cases. Of the TB/HIV co-infected patients reported by 26 out of 36 countries, 77% were given ART, and 6 of the countries (ANI, BAR, BLZ, BOL, BRA, and SAL) were already providing the treatment to all co-infected patients.

c) By the end of 2013, a total of 24 countries/territories were procuring essential medicines and diagnostic supplies for HIV and TB through the PAHO Strategic Fund in an effort to forestall shortages of antiretroviral drugs and avoid interruption of treatment for HIV/AIDS-affected patients. At least 12 countries procured 2nd- and 3rd-line TB drugs and the new TB diagnostic tool, Xpert MTB-Rif, was made available to the countries through this mechanism in 2013.

d) The Region is on track to achieve malaria disease burden reduction targets, as witnessed by a 60% decline in reported cases and a 72% decline in deaths during the period 2000 to 2012. Currently, six countries (ARG, COR, ECU, ELS, MEX, and PAR) are in the pre-elimination phase and 14 countries are free of local malaria transmission.

e) The successful establishment of annual Malaria Day in the Americas and Search for Malaria Champions has served as an important mechanism for reinforcing malaria coordination and advocacy efforts, particularly in malaria-affected areas. Furthermore, this continued campaign has served as a forum in which successful malaria programs have been able to share lessons learned that could be applied in other situations where malaria remains endemic.

SO2 Main Challenges

a) Persisting challenges for scaling up HIV treatment and care programs include weak health systems, vertical approaches, dependence on external funds in some countries, and barriers to provide services for key populations, including the MSM and transgender populations.

b) Reaching the desired detection and treatment success rate for tuberculosis has been impeded by the need to justify program integration into primary health care; the use of controversial disease burden estimates generated at the global level; delays in introducing new diagnostic and treatment tools; difficulties in patient follow-up; and a lack of inclusion of other stakeholders/sectors at the country level.

c) Despite noted progress, mechanisms for collaboration between TB and HIV programs are still weak, thus limiting implementation of the collaborative activities. Current modalities for HIV and TB service delivery and limited monitoring of TB/HIV collaborative activities hamper integration of services for co-infected patients.

d) Timely treatment and response to malaria cases is hindered in some countries by challenges in establishing and maintaining strong surveillance systems in remote and difficult-access locations. Weak surveillance systems may also hinder national capacities to monitor antimalarial drug resistance. Challenges persist in rationalizing malaria treatment and integrating interventions within the framework of a broader health system response.

SO2 Lessons Learned

a) The process of developing the Malaria Research Agenda for the Americas provided the mechanism not just for identification of key knowledge gaps but also linkages and partnerships among malaria researchers and program implementers. These lessons could be applied to other research efforts in the Organization, such as research into how to best target indigenous and Afro-descendant populations.

b) Clear strategic road maps and strong alignment/synergy between global, regional, and country strategies have strong added value in effectively and systematically addressing the evolving challenges of malaria. These lessons could be drawn upon for other thematic areas.

c) Coordination with multiple partners and the identification of interprogrammatic work opportunities has resulted in greater coherence in HIV response and results at the country level, even in the context of constrained resources.

d) Issues of human rights are deeply embedded in the HIV response; hence the importance of capacity-building in the application of human rights instruments. The application of a human rights approach is essential and should be accompanied by legislative changes.

e) Epidemiological and programmatic situation analysis, as well as identification of gaps, has facilitated the development of national plans and projects. The joint work with other programs (e.g., HIV and diabetes) and sectors (e.g., penitentiary and political) at the regional, national, and local level with a perspective of social determinants for health has broadened the scope of action and contributed to joint TB prevention and control efforts.

Progress towards Impact Results

SO2 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)
Reduction of 1.9% in the incidence of HIV infections

As a result of refinements and retrospective corrections in the global modeling and estimate methodologies, the estimated number of new infections per 100,000 inhabitants has changed: according to the new estimates, the 2006 baseline was 16.9, and new infections were down to 15.0 per 100,000 inhabitants in 2012. Consequently, the reduction is 1.9 points, or more than the 1 point decrease projected in the indicator.

SO2 Indicator 2: Access to antiretroviral treatment in Latin America and the Caribbean based on needs assessments
Baseline: 72% in 2006
Target: 80% by 2013 (per the Regional HIV/STI Plan for the Health Sector 2006-2015)

75% of patients with access to ART

In 2012, 75% (66% to 87%) of all patients who met the WHO criteria for treatment under the 2010 guidelines received antiretroviral treatment. For comparisons with the 2006 baseline, it is important to note that the eligibility criteria were updated in 2010, resulting in an additional group of qualifying patients. The data available at this time clearly demonstrate that the Region is well on its way to reaching the universal access target of 80%.

SO2 Indicator 3: Number of countries that have achieved less than 5% incidence of mother-to-child transmission of HIV
Baseline: 3 countries in 2006
Target: 16 countries by 2013 (per the Regional HIV/STI Plan for the Health Sector 2006-2015)

19 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, CAN, CHI, COR, CUB, DOM, ECU, GRA, GUY, NIC, PAN, PAR, PER, TRT, URU, USA.

According to 2010-2011 data reported to PAHO and data reported by countries in the 2012 Global AIDS Response Progress reporting system, 19 countries were down to less than 5% MTCT of HIV. Additional countries, including the Netherlands Antilles, indicated that they may have achieved the target, but currently they do not have the substantiating data. At least 33 countries developed strategies and/or operational plans, and 30 countries updated their national guidelines. In addition, several tools were developed, including a field guide and a regional monitoring and evaluation strategy, and regional and subregional capacity-building activities were implemented. Strengthening of surveillance and monitoring systems remains a priority in order to improve country-level and regional monitoring of progress.

SO2 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

At least 13 countries/territories achieved this indicator: ABM (Anguilla), ANI, BAR, BLZ, CAN, CHI, CUB, GUY, JAM, NCA (Bermuda), PAN, PUR, SAL, SAV, and USA.

According to the most recent data reported to PAHO in 2011-2012, at least 13 countries have achieved the congenital syphilis elimination target. More countries indicated that they may have achieved these targets, but the substantiating data is currently lacking. Strengthening of surveillance and monitoring systems remains a priority in order to improve country-level and regional monitoring of progress. Accelerated progress towards the congenital syphilis elimination targets will require strengthening of primary prevention and further expansion of access to maternal and child health services, along with improvement of their quality and provision of routine ANC syphilis testing and appropriate treatment and follow-up of syphilis seropositive pregnant women and exposed infants.

SO2 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)

Estimated incidence of 29 per 100,000 population
According to the latest available data from 2012, the estimated incidence was 29 per 100,000 population, falling within the expected range of 27-31 per 100,000 population. Considering the 2% yearly reduction trend in incidence, this indicator most probably will be achieved once the 2013 data are available.

SO2 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

A 49% reduction in malaria incidence was observed between 2006 and 2012 (2013 data were unavailable). In the last two years there has been an average yearly reduction of 16%. Given this trend, it is estimated that in 2013 there would have been approximately 395,000 malaria cases reported. PAHO continues to support countries in implementing the most updated available tools to prevent and control malaria cases and reduce the burden of the disease in the Region. Given the sustained achievements in reducing the incidence of malaria, efforts are underway in Central America and Hispaniola to map out technically sound strategies to accelerate the move towards malaria elimination.

SO2 Indicator 7: Number of countries retaining their malaria nonendemic status
Baseline: 19 countries in 2007
Target: 19 countries by 2013

19 countries retain their nonendemic status.

Bahamas and Jamaica successfully controlled and interrupted transmission during reported malaria outbreaks in 2006, thereby preventing reintroduction. These countries were still considered nonendemic at the end of 2013. Continued efforts to utilize relevant available malaria strategies have contributed to the identification of possible risk events and helped to prevent the re-establishment of malaria in these countries.

Assessment of the Region-wide Expected Results

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, hard-to-reach, and vulnerable populations	Partially Achieved

RER Assessment Summary (3 out of 7 RER indicator targets achieved; 4 not achieved)

21. PAHO continued to provide technical cooperation and to strengthen prevention, treatment, and patient care for HIV/AIDs, tuberculosis, and malaria with focus on vulnerable populations. The Dual Elimination Initiative (mother-to-child transmission (MTCT) of both HIV and syphilis) made great strides as the countries worked toward reducing the incidence of MTCT of HIV and achieving the regional target for the elimination of congenital syphilis, while fostering synergies between the two programs. The majority of countries/territories are aligning their national strategies with guidelines from updated PAHO Malaria Strategy and Plan of Action 2011-2015. Despite high detection rates of TB cases in the countries, persisting challenges related to quality of DOTS in large and small countries, challenges in TB control efforts at the country level, and delays in introducing new treatment tools have impeded the achievement of the desired treatment success rate of 85% among patients. Changes in eligibility criteria for ART negatively affected coverage, since additional patients were included and in immediate need of treatment. Persisting challenges for scaling up treatment and care programs, including weak health systems, dependence on external funds (in some countries), stigma and discrimination, as well as other barriers to effective provision of services for key populations (i.e., men who have sex with men and transgender populations) have impeded target achievement.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.1	Number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV-positive pregnant women	9	17	No
Comments: 15 countries achieved this indicator: ANI, ARG, BAH, BRA, CAN, CHI, ECU, GRA, GUY, PAN, SAL, SAV, TRT, URU, and USA. A total of 15 countries achieved this indicator. It is possible that more of them did so, but weak information systems and lack of data precluded the addition of their names to the list. Also, data were not readily available because they depended on accurate information or estimates at the country level. Also, UNAIDS does not release estimates for concentrated epidemics because of the wide margin of uncertainty. Overall, UNAIDS estimates that in the Caribbean more than 95% of pregnant women living with HIV receive antiretroviral treatment (ART); in North America, more than 95%; and in Latin America, 83%.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.2	Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need per PAHO/WHO guidelines	6	15	No
Comments: 8 countries achieved this indicator: ARG, BAR, BLZ, BRA, CHI, CUB, GUY, and MEX. A total of 8 countries achieved 80% coverage (2012 data), while an additional 7 of them, at (>70%, were close to reaching the target (BAH, COR, NIC, PAN, PAR, TRT, and VEN). Persisting challenges in scaling up treatment and care programs, including weak health systems, dependence on external funds (in some countries), stigma and discrimination, as well as other barriers to the effective provision of services for key populations (i.e. men who have sex with men and transgender persons) impeded target achievement.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.3	Number of countries implementing components of the Global Malaria Control Strategy within the context of the Roll Back Malaria initiative and the PAHO Regional Plan for Malaria in the Americas 2006-2010	20	33	Yes

Comments:
33 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, COL, COR, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SUR, TRT, USA, and VEN.

Most of the countries/territories are aligning their national strategies with guidelines from the updated PAHO Malaria Strategy and Plan of Action 2011-2015. The nonendemic Caribbean countries (i.e., ABM, ANI, and DOM) are implementing components of global and regional malaria strategies, particularly Integrated Vector Management to prevent malaria reintroduction. PAHO has actively encouraged all the countries to strengthen/retain strong alignment of their national strategies with PAHO/WHO strategies and technical guidelines, including those that are reorienting their programs towards elimination and those seeking to prevent reintroduction.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.4	Number of countries detecting 70% of estimated cases of pulmonary tuberculosis through a positive TB smear test	12/27	26/27	Yes

Comments:
30 countries/territories achieved this indicator: ANI, ARG, BAH, BAR, BRA, CAN, CHI, COL, COR, CUB, DOM, ELS, GUY, HAI, HON, MEX, NCA, NEA, NIC, PAN, PAR, PER, PUR, SAL, SCN, SAV, TRT, TCA, URU, and USA.

A total of 19 of these countries/territories reached a case detection rate of more than 85% (ANI, BAH, BAR, CAN, CHI, COR, ELS, GUY, NCA, NIC, PER, PUR, SAL, SCN, SAV, TCA, TRT, URU, USA) and are on track to reaching the STOP TB Partnership 2015 target.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.5	Number of countries with a treatment success rate of 85% for tuberculosis cohort patients	6/27	23/27	No

Comments:
15 countries achieved this indicator: BOL, COR, CUB, DOM, DOR, ELS, GRA, GUT, HAI, HON, MEX, NIC, PAN, SCN, and URU.

Treatment success includes the patients who completed 6 months of treatment and those who were declared cured with a smear test. This information is only available after two years, when the time to complete the treatment has passed. As a result, there is a delay in determining treatment success. Additional challenges include: (1) problems with the quality of the DOTS programs in both large and small countries; (2) challenges with TB control efforts at the country level; (3) delays in the introduction of new treatment tools; and (4) insufficient engagement of other stakeholders/sectors at the country level. In 2011 some of the countries were moving closer to the set target, including BRA, COL, ECU, PAR, SUR, and VEN.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.6	Number of countries that have achieved the regional target for elimination of congenital syphilis	2	26	No

Comments:
13 countries/territories achieved this indicator: ABM, ANI, BAR, BLZ, CAN, CHI, CUB, GUY, JAM, NCA, SAL, SAV, and USA.

A total of 13 countries or territories achieved the regional target for the elimination of congenital syphilis (CS), which is defined as a reported CS rate under 0.5 per 1,000 live births and at least 80% testing coverage among antenatal care attendees. Significant progress was made by ELS, PER, and SCN, all of which are close to achieving the elimination goal. Technical cooperation was provided to countries to improve national plans for the elimination initiative; strengthen surveillance, including monitoring and evaluation efforts; expand HIV and syphilis testing coverage; update or develop guidelines, protocols, and standards; improve primary prevention of HIV and syphilis; and build health worker capacity. Persisting challenges include low antenatal care (ANC) coverage in some countries, weak recording systems for antenatal syphilis testing and treatment, and high syphilis prevalence in the general population and those receiving antenatal care services.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.1.7	Number of countries with quantifiable targets in their health plans for prevention and control of HIV and other sexually transmitted infections	4	14	Yes

Comments:
14 countries achieved this indicator: ARG, BLZ, BRA, COL, COR, DOR, ECU, GUT, HON, JAM, NEA, PAR, PER, and URU.

Despite the fact that 14 countries achieved this indicator, ongoing efforts are required to closely monitor these targets, particularly with regard to evidence of new cases reported among key populations.

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	Fully Achieved

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

22. The countries have received ongoing support to update and align plans and policies with the recommended Universal Access Framework and to adapt to new guidance that is issued, such as the 2013 WHO guidelines on the strategic use of ARVs for the prevention and treatment of HIV. Continued efforts to increase collaboration between HIV and TB programs have proven effective as 39 countries/territories have adopted and implemented recommendations for HIV-TB collaborative activities at varying levels of implementation.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	Yes

Comments:
40 countries/territories achieved this indicator: 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, SAL, SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.

Ongoing support has been provided to the countries to update their policies and plans as new guidance is issued, such as the 2013 WHO guidelines on the strategic use of ARVs for prevention and treatment of HIV.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.2.2	Number of countries implementing the WHO 12 collaborative activities against HIV/AIDS and tuberculosis	3	30	Yes

Comments:
39 countries/territories achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NCA, NEA, NIC, PAN, PAR, PER, PUR, SAL , SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.

All 39 countries/territories are currently implementing TB/HIV collaborative activities. Both ELS and GUY are implementing all collaborative activities at the country level, while the remaining countries/territories have various degrees of implementation. Almost all the countries report on key collaborative activities such as HIV testing in TB patients and ART in co-infected patients. Others are assessed through TB and HIV program reviews and regular monitoring.

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	Fully Achieved

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

23. Improving equitable access to quality essential medicines, diagnostics, and other commodities for the prevention and treatment of HIV, tuberculosis, and malaria continues to be a priority in the Region. By the end of 2013, a total of 24 countries and territories had signed an agreement with the PAHO Strategic Fund for the procurement of essential medicines for these diseases. Specifically for HIV/AIDs, the number of countries/territories procuring medicines and diagnostic supplies has increased as the result of an exerted effort to prevent shortages of antiretroviral drugs that can result in gaps in treatment. An important regional achievement is that the majority of countries and territories continued to implement quality-assured HIV screening for 100% of all units of donated blood. Following several years of ongoing support and advocacy efforts provided by PAHO, the regional target was surpassed and16 countries have updated their national diagnostic and treatment guidelines in accordance with PAHO/WHO recommendations. The new diagnostic tool for TB, Xpert MTB-Rif, was recently made available through the PAHO Strategic Fund. The Regional TB program worked with countries to strengthen capacity at country level on laboratory quality control for drugs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.3.1	Number of countries implementing WHO revised/updated diagnostic and treatment guidelines on tuberculosis	0/27	14/27	Yes

Comments:
16 countries achieved this indicator: BAH, BAR, BOL, BRA, CAN, COL, COR, DOR, ECU, ELS, GUT, HON, MEX, NIC, PAR, and PER.

Several countries updated their national guidelines to include the recent WHO recommendations. It is worth mentioning that PER, the country with the highest burden of MDR-TB (56%) in the Region, successfully adapted its national guidelines to align with international recommendations, resulting in better control of MDR-TB.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.3.2	Number of countries that participate in the Strategic Fund mechanism for affordable essential medicines for HIV/AIDS	19	21	Yes
Comments: 21 countries/territories achieved this indicator: BAH, BLZ, BOL, BRA, CHI, COL, COR, DOR, ECU, ELS, GUT, HAI, HON, NIC, PAN, PAR, PER, TCA, TRT, URU, and VEN. By the end of 2013, a total of 21 countries/territories were procuring essential medicines for HIV/AIDs in an effort to prevent shortages of antiretroviral drugs, which in the past had led to interruption of treatment for HIV/AIDS affected patients. Also noteworthy is that 24 countries/territories had signed an agreement with the PAHO Strategic Fund for the procurement of essential medicines for HIV/AIDS, tuberculosis, and malaria.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.3.3	Number of countries implementing quality-assured HIV screening of all donated blood	32	40	Yes
Comments: 40 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HAI, HON, JAM, NCA, NEA, NIC, PAN, PAR, PER, PUR, SAL, SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN. A total of 40 countries/territories are implementing quality-assured HIV screening for 100% of all units of donated blood. Of the Latin American countries, only Mexico had not reached the 100% mark, but it reported that 98.43% of all units were being screened.				

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	Fully Achieved

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

24. The countries of the Region have achieved and/or surpassed the established indicators on monitoring the timely availability of surveillance data for HIV, malaria, and tuberculosis disaggregated by sex and age, which facilitates more profound data analysis. Improvements in data quality have also been noted in many countries as a result of ongoing support to strengthen health information systems.

25. In addition, selected countries continue efforts to strengthen and expand routine surveillance for antiretroviral, antimalarial, and antitubercular drug resistance. One example of this expansion is the establishment of early warning indicators (EWIs) for monitoring of HIV drug resistance in Latin America and the Caribbean, which have been integrated into national monitoring and evaluation and information systems. Despite these notable achievements, PAHO encourages countries to continue strengthening the quality of their surveillance systems in order to detect all cases and ensure timely case investigations and tailored responses.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.1	Number of countries reporting HIV surveillance data disaggregated by sex and age to PAHO/WHO	25	33	Yes

Comments:
33 countries achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, 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.

33 countries were reporting HIV data disaggregated by sex and age in accordance with second generation surveillance guidelines. The quality of data has improved, and PAHO has been providing ongoing support to continue strengthening the health information systems.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.2	Number of countries reporting tuberculosis surveillance data disaggregated by sex and age to PAHO/WHO	27	37	Yes

Comments:
39 countries/territories achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NCA, NEA, NIC, PAN, PAR, PER, PUR, SAL ,SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.

The countries of the Region have quality surveillance in place and reported timely TB data disaggregated by sex and age, in addition to data related to implementation of The Stop TB Strategy. Compared with other WHO regions, the Region of the Americas has the highest number of countries reporting disaggregated TB data.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.3	Number of countries reporting malaria surveillance data disaggregated by sex and age to PAHO/WHO	21/21	21/21	Yes

Comments:
21 countries/territories achieved this indicator: ARG, BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, and VEN.

All the endemic countries report malaria surveillance data disaggregated by sex and age. Nevertheless, PAHO encourages countries to continue strengthening the quality of their surveillance systems, including linkage to prompt and good-quality diagnosis and treatment, in order to capture all cases. Prompt case investigations and tailored responses are also warranted in areas where the primary goal is elimination of local transmission.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.4	Number of countries reporting HIV drug resistance surveillance data to PAHO/WHO per PAHO/WHO guidelines	1	16	Yes

Comments:
17 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, ECU, ELS, GUT, GUY, HAI, HON, MEX, NIC, PAN, PER, and URU.

PAHO technical cooperation focused on consolidation of HIV drug resistance (HIV-DR) and EWI monitoring in Latin America and the Caribbean integrated into national monitoring and evaluation and information systems. A total of 17 countries received support in maintaining, strengthening, or starting the implementation of EWI monitoring. In addition, GUY and HAI implemented WHO HIV-DR monitoring surveys.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.5	Number of countries reporting tuberculosis drug resistance surveillance data to PAHO/WHO per PAHO/WHO guidelines	14/27	27/27	Yes

Comments:
27 countries achieved this indicator: ARG, BAH, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, PUR, TRT, USA, URU, and VEN.

Technical cooperation to countries has resulted in the rapid expansion of MDR-TB surveillance, in accordance with PAHO/WHO guidelines. A total of 8 of these countries capture data through routine surveillance efforts (BAH, CAN, COR, CUB, PER, PUR, USA, and URU).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.4.6	Number of countries reporting malaria drug resistance surveillance data to PAHO/WHO per PAHO/WHO guidelines	9/21	20/21	Yes

Comments:
20 countries/territories achieved this indicator: BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, and VEN.

Malaria-endemic countries have carried out studies on drug efficacy and resistance. Within the framework of the Amazon Malaria Initiative/Amazon Network for the Surveillance of Antimalarial Drug Resistance (AMI/RAVREDA), PAHO has provided the Amazon Basin, Central American, and other countries in the Region with technical support to ensure continued vigilance for antimalarial 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	Fully Achieved

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

26. PAHO regional teams worked closely with national counterparts to establish functioning coordination mechanisms for HIV/AIDS, malaria, and tuberculosis in an effort to harness political commitment, mobilize resources to ensure program sustainability, cultivate partnerships, and engage key stakeholders. Priority areas included the integration of HIV/AIDs into the health sector, expansion of The Stop TB Partnership, use of regional platforms for malaria advocacy, and increased involvement of stakeholders in the design, implementation, and evaluation of HIV/AIDS programs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.5.1	Number of countries with functional coordination mechanisms for HIV/AIDS	40	40	Yes

Comments:
40 countries/territories achieved this indicator: 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, SAL, SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.

All the countries/territories have coordination mechanisms for HIV/AIDS. The focus of PAHO technical

cooperation was on strengthening the health sector response and coordination, integration of HIV into the health sector, and leveraging the contributions and comparative advantages of the various stakeholders, including civil society, towards optimization of the HIV response. PAHO built strong partnerships with civil society and with the Horizontal Technical Cooperation Group of Latin America and the Caribbean (GCTH).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.5.2	Number of countries with functional coordination mechanisms for tuberculosis	5/27	15/27	Yes

Comments:
19 countries achieved this indicator: BOL, BRA, CAN, COL, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, and URU.

A total of 19 countries have coordination mechanisms for tuberculosis in place. PAHO technical cooperation was provided to strengthen country coordinating mechanisms, build upon The Stop TB Partnership, support collaboration with organized groups (specifically in Panama), and work with the Anti-tuberculosis leagues (COL and URU).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
2.5.3	Number of countries with functional coordination mechanisms for malaria	21/21	21/21	Yes

Comments:
21 countries/territories achieved this indicator: ARG, BLZ, BOL, BRA, COL, COR, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, and VEN.

The 21 countries/territories continue to maintain functional coordination mechanisms for malaria. These efforts are strengthened through the annual commemoration of Malaria Day in the Americas and the ongoing search for the Malaria Champions of the Americas, which serve as Regional platforms for malaria advocacy and affirmation of best practices.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	Yes

Comments:
41 countries/territories achieved this indicator: 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, PUR, SAL, SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.

A total of 41 countries/territories successfully maintained the involvement of key stakeholders in the planning, design, implementation, and evaluation of programs against HIV/AIDS. In particular, the engagement of civil society organizations has been maintained throughout the Region. However, the involvement of representatives of lesbian, gay, bisexual, and transgender populations remains a challenge, which is more pronounced in the Caribbean because of a number of factors, including the continued criminalization of same-sex relations. The involvement of the private sector has also been indifferent, and the participation of faith-based organizations has decreased in comparison with previous years.

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	Fully Achieved

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

27. PAHO technical cooperation has focused on generating new knowledge, identifying key interventions, and developing and implementing strategies with proven effectiveness related to tuberculosis and malaria. There were several examples from tuberculosis over the last several years, such as the Public-Private Mix for TB Care and Control, the Practical Approach to Lung Health, the use of new diagnostic assays endorsed by WHO, and the TB Control Initiative in Large Cities in Latin America and the Caribbean. With regard to malaria, the Strategy and Plan of Action for Malaria in the Americas 2011-2015 and the External Quality Assurance Program are being successfully implemented. The identification and prioritization of research gaps for TB and malaria will continue.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	1	3	Yes

Comments:
A total of 4 new or improved interventions were introduced during 2008-2013.

PAHO technical cooperation with the countries has focused on strengthening key interventions and implementation strategies of proven effectiveness. These include: (1) the Public-Private Mix for TB Care and Control in 17 countries (BOL, BRA, CAN, CHI, COL, COR, ECU, ELS, GUT, GUY, HAI, HON, MEX, PAR, PER, URU, and VEN), which involves health care providers from all sectors (i.e., public, private, formal, and informal) in the provision of care for patients who have or are suspected of having tuberculosis; (2) the Practical Approach to Lung Health in 8 countries (ARG, BOL, BRA, CHI, CUB, ELS, MEX, and NIC, which targets health workers, nurses, doctors, and managers in a primary health care setting; (3) the use of new diagnostic assays endorsed by WHO, Xpert MTB/RIF assay, and line-probe assay in 12 countries (BRA, COL, COR, ELS, GUT, GUY, HAI, MEX, PAN, PAR, SUR, and VEN); and (4) the TB Control Initiative in Large Cities in Latin America and the Caribbean in 3 countries (BRA, COL, and PER) to scale up efforts to prevent and control tuberculosis in the Americas, especially in vulnerable populations living in large cities.

The introduction of the new Xpert MTB-Rif diagnostic technology resulted in increased case detection of TB and MDR-TB in ELS, the first country to introduce it with organized follow-up, thus documenting evidence of its effectiveness in the Region. Pilot implementation of the TB in Big Cities framework in Lima (Peru), Bogotá (Colombia), and Guarulhos (Brazil) has identified urban areas and populations at risk for TB, key formal and informal health providers, and the socioeconomic aspects needed in order to develop strategies to better address TB control within the context of social determinants of health and social protection schemes.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	0	2	Yes

Comments:
A total of 3 interventions and/or strategies were introduced during 2008-2013, as follows:
1) The Strategy and Plan of Action for Malaria in the Americas 2011-2015 (Document CD51/11) is currently being implemented in the Region.
2) The External Quality Assurance Program has successfully been established, with 21 countries and 22 national laboratories collaborating to assure malaria diagnosis and improve malaria diagnostic capacity in the countries.
3) Collaboration on the systematic review of malaria research gaps in the Region is ongoing and a technical advisory group convened twice in 2013. Further collaboration to identify and prioritize malaria research gaps is planned for the 2014-2015 biennium.

SO3: To prevent and reduce disease, disability, and premature death from chronic noncommunicable conditions, mental disorders, violence, and injuries					Partially Achieved[7] (96% of indicator targets achieved)	
RER Status[8]	3.1	3.2	3.3	3.4	3.5	3.6

SO3 Budget Overview

Approved Budget (PB 08-13)	**Funds Available (in US$ millions)**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
94.1	36.2	34.1	70.3	93%	75%

SO3 Programmatic Assessment Summary

28. During this period, efforts to tackle the rising burden of disease caused by NCDs were significantly strengthened in the Region. Several efforts led by the Region called for and culminated in a political commitment at the United Nations High Level Meeting (UNHLM) on NCDs in 2011 which later contributed to the WHO Global Action Plan on NCDs and the Global Monitoring Framework on NCDs. Countries are responding to the political and technical commitments made in these mandates and have started reviewing or updating their national plans, regulations, policies, and programs on NCDs and their risk factors, as well as on violence, mental health, disabilities, ocular health, oral health, and road safety. Many countries have allocated additional human and financial resources and have adapted guidelines to address these issues.
29. During the period, several regional plans of action were adopted by Member States for the key technical areas included in this Strategic Objective, including mental health, epilepsy, noncommunicable diseases, road safety, violence, harmful use of alcohol, and substance use.

30. Most countries of the Region have collaborated in providing information for global and regional reports on mental health, road safety, and violence, among others, and this information has prompted work at the country level to improve health system and policy response on these topics. Additional efforts in surveillance and global reporting have yielded NCD-specific mortality data; registries for specific diseases such as cancer, stroke, and diabetes; observatories for road safety and suicide prevention; evidence for violence against women; and clear progress indicators on oral and ocular health as well as disabilities.

[7] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[8] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

Other sectors were mobilized in the implementation of actions as a result of this effort, in particular for road safety, violence, and disabilities.

31. The challenges ahead are enormous given the high burden of NCDs, mental disorders, road traffic injuries, violence, and disabilities; the grand expectations for a global response; and the limited resources available to meet these expectations. In the short term, all countries will have to report on progress since the UNHLM at the 2014 United Nations General Assembly (UNGA), and there is ongoing discussion about how the process will take place, accountability for the commitments made, and what will be reported. Other challenges include the need to better align implementation efforts with political commitments; improve surveillance efforts, which are currently uneven and sometimes duplicated; expand application of the integrated health care model; and promote simple interventions, such as the integration of tobacco cessation into primary health care (PHC), which is still not widely implemented. There is an urgent need to define the rules of engagement with other sectors, inasmuch as the response to NCDs is a multisectoral effort. PAHO has established a new NCDs and Mental Health (NMH) Department to provide regional leadership in these areas, develop a Regional NCD Action Plan, and build synergies with universal health coverage and other priorities with a view to increasing efficiency at all levels.

SO3 Main Achievements

a) The political commitment towards combating NCDs as part of the development agenda has been well established worldwide and in the Region. The operational framework to achieve a 25% reduction in premature mortality has also been established. Efforts led by the Region culminated in political commitments made at the United Nations High Level Meeting on NCDs in 2011 and in the Global Monitoring Framework for NCDs and the WHO Global and PAHO Regional Action Plans on NCDs.

b) In addition to the regional plans adopted by the Member States in mental health, epilepsy, noncommunicable diseases, road safety, violence, harmful use of alcohol, and substance use, three other plans were being developed or updated (on disabilities, obesity, and mental health). These documents constitute a framework that will guide regional efforts aimed at responding to NCDs, mental disorders, road traffic injuries, violence, and disabilities.

c) Pursuant to the PAHO and WHO updated guidelines and frameworks, countries have made considerable efforts to revise their national plans, programs, or regulations on NCDs (notably cardiovascular disease, the principal cancers, and diabetes), mental health, disabilities, road safety, prevention of violence and injuries, eye care, and oral health, and in some cases implementation has commenced.

d) Surveillance systems and global and regional reporting were strengthened during the period. All the countries reported data on NCD-specific mortality; all the countries in the Region were participating in the oral health surveillance system; 28 countries reported data on disabilities; all the countries participated in the development of two regional reports on road safety and gathered relevant data; 21 countries took part in preparation of the Global Status Report on Violence Prevention; 21 countries reported having mental health information systems; 19 countries contributed to the global report on resources for the prevention and treatment of substance use disorders; most of the countries were regularly reporting on cataract surgery rates; the first regional comparison of nationally representative data on violence against women was developed; Central America advanced the development of a subregional observatory on suicidal behavior; 11 countries had national disease registries on cancer, stroke, or diabetes; and most of the countries in the Region were part of the Regional Road Safety Observatory. The WHO Global NCD Action Plan, with 9 voluntary targets and 25 indicators, has been established, and ways to improve surveillance systems at the global level were being discussed.

e) Capacity-building efforts took place during the period, including virtual courses on NCDs in the Caribbean; assessments of mental health plans and systems in the Region; training workshops with primary health care providers to improve quality of care for diabetes and earlier detection of cancer; improved training and cross-cutting alliances on disabilities in many countries; capacity-building workshops on primary prevention of violence against children and women for over 200 decision-makers in multiple countries of the Region; and training on the collection of road safety data in 16 countries.

f) The Pan American Forum for Action on NCDs (PAFNCD) was created with the aim of building partnerships, networking, and mobilizing resources in support of PAHO technical cooperation. The Women's Cancer Initiative and the Salt Reduction Initiative are two successful examples of the PAFNCD private-public partnership.

g) A number of documents were prepared in the Region on cost-effective interventions to address NCDs, mental disorders, road traffic injuries, violence, and disabilities—for example: economic analyses of NCDs, prepared in several countries; a regional study on treatment gaps and assessment of programs and services on mental health; IDB-led documentation of costs attributed to road traffic injuries; nine national surveys on eye health, most of which resulted in publications in peer-reviewed journals; studies in five countries on alcohol and injuries and studies in 10 countries on alcohol and violence against women; and several studies on violence. These documents are intended to inform and influence decision-makers in committing resources for NCDs, mental disorders, road traffic injuries, violence, and disabilities.

h) PAHO has created a new Noncommunicable Diseases and Mental Health Department to coordinate an integrated and strategic response to risk factors for NCDs, mental health, road safety, violence, and disabilities in the Region.

SO3 Main Challenges

a) The political will that has been evident in all the countries of the Region has not been fully translated into definitive actions and allocation of resources to the prevention and control of NCDs, mental disorders, road traffic injuries, violence, and disabilities.

b) Programs within Ministries of Health might have to be reorganized in several countries to find synergies in the response to these health issues.

c) Surveillance systems in the Region, though they have advanced, remain unsustainable, uneven, and sometimes susceptible to duplication of effort.

d) In the short term, all countries will have to report on progress since the UNHLM at the 2014 United Nations General Assembly, and it is unclear how the reporting process will be conducted.

e) Sustainability of progress already achieved is always a challenge. Some countries are working on development of their action plans, while others are already implementing and assessing them.

f) The concept of universal health coverage, when applied to NCDs and mental health, involves not just access but also integration, quality, and sufficient services. This concept needs to be further operationalized for optimal implementation in the countries so that simple and virtually cost-free interventions that are not yet widely implemented—for example, integration of tobacco cessation into PHC—can be scaled up.

g) The response to these major health problems goes beyond the health sector. There is not a structured, coordinated approach to engaging the non-health sectors in the response to NCDs.

h) Although efforts have been made to build capacity to develop cost-effective interventions, more progress is needed in this area to support recommendations to decision-makers, especially outside the health sector.

i) There are certain public health topics, such as prevention of violence, that are still not recognized as important public health priorities despite the magnitude of the problem and the fact that it is a leading cause of mortality in the Region.

j) Changing the health paradigm from acute care to chronic care will require more investments in training providers, establishing evidence-based guidelines, and providing incentives for continuous rather than episodic care.

SO3 Lessons Learned

a) Early involvement of the Member States in regional and public health decision-making processes such as the Regional Plan on NCDs and the PAHO Strategic Plan) results in stronger commitment to implementation of the measures adopted.

b) Multisectoral action is key the response to NCDs, mental disorders, road traffic injuries, violence, and disabilities. Clear rules of engagement with nongovernmental stakeholders, such as academia, civil society, and the private sector, as well as coordinated action with these players and other international agencies will facilitate the achievement of outcomes by PAHO and the Member States.

c) It is critical to continue to strongly advocate for NCDs as a priority public health issue in national health and development agendas, a challenge that will call for leadership, resources, and a multisectoral and multistakeholder approach.

d) It will be necessary to revisit the Pan American Forum for Action on Noncommunicable Diseases so that its role as a partnership mechanism can be fulfilled.

e) A primary health care approach is necessary in order to provide an integrated health system response to NCDs and their risk factors.

f) The community-based approach to mental health and rehabilitation, articulated through intersectoral participation, has allowed for greater coverage of the care needs of persons with mental health disorders or disabilities and their families.

Progress towards Impact Results

SO3 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

This indicator was established before there was clarity on how to monitor deaths in the four main groups of NCDs. Since the United Nations High Level Meeting and endorsement of the Global Action Plan on NCDs, the focus has shifted from overall mortality to reducing premature mortality.

The number of deaths is related to the overall population of the country/region and it is therefore expressed as a mortality rate, which is age-adjusted to eliminate differences in the population age structure, so that countries and regions can be compared.

The trend analysis of premature mortality (in the population aged 30-69 years) for the four major groups of NCDs showed that age-adjusted rates per 100,000 dropped from 379.9 in 2000 to 318.7 in 2010, reaching an overall decrease of 16.1%. The average annual percentage change was -1.7%, which is statistically significant.

SO3 Indicator 2: Reduction of 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

There are challenges with measuring this indicator because of methodological problems in comparing different studies on treatment gaps. To address this issue, the PASB developed a compilation and analysis of the most relevant studies on prevalence (2013), use of services, and the treatment gap for mental disorders. This information now is available on the PAHO website. Following are some of the conclusions, reached by the study:

- The availability of more representative data on the prevalence of mental disorders and mental health services has provided a better understanding of the magnitude of the treatment gap in the Region.
- Information on mental health resources and services is available for nearly all the countries in the Region from the WHO-Atlas Project and the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS). These reports revealed that disparities continue to exist in mental health services and resources and that the psychiatric hospital continues to be the focal point of care in several countries.

- It is difficult to assess how the current estimates of the treatment gap compare with earlier ones for the Americas because the methodologies in the earlier studies varied significantly in how they derived the prevalence and use of services rates. Given these limitations, the current analysis suggests little change in the treatment gap. Advances in public health research on mental health show that there is need to revise the estimates of the treatment gap in the Americas.

According to current reviews, the treatment gap in the United States for schizophrenia is 42.0%, while in LAC it is 56.4%. Chile is an example of the impact of the services model on the treatment gap (46.3%). There is an inverse relationship between the treatment gap and the number of outpatient facilities available to the population and the amount of community care follow-up provided by outpatient programs.

The treatment gap for 12-month prevalent anxiety disorders is 56.2%. For affective disorders it is 66.3%. Substance use disorders have the highest treatment gap, at 70.6% in the Americas.

SO3 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

The average death rate for the Region from road traffic injuries was 16.1 per 100,000 population in 2010 (the most recent data). Among subregions, the average road traffic death rate per 100,000 population ranged from 11.0 in North America to 22.2 in the Latin Caribbean. At the country level, the estimated death rates from road traffic injuries ranged from 4.6 to 41.7 per 100,000 population. Pedestrians, motorcyclists, and bicyclists are the primary victims of road traffic fatalities in all the subregions except North America, where car occupants are the main victims. Men run a greater risk of dying from road traffic injuries than women. Lack of accessible and affordable public transportation and the increasing trend in motorcycle use is a barrier to achieving this indicator in the Region.

Data from 2013 will be available at the end of 2014, when the current data collection period comes to an end.

SO3 Indicator 4: Number of countries/territories in the Region that have reduced their Decayed, Missing, and Filled Teeth at Age 12 (DMFT-12) score
Baseline: DMFT-12 scores of > 5 in 2 countries/territories, 3–5 in 8 countries/territories, and < 3 in 29 countries/territories in 2004
Target: DMFT-12 scores of > 5 in 0 countries/territories, 3–5 in 2 countries/territories, and < 3 in 37 countries/territories by 2013

The period 2008-2013 was productive and significant for the target countries and DMFT indicators at age 12. This positive result showed that 33 countries reached the consolidation category of DMFT of ≤ 3 (8 countries ≤ 1, 14 countries ≤ 2, 11 countries ≤ 3). In the category of growth, DMFT = 3.1–5.2 (6 countries ≤ 4, 3 countries ≤ 5.2).

The category of emergent countries, referring to countries with a DMFT score > 5 has been eliminated because there is only one remaining country in this category (Guatemala) and it is expected to achieve the target once preventive interventions are in place. The Caries-Free Initiative focuses on vulnerable populations and reducing the gap in inequalities in access to oral health care. It also uses innovative approaches based on common risk factors, oral health, and integration of oral health into primary health care, all of which are expected to lead to further improvements.

Assessment of the Region-wide Expected Results

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	Fully Achieved

RER Assessment Summary (5 of 5 RER indicator targets achieved)

32. This indicator refers to the political, financial, and technical commitments made by governments of the Region with PAHO support. Mobilization within regional and subregional political entities and commitment by countries have shown that it is possible to increase the capacity and commitment to realize substantial progress in the response to NCDs, mental disorders, road traffic injuries, violence, and disabilities in the Region. This work continues to be of the utmost importance, and organizational changes in PAHO with the new NCDs and Mental Health Department (NMH), the new Strategic Plan, and the new NCD Action Plan will serve as a good base for continuity of this work.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.1.1	Number of countries implementing institutional development mechanisms (human/budget resources, training, intersectoral partnerships) related to violence	9	24	Yes

Comments:
24 countries achieved this indicator: ARG, ANI, BAR, BOL, BRA, CAN, CHI, COR, CUB, DOR, DOM, ECU, ELS, GUT, HAI, JAM, MEX, NIC, PAN, PAR, PER, TRT, URU, and USA.

Actions focused on three levels: intersectoral public policy (BOL, CHI, ELS, NIC, PAN, and PER); health plans, either national (NIC and TRT) or sector-specific (NIC and PAR); and community action (DOM).

Four countries placed an emphasis on preventing gender-based violence (BAR, DOM, GRA, and PAN). Also, 21 countries (BLZ, BOL, BRA, CAN, COL, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NIC, PAN, PER, TRT, and USA) have participated in the data collection process for the WHO Global Report on the Situation of Violence Prevention. Thanks to this process, several of these countries, including PER and CUB, increased their institutional capacity by reaching consensus among the major national institutions responsible for violence prevention.

During 2012-2013, ANI established an institutional mechanism between the Ministry of Health and the Gender Affairs Department; CUB reached a consensus among agencies on the Global Report, and trained nurses and medical doctors, on care for victims of violence; DOR created an intersectoral group led by the Ministry of Health and contributed to the Global Report; and HAI developed guidelines for sexual violence.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.1.2	Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to mental health	24	29	Yes

Comments:
36 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, TCA, URU, USA, VEN.

A total of 36 countries completed assessments of their mental health (MH) systems. In addition, three subregional reports were finalized and the regional report was published (2013). The countries are working on the recommendations of the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS). The establishment of baselines for mental health will facilitate the definition of future interventions in this area.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.1.3	Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to chronic diseases	21	38	Yes

Comments:
39 countries/territories achieved this indicator: 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, NCA, NEA, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, and VEN.

This indicator translates into political commitment to institutional development for NCDs. The United Nations High-Level Meeting on NCDs (UNHLM) provided a political and technical imperative for countries to accelerate strengthening their NCD programs. Four countries (ARG, BRA, CHI, and COL) have set national targets related to NCDs and four others (BLZ, COR, ECU, and PAR) have reviewed or developed their national NCD plans, which include multisectoral activities and partnerships, financial plans, and capacity-building. The Caribbean Subregion led the global process that resulted in the UNHLM and has particularly strengthened their response to NCDs, in particular with the Call for Action on Childhood Obesity by Aruba.

The newly formed Caribbean Public Health Agency has an NCD department that works with PAHO on strengthening response to NCDs. CARICOM has made important political contributions to the implementation and evaluation in the Port-of-Spain Declaration. The Healthy Caribbean Coalition, an NGO in special relations with PAHO, has supported advocacy on cervical cancer screening and salt reduction; The University of the West Indies has provided support to the Caribbean in assessing their progress and gaps so that national NCD programs can improve their performance. Representatives of different countries and sectors in the Caribbean attended a virtual course for NCD coordinators entitled "How to effectively address NCDs in 21st century" and supported building information on NCDs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.1.4	Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to disabilities	10	24	Yes

Comments:
24 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, GUT, GUY, ECU, ELS, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN.

Among the countries that achieved this indicator, updated legislation on matters relating to persons with disabilities helped to: *(i)* strengthen National Disability Councils, and *(ii)* create specific technical secretariats where social policies on people with disabilities are coordinated and intersectoral actions are articulated with other areas. SUR has prioritized disability as a cross-cutting issue to be addressed by all its Ministries.

In the health sector, BOL, BRA, CHI, COL, CUB, ECU, GUY, PAN, PAR, and VEN have developed technical units within the structure of the Ministries of Health for the control, management, and stewardship of health activities for people with disabilities. These achievements have involved a significant investment of human and financing; resources, training, and cross-cutting strategic alliances (examples: COR, between the Ministries of Health and Social Security/Welfare, and CHI, between the Ministry of Health and the National Service for Disabilities).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.1.5	Number of countries implementing institutional development mechanisms (human/financial resources, training, intersectoral partnerships) related to road safety	9	21	Yes

Comments:
21 countries achieved this indicator: ARG, BOL, BRA, CAN, CHI, COR, DOR, ECU, ELS, GUT, GUY, JAM, MEX, NIC, PAN, PAR, SUR, TRT, USA, URU, and VEN.

There was important progress during 2008-2013. GUY, PAN, and TRT made progress in developing their Road Safety (RS) Plans of Action, which allow them to improve institutional mechanisms related to RS. DOR has included RS as a priority in its government agenda, and the Ministry of Health (MoH) has played an important role in convening key sectors to work on the RS agenda. VEN has been working with alcohol control and has promoted educational activities in schools. PER finished a comprehensive situation analysis of RS in the country and expanded RS activities in different regions in the country. ARG, BOL, ECU, MEX, and URU made a remarkable improvement in institutional development for RS. ARG created a National Road Safety Agency in 2008, which resulted in a decline in the number of deaths due to road traffic injuries and serves as an example for other countries in the Region. URU also created a national agency during the period. MEX expanded RS activities to all Mexican states and hired a team of RS experts within the MoH. ECU revised and updated its RS legislation. BOL worked with ARG in a cooperative agreement between the two countries. ARG, BRA and URU also had a good experience of collaboration among countries.

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	Fully Achieved

RER Assessment Summary (7 of 7 RER indicator targets achieved)

33. Technical cooperation under this Regional Expected Result was very rich and succeeded to (*a*) secure national NCD plans in 31 countries of the Region; (*b*) support the area of violence against women and produce relevant documentation/tools to support the development of evidence-based policies; (*c*) support the implementation of mental health policies, with successful and innovative experiences in several countries; (*d*) address the prevention of blindness and visual impairment using PAHO/WHO guidelines in 28 countries; and (*e*) develop or improve road safety national plans, inspired by the Road Safety Decade. The main challenge for the future is to maintain the commitments and secure the continuity in resources and capacity to further address and move forward on these issues at national and subnational levels.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.1	Number of countries implementing a multisectoral national plan to prevent interpersonal and gender-based violence aligned with PAHO/WHO guidelines	15	23	Yes

Comments:
29 countries/territories achieved this indicator: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, ELS, FEP, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAV, SCN, TRT, USA, URU, and VEN.

Some of the key achievements worth highlighting include work in TRT for the development of a national plan on violence and prevention of injuries and the implementation of capacity-building workshops on primary prevention of violence against children and women with BOL, COR, ECU, ELS, FDA, HON, NIC, PAR, and PER. In addition, PAHO produced relevant documentation/tools to support

the development of evidence-based policies, including a series of information sheets summarizing the latest evidence on violence against women and Spanish and Portuguese translations of the document Preventing Intimate Partner and Sexual Violence against Women." Challenges in achieving this indicator included lack of priority assigned to work on violence prevention in general, which results in limited human and financial resources being made available for programs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.2	Number of countries implementing a national plan on disability management and rehabilitation according to PAHO/WHO guidelines	5	25	Yes

Comments:
26 countries achieved this indicator: ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN.

National health and social sector plans developed have followed the technical guidance of PAHO/WHO and recommendations contained in WHO Resolution WHA58.23 and PAHO CD47.R1. In addition, countries complied with the United Nations Convention on the Rights of Persons with Disabilities. GUT, although it does not have a disability plan in the health sector, has developed a national plan approved by the National Council on Disability (social sector) following recommendations from PAHO/WHO.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.3	Number of countries implementing a national mental health plan according to PAHO/WHO guidelines	26	30	Yes

Comments:
30 countries achieved this indicator: 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, SCN, SUR, URU, USA, and VEN.

PAHO supported the Ministries of Health in the process of implementing national mental health plans. This is a key component of the regional Strategy and Plan of Action on Mental Health adopted by the PAHO 49th Directing Council in 2009. The most successful and innovative experiences in the Region were, among others, reported by BLZ, BRA, CHI, CUB, and PAN. These countries all have excellent national plans with a high level of implementation and excellent organization of services based in the community model, which have significantly reduced the number of beds in psychiatric hospitals.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	15	36	Yes

Comments:
38 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NCA, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, USA, and VEN.

The level of implementation of NCD national plans is different, as some countries still struggles with multiple priorities. For example, the Central American countries were occupied with chronic kidney disease and focused their work on strengthening surveillance and response to this issue, while others, like Aruba, COL, and MEX, have chosen to address NCDs through national plans to fight obesity. Countries that have an overall well-advanced response to NCDs include ARG, BRA, CHI, and some of the Caribbean countries, including BAH, BAR, JAM, and TRT. More recently, BLZ, COR, ECU, and PAR developed plans with national targets.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.5	Number of countries implementing a national plan for the prevention of blindness and visual impairment according to PAHO/WHO guidelines	8	26	Yes

Comments:
28 countries achieved this indicator: ARG, BAR, BLZ, BRA, CAN, CHI, COL, COR, CUB, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, TRT, USA, and VEN.
Main achievements

a) 9 countries, ARG, DOR, ECU, ELS, HON, PAN, PAR, PER, and URU, finalized national eye care surveys, and 3 countries, TRT, PAN, and CUB, initiated national eye care surveys.
b) 16 countries, ARG, BAR, BLZ, COL, DOM, ELS, GRA, GUY, GUT, JAM, NIC, PAN, PER, SAL, SAV, SCN, reviewed and updated their national eye care plans of action.
c) 5 countries, ANI, BLZ, COR, HON, and JAM, made national assessments of their diabetic retinopathy services.
d) 2 countries, BLZ and JAM, developed diabetic retinopathy plans.
e) 13 countries reported that they have a program to prevent retinopathy of prematurity blindness: ARG, BRA, CHI, COL, COR, CUB, DOR, ELS, JAM, MEX, PER, SAV, and VEN.
f) 3 countries, HON, COR, and ELS, established programs for strengthening public ophthalmology units.
g) CHI generated evidence to update its national guidelines on programs that address refractive errors in schoolchildren.
h) 17 countries (ARG, BAH, BAR, BRA, CAN, CHI, COR, CUB, CUR, DOM, MEX, NEA, SAL, TRT, URU, USA, and VEN) reported a cataract surgical rate of over 2,000 procedures per 1,000,000 population per year.
i) 10 publications appeared in peer-reviewed journals during the period.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.6	Number of countries implementing a national plan for the prevention of oral diseases according to PAHO/WHO guidelines	26	35	Yes

Comments:
37 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BRA, BLZ, BOL, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, NCA (BER), PAN, PAR, PER, PUR, SAL, SCN, SUR, TCA, TRT, URU, USA, and VEN.

Significant improvement is demonstrated by improved DMFT scores through national oral health surveys conducted in the countries. The majority of countries have sustainable oral health programs with plans, targets, and evaluation processes. The countries with mature oral health policies are BAR, BAH, BRA, CAN, CHI, COL, CUB, JAM, MEX, NCA (BER), PAN, PER, TRT, USA, and URU. Although GUT has been making efforts to improve oral heath, challenges remain, as the country has the highest DMFT in the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.2.7	Number of countries implementing a multisectoral national plan to prevent road traffic injuries aligned with PAHO/WHO guidelines	15	23	Yes

Comments:
25 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ELS, ECU, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, TRT, USA, URU, and VEN.

The PAHO Plan of Action on Road Safety was approved in 2011 and it was an important incentive, added to the Road Safety Decade, to push countries to prepare their plans. Eleven countries prepared a Road Safety Decade plan and launched it in May 2011. Also, CUB, ECU, GUY, PAR, TRT, and URU achieved this goal later. DOR and NIC also achieved it, even though some improvement is still needed in these countries. ARG, BRA, COL, ELS, JAM, MEX, PER, and USA made a commitment to the Road Safety Decade and improved their RS plans.

RER 3.3 Member States supported through technical cooperation to improve 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	Fully Achieved

RER Assessment Summary (5 of 5 RER indicator targets achieved)

34. The Region made strong progress in the surveillance and monitoring of NCDs, risk factors, mental disorders, road traffic injuries, violence, and disabilities in the last few years. With regard to NCDs and risk factors, all the countries now have NCD-specific mortality data; 22 countries have detailed risk factor distribution; 10 have trends in risk factors because they have at least two data points; and 11 countries have national disease registries on cancer, cardiovascular disease/stroke, or diabetes. As for violence, countries made significant progress in improving the availability of data on violence, even when they were not able to implement a national health information system that includes indicators on violence. In regard to progress in mental health information systems, regional guidelines on MH information were published and disseminated, and several countries were working to improve the availability of MH information. Regarding disability, countries collected data on disability using different sources, and several countries already have well-established monitoring based on a disability information system. The regional report on road safety was published in 2009 and all countries contributed data, which facilitated the inclusion of data on road traffic accidents in national information systems. Even though this RER was fully achieved, the work on improving the quality of information and strengthening information systems to support NCDs, disabilities, mental health, violence and road safety requires further attention and the technical cooperation of PAHO.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.3.1	Number of countries that have a national health information system that includes indicators of interpersonal and gender-based violence	12	22	Yes

Comments:
22 countries achieved this indicator: ARG, BAR, BLZ, BOL, BRA, CAN, COL, COR, ECU, ELS, FEP, GUT, GUY, HON, JAM, MEX, NIC, PAN, PER, TRT, USA, and VEN.

Achievement of this indicator has been interpreted to include countries that have made significant progress in improving the availability of data on violence even if they have not been able to implement a national health information system that includes indicators on violence. For example, TRT assessed its surveillance of violence and injuries and a capacity-building effort was carried out in the country's main hospital to improve surveillance. Similarly, ELS implemented a nationally representative survey on violence against women and BLZ analyzed its existing gender violence surveillance system. Finally, PAHO, in collaboration with the CDC, produced the first-ever regional comparison of nationally representative data on violence against women. Challenges in achieving this indicator include the lack of priority accorded to work on violence prevention in general, which results in limited human and financial resources being made available for this health problem.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.3.2	Number of countries that have a national health information system that includes indicators of mental health	8	20	Yes

Comments:
21 countries/territories achieved this indicator: ABM, ARG, BLZ, BOL, BRA, CHI, COL, COR CUB, DOR, ECU, ELS, GUT, HON, JAM, NIC, PAN, PAR, TRT, URU, and VEN,

There are several countries working on improving their mental health (MH) information systems. CHI and ELS have information systems with MH indicators. In Central America, advances have been made in developing a subregional observatory on suicidal behavior. Also, regional guidelines on MH information were published and disseminated.

This indicator is a critical point for PAHO/WHO technical cooperation. Countries need to continue working on the incorporation of MH indicators into their national Health Information Systems. At the same time, PAHO needs to reinforce its technical cooperation in this area in the next biennium, especially in the group of countries without reliable data on MH.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.3.3	Number of countries that have a national health information system that includes indicators of disabilities	18	26	Yes

Comments:
28 countries achieved this indicator: ARG, BAR, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, TRT, USA, URU, and VEN.

Countries have disability data of interest to the health sector from several sources:

- Records: ARG, BRA, BOL, COL, COR, DOR, ELS, GRA. NEA, NIC, PAN, PAR, PER, SCN, URU, and VEN,
- Multipurpose surveys: ECU, GUY, MEX, PER, TRT, and URU;
- Specific surveys: ARG, CAN, CHI, ECU, NIC, PAN, and USA;

Within and outside the health sector, articulated intrasectoral and intersectoral efforts contributed to the development of actively updated information systems based on standards recommended by PAHO/WHO in ARG, CHI, ECU, HON, MEX, and VEN. Articulated efforts resulted in the production of data on disabilities from different health programs and other sectors, such as social security, social development, and education. In all cases, the International Classification of Functioning, Disability and Health was used as the technical standard.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.3.4	Number of countries that have a national health information system that includes indicators of chronic noncommunicable conditions and their risk factors	14	33	Yes

Comments:
35 countries and territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUY, HAI, HON, JAM, MEX, NCA, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TCA, TRT, URU, USA, and VEN.
Countries have incorporated NCDs and certain risk factors into their own basic data set, which prompted PAHO to publish a brochure on NCD basic indicators (2011). All the countries have NCD-specific mortality data; 22 countries have detailed risk factor distribution; 10 have trends in risk factors because they have at least two data points; and 11 countries have national disease registries on cancer,

cardiovascular disease/stroke, or diabetes. Efforts will continue to be devoted to strengthening these systems and reviewing their contributions to the global targets and reporting of the 25 global indicators.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.3.5	Number of countries that have a national health information system that includes indicators of road traffic injuries	12	22	Yes

Comments:
22 countries achieved this indicator: ARG, BAR, BLZ, BRA, CAN, COL, COR, DOR, ECU, ELS, FEP,GUT, GUY, JAM, MEX, NIC, PAN, PAR, PER, USA, URU, and VEN.

The Regional Report on Road Safety was published in 2009 and a factsheet with regional data was published in 2013 in three languages (Portuguese, Spanish, and English). All the PAHO Member States (except HAI) participated in this data collection process, which contributed to the inclusion of road safety information in national health information systems. In Nov 2013, road safety data training was promoted by PAHO in order to continue improving and standardizing the quality of road safety data. Also, most of the PAHO Member States take part in the Road Safety Observatory, which seeks to integrate data from the health sector, the transportation sector, the police, and other key actors working on road safety information.

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	Partially Achieved

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

35. While important progress has been made by the countries in the different areas under this RER and there is accumulated knowledge of successful interventions to address NCDs, mental health, violence, oral health, and road safety, it is evident that further efforts are required in order to have a comprehensive mechanism to integrate programs with related policies. Economic studies on NCDs were conducted in various countries to generate evidence and build the case to strengthen country programs. These studies need to be disseminated. Significant progress was made in mental health, and various publications were prepared for future reference. Through the Caries-Free Initiative, gains were made to integrate oral health and risk factors into primary health care interventions in several countries. Tools to invest in road safety are now available, but there is also a need to disseminate results. With respect to violence, the target for 2013 was not achieved, but 14/15 countries achieved the indicator to varying degrees in terms of projects implemented and challenges for PAHO technical cooperation with regard to capacity available in this area.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.4.1	Number of cost analysis studies on interventions related to mental and neurological disorders	1	3	Yes

Comments:
The following four studies were conducted:

1. Depression in Panama: *Conozca la depresión, y enfréntela* (OPS. 2009);
2. *Epidemiología de los trastornos mentales en América Latina y el Caribe* (OPS, 2009), published with a compilation of epidemiological studies on mental disorders in LAC, focused on morbidity, mortality, disability, and assessment of services
3. The Treatment Gap. (R. Kohn, 2013), a regional study on treatment gaps; and
4. WHO-AIMS. *Report on Mental Health Systems in Latin America and the Caribbean* (PAHO, 2013), an assessment of programs and services.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.4.2	Number of countries with cost analysis studies on violence conducted and disseminated	8	15	No

Comments:
14 countries achieved this indicator: ARG, BLZ, BRA, CAN, CHI, COL, COR, ELS, FEP, GUT, HON, MEX, PER, and USA but the depth of the projects was heterogeneous.

The participation of the PAHO/WHO Collaborating Centers was important in that they managed to advance several initiatives in the countries. In ARG and BLZ noteworthy lessons were learned on gender and domestic violence. With regard to the 2 countries that achieved the indicator in 2012-2013, GUT conducted a study on the cost of community violence and its impact on health, and MEX disseminated a study on the status of violence in the country which included a cost analysis.

Despite this progress, the 2013 target was not achieved; the depth of country projects was heterogeneous; and the capacity of the Organization to support the countries was significantly challenged. Further efforts should be made to establish strong working relationships with institutions of excellence in the area of cost analysis, including the World Bank and the Inter-American Development Bank.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.4.3	Number of countries with cost analysis studies on oral health conducted and disseminated	4	9	Yes

Comments:
12 countries achieved this indicator: BOL, COL, ECU, GUT, HAI, HON, JAM, MEX, PAN, PAR, PUR, and URU.

12 countries participated in the Caries-Free Initiative, which promotes cost-effective interventions and monitors the effectiveness of programs. The oral health surveys showed that oral health DMFT indicators improved thanks to prevention programs, particularly fluoridation. However, the scores showed that improved access to oral health care was not realized and vulnerable populations were most affected.

The Caries-Free Initiative, launched in 2008, has been a vehicle to improve access to oral health care for the most vulnerable populations and integrate oral health into primary health care approaches, including risk factors for NCDs. Currently, using the oral health and risk factors approach, 9 countries have ongoing programs to improve access and integrate oral health into PHC (COL, ECU, GUT, HAI, JAM, MEX, PAN, PUR, and URU).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.4.4	Number of countries with cost analysis studies on chronic noncommunicable conditions conducted and disseminated	9	18	Yes

Comments:
18 countries achieved this indicator: ARG, BAH, BAR, BRA, CAN, CHI, COL, COR, FEP, GUT, GUY, JAM, MEX, NIC, PER, SUR, TRT, and USA.

Economic analysis of NCDs has been an area of recent intensive development in the Region. After PAHO held a regional workshop on the economic dimensions of NCDs in partnership 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, the countries conducted national NCD economic studies to strengthen their ability to generate the evidence to deal with the NCD epidemic.

Countries have used information received through the economic studies they conducted to build a case for strengthening their national NCD programs and adopting policies based on the evidence provided in the studies. For example, SUR adopted a tobacco control policy based on the findings; GUY finalized its cost analysis of diabetes with a view to improving its diabetes prevention and control program, and the results of the study are being reviewed by PAHO; COR has disseminated results of its cost study, which it also used in the preparation of its national NCD plan; and GUT finalized implementation of its economic study.

A publication on economic assessment methods applied in the Americas is being prepared, with a view to offering innovative methods that countries can use with the support of PAHO and its partners to make an economic case for NCDs to the Ministries of Finance.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.4.5	Number of countries with cost analysis studies on road safety conducted and disseminated	6	12	Yes

Comments:
13 countries achieved this indicator: ARG, BLZ, BRA, CAN, CHI, COL, COR, DOR, ELS, MEX, PAR, USA, and VEN.

A methodology developed by IDB was applied in some of these countries so that they could see the distribution of the total costs among road users. These results are important as an advocacy tool for improving investment in the prevention of road traffic injuries in the Region. More sharing of these results is needed.

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	Fully Achieved

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

36. The proposed indicator targets under this RER were achieved or exceeded their proposed targets for the period: 18 countries established activities for early detection and intervention under several conditions in order to prevent disabilities; 19 countries implemented programs on promotion and prevention with respect to mental health, with special focus on suicide; almost all the countries in the Region have implemented multisectoral programs to promote and prevent NCDs. The challenge is to transform the policies and plans that are developed into real actions on the ground at a national scale.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.5.1	Number of countries implementing multisectoral, population-wide programs to prevent disabilities	5	15	Yes

Comments:
18 countries achieved this indicator: ARG, BLZ, BOL, CHI, COL, COR, CUB, DOR, ECU, ELS, GUY, MEX, NIC, PAN, PAR, PER, URU, and VEN.

The abovementioned countries have established specific activities for early detection and intervention for metabolic disorders, birth defects, and visual and hearing problems in high-risk populations, detection of postural problems, health promotion activities, and prevention of disability caused by noncommunicable diseases.

Several of the countries, including ARG, CAN, COR, MEX, PAN, and URU, have developed legislation

on compulsory screening for such conditions as metabolic disorders; NIC and URU have developed a birth defects monitoring system; and ARG, BRA, PAR, URU, and VEN reached consensus on strategies for monitoring birth defects.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.5.2	Number of countries implementing interventions to promote mental health and the prevention of mental disorders and substance abuse	0	15	Yes

Comments:
18 countries/territories achieved this indicator: ARG, BAR, BLZ, BOL, BRA, COR, ECU, ELS, GUT, GUY, NCA, NIC, PAN, PAR, PER, TRT, URU, and VEN.

19 countries of the Region reported having implemented programs on the promotion of mental health and the prevention of mental illness.

Suicide prevention has been an important program in the promotion-prevention field, especially in some of the countries with the highest rates of suicide mortality. On suicide prevention, it is important to recognize the efforts of BLZ, CUB, CHI, GUY, NIC, and URU, among others, for their improved surveillance systems to detect suicidal behaviors, their educational programs, and their reduced access to lethal means.

Regional guidelines on mental health prevention and promotion were published and disseminated. All the countries have integrated the promotion-prevention component into their respective national mental health plans. A regional report on suicide was completed in 2013.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.5.3	Number of countries implementing multisectoral, population-wide programs to promote the prevention of chronic diseases	2	31	Yes

Comments:
31 countries/territories achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COR, CUB, DOM, ECU, ELS, FEP, GRA, GUT, GUY, HON, JAM, MEX, NCA, NIC, PAR, PER, PUR, SAL, SAV, SCN, SUR, TRT, and URU.

This indicator is very broad, and practically all the countries have implemented multisectoral population-wide programs to promote the prevention of NCDs.

Countries have worked on implementation of the Political Declaration emanating from the United Nations High Level Meeting, and they have shared their experience with development of global and regional action plans and construction of the nine global voluntary targets and 25 related indicators. All the countries have indicated that they are strengthening and expanding their NCD programs and plans. ARG, BAR, BRA, CHI , COL, and TRT are leaders in their subregions in engaging other sectors such as agriculture, trade, transport, education, and the private sector in shaping NCD preventive interventions.

During 2013, BLZ, COR, ECU, and PAR reviewed their national multisectoral plans. Discussions were held with different sectors within the government as well as NGOs and the private sector. These countries also set up national targets that depend on collaboration with non-health sectors for their fulfillment.

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	Fully Achieved

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

37. Almost all the countries in the Region are implementing strategies to integrate chronic NCD care into primary health care. 34 countries were trained in the organization of NCD care through PAHO collaboration with Miami University. Also, 21 countries incorporated smoking cessation support, including nicotine replacement therapy, covered by the government. Despite these advances, we have a long way ahead. It is necessary to continue strengthening the integration of NCDs and risk factor control into primary health care. Integration into PHC remains a challenge for the next biennium.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
3.6.1	Number of countries implementing integrated primary health care strategies to improve quality of care for chronic noncommunicable diseases according to WHO innovative Care for Chronic Conditions	12	32	Yes

Comments:
34 countries/territories achieved this indicator: ABM, ARG, ANI, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HON, JAM, NIC, MEX, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, USA, and URU.

National officials from 34 countries were trained in the organization of care for chronic conditions in courses implemented in 2009 and 2011 throughout collaboration between PAHO and the University of Miami.

ARG, CHI, DOR, and PAR are using the chronic care model nationwide to improve quality of care for chronic conditions. National training of health professionals in the management of chronic diseases was conducted in ARG, BRA, CHI, and COL.

The PAHO Chronic Care Passport (CCP) is being used to manage chronic diseases in 17 countries. Evaluations carried out in ABM (Anguilla), ANI (Antigua), ARG, JAM, and SAL indicate that the CCP can be used effectively to improve chronic care.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	4	9	Yes

Comments:
21 countries achieved this indicator: ARG, BAH, BAR, BOL, BRA, CAN, COR, CUB, ECU, ELS, GUT, GUY, HON, JAM, MEX, PAN, PAR, TRT, URU, USA, and VEN.

These countries reported to WHO that they have incorporated smoking cessation support, including nicotine replacement therapy, and that at least the cost of one of the components is covered by the government.

Of special note: BRA, CAN, ELS, PAN, URU and USA, reported that their services are totally free of charge and that they also have a free smoking cessation quitline. Despite this progress, however, the extent of service coverage and successful quitting rates are still unknown in most of the countries.

While significant progress has been made, much remains to be done in this area. Countries should be

encouraged to use the services that are already available at the PHC level and ensure that health workers systematically ask every patient if he/she smokes or not, and, if the patient is a smoker, provide brief advice encouraging cessation.

SO4: To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood, and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals							Fully Achieved[9] (100% of indicator targets achieved)	
RER Status[10]	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8

SO4 Budget Overview

Approved Budget (PB 08-13)	**Funds Available (in US$ millions)**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
114.5	36.7	72.1	108.8	80%	95%

SO4 Programmatic Assessment

38. Over the six-year period of the Strategic Plan 2008-2013, PAHO provided technical cooperation to strengthen policies, health systems, and primary health care in the countries, as well as to improve health throughout the life course, including the topics of sexual and reproductive health, pregnancy, childbirth, the neonatal period, childhood and adolescence, and aging.

39. As a result of regional and country efforts, human resources were expanded; community based-interventions were promoted (IMCI, PAHO/WHO Key Family Practices, the PAHO *Familias Fuertes* program); and surveillance systems and vital statistics were improved. Also, throughout the six years, emphasis on partnership was intensified. Commitments made at the 36th G8 Summit in Muskoka (2010) allowed for increased funding and improved harmonization between partners (UNFPA, UNICEF, UNWOMEN, UNAIDS, and the World Bank, among others).

40. Of note, child deaths have declined substantially. If current trends continue in all the countries, the Region of the Americas will achieve MDG 4 in 2014. A number of countries in the Americas were among the first to demonstrate that it is possible to sharply lower child mortality, even from high initial rates, when concerted action, sound strategies, adequate resources and political will are consistently applied. Although there has been a significant reduction in maternal deaths, the rate of decline is less than what is necessary to achieve MDG-5. Recently, efforts have focused on reducing the leading causes of maternal mortality and removing barriers to quality care.

SO4 Main Achievements

a) 25 countries have information systems and surveillance systems to track sexual and reproductive health and maternal, neonatal, and adolescent health with information disaggregated.

b) 16 countries have a policy of universal access to sexual and reproductive health and 20 countries have adopted comprehensive reproductive health strategies.

[9] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[10] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

c) Most countries in the Region report over 90% of births attended by trained personnel. Efforts focused on training and deploying skilled birth attendants and upgrading emergency obstetric care facilities.

d) In a large number of countries maternal and neonatal health plans are incorporated within the framework of the care continuum. There is high awareness of the growing proportion of newborn deaths in children under 5 years of age.

e) The Member States approved the Strategy and Plan of Action for Integrated Child Health 2012-2017, calling for actions to improve child health outcomes and well-being beyond survival.

f) 18 countries have functioning adolescent and youth health and development programs, and 22 countries are implementing a comprehensive package of norms and standards to provide adequate health services for this age group.

g) 18 countries are implementing multisectoral community-based programs to address healthy aging.

SO4 Main Challenges

a) Extension of women's reproductive rights and promoting maternal and neonatal health as a global priority also for the post-2015 era.

b) Adoption and implementation of the life course approach within the health system and beyond through intersectoral coordination with the education, labor, and environment sectors (addressing the social determinants of health).

c) Need to address the specific health needs of the adolescents and ensuring they are reached with preventive interventions.

d) Population aging and increased demand of care.

e) Strengthening of health information systems and availability and use of disaggregated information to evaluate the quality of health services, epidemiological surveillance, and decision-making, with universal and effective civil registration and vital statistics systems.

f) Reduction of health inequities.

g) The controversy surrounding medical abortion, which is impairing faster progress towards the provision of comprehensive sexual and reproductive health services.

SO4 Lessons Learned

a) Regional plans that target mothers, the newborn, children, adolescents, and older adults have allowed for accelerated progress. Although achievements are uneven among and within countries, the available evidence suggests that accelerated progress toward achieving the indicator targets is stimulating political support, fostering research, and encouraging debate on systematic approaches to improving health outcomes.

b) Improving the quality of care, including expansion of the skilled health workforce, is the foundation for achieving equity.

c) Integration of polices and of health services delivery demands a shared vision and joint planning. Capacity-building efforts and the introduction of new technologies have proved useful in this regard. Also, institutionalization at of health information systems at the ministerial level, with common definitions and standards, is a key step.

d) The development of guidelines and standards requires technical cooperation provided on an ongoing basis, for which the availability of financial resources is crucial.

Progress towards Impact Results

SO4 Indicator 1: Proportion of births attended by skilled birth attendants in Latin America and the Caribbean
Baseline: 85% in 2006
Target: 90% by 2013

According to the PAHO Basic Indicators 2013, 92.5% deliveries were attended by skilled personnel in Latin America and the Caribbean. All the subregions showed an increase in coverage of deliveries attended by skilled personnel.

SO4 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

In 2013, only DOM, DOR, GUT, and SCN reported an estimated MMR above 100 per 100,000 live births. Of note, absolute numbers of maternal deaths were only 1 and 2, respectively for DOM and SCN. The following countries/territories did not report an RMM estimate: ABM, ANI, BOL, Guadeloupe, HAI, NEA, NCA, SAL, TRT, and USA.

SO4 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 the PAHO Basic Indicators for 2013, the under-5 mortality rate per 1,000 live births was 19.7 in Latin America and the Caribbean. The only country that reported an under-5 mortality rate over 32.1 per 1,000 lb. was HAI (88).

SO4 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

Countries in the Americas have expanded access to comprehensive sexual and reproductive health services and commodities in the context of women's rights. Some of the countries made impressive progress in improving the coverage of family planning. According to the last estimates available (Source: PAHO Basic Indicators 2013; UNFPA State of World Population; World Bank document Unmet Need for Contraception, March 2010), 19 countries and territories have contraceptive prevalence rate above 60%: ARG, BOL, CAN, CHI, COR, CUB, DOR, ECU, ELS, HON, JAM, NEA, NIC, PAR, PER, PUR, SCN, URU, and VEN.

SO4 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 data on the adolescent fertility rate are still scarce on the Region, according to the United Nations Population Division, World Population Prospects 2014, the following 20 countries/ territories have an adolescent fertility rate below 75.6 (per 1,000 adolescent girls aged 15-19): ARG (55), NEA (Aruba) (28), BAH (29), BAR (49), BLZ (73), BOL (73), BRA (72), CHI (56), COL (70), COR (62), CUB (44), GRA (37), HAI (43), JAM (72), PAR (68), PER (52), SAL (57),SAV (55), TRT (35), and URU (59).

SO4 Indicator 6: Number of countries in the Region in which 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

No estimates were available.

Assessment of the Region-wide Expected Results

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 life course; 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)	Fully Achieved

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

41. Over 2008-2013, national health policies and strategies moved towards integration, though translating this integration into service delivery remains a challenge. The PASB placed particular emphasis on supporting policies for integrated service delivery across the life course. Thus, technical cooperation was provided to support and promote evidence-based comprehensive health policy-making towards universal access to a continuum of care, including predictable and sustainable financing of the health system. Also, partnerships were brokered with key actors such as the United Nations system, academia, professional associations, NGOs, and civil society.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.1.1	Number of countries that have an integrated policy on universal access to effective interventions for improving maternal, newborn, and child health	0	4	Yes
Comments: 12 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, CUB, DOR, ELS, HON, NIC, URU, and VEN. The countries reported that they have an integrated policy on universal access to effective interventions for maternal, newborn, and child health. However, levels of implementation varied greatly between countries; ARG, CHICUB, and URU are greatly advanced. The Rede Cegonha [Stork Network] in BRA is an example of best practices. SUR is aiming towards universal MNC coverage through a basic health insurance.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.1.2	Number of countries that have a policy of universal access to sexual and reproductive health	7	16	Yes
Comments: 16 countries achieved this indicator: ARG, BLZ, BOL, CAN, CHI, COR, CUB, ECU, ELS, GUY, HON, JAM, PER, SUR, URU, and VEN. These countries are reported as having a policy of universal access to sexual and reproductive health approved by their Ministries of Health. The countries have greatly advanced in guaranteeing sexual reproductive rights in the path towards universal health coverage.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.1.3	Number of countries that have a policy on the promotion of active and healthy aging	11	18	Yes
Comments: 18 countries/territories achieved this indicator: ABM, ANI, ARG, BAR, BLZ, BOL, CHI, COR, CUB, DOM, ECU, HON, PAR, PER, SAL, SAV, SCN, SUR, and URU. These countries have explicit or implicit policies on the promotion of active and healthy aging. They all made great strides in the development and approval of policies, plans, and programs related to active and healthy aging. Still, there are weaknesses in the implementation, monitoring, and evaluation of such policies.				

RER 4.2 Member States supported through technical cooperation to strengthen national/local capacity to produce new evidence and interventions; and to improve surveillance and information systems on sexual and reproductive health, and in maternal, neonatal	Fully Achieved

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

42. Maternal and perinatal health information and surveillance have been strengthened in the countries of the Americas, mainly in terms of improving tools and the capabilities of national experts in best practices and operational research. As a result, the availability and quality of strategic information improved, allowing for the establishment of research networks.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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.	10	20	Yes
Comments: 24 countries/territories achieved this indicator: ABM, ARG, BOL, BRA, COL, COR, CUB, DOR, ECU, ELS, FEP, GUY, GUT, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN. These countries have well-functioning information and surveillance systems. In addition, implementation of a perinatal information system (SIP) is in the initial stages in BAH, BAR, BLZ, and the countries/territories of the Organization of Eastern Caribbean States (OECS).				

4.2.2	Number of PASB systematic reviews on best practices, operational research, and standards of care	5	10	Yes
Comments: 11 systematic studies were conducted during the period, as follows: • Operational research, 7 countries (ELS, GUY, HON, NIC, PAN, PAR, and URU) in 2011; • Best practices in gender and ethnicity mainstreaming in maternal health, ECU; • SIP-based study on birth spacing, ARG (CREP-CLAP) (in press); • 10-country study of the Sentinel Surveillance Network to evaluate congenital syphilis elimination, by CLAP (in press); and • Evaluation of service quality, HON.				

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	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

43. Over the last six years, efforts to reduce maternal and neonatal mortality in the Americas have focused primarily on two long-term aims: training and deploying skilled birth attendants, and upgrading emergency obstetric care facilities. In this regard, technical cooperation allowed for a significant increase in skilled care at birth, including prenatal, postnatal, and newborn care, to address the immediate safe delivery needs of women while at the same time strengthening health systems in the long run.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	10	23	Yes
Comments: 23 countries achieved this indicator: ARG, BLZ, BOL, BRA, COL, COR, CUB, DOR, ECU, ELS, FDA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SUR, URU, and VEN. These countries have adapted and are utilizing PAHO/WHO norms and guidelines for increasing coverage with skilled care. BRA adopted and adapted the Strengthening Midwifery Toolkit in its national *Rede Cegonha* [Stork Network] initiative. In addition, BAR/ECC committed to adopting the PAHO/CLAP guidelines and norms.				

RER 4.4 Member States supported through technical cooperation to improve neonatal health	Fully Achieved

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

44. Over the last six years, guidelines to improve neonatal care and survival were elaborated and disseminated throughout the Region, and technical cooperation was provided. As a result, specific interventions have been implemented and included in national norms in a large number of countries. As stated in the mid-term evaluation of the Regional Strategy and Plan of Action for Neonatal Health 2008-2015, 72% of the 29 countries participating have national plans that include maternal and neonatal health within the framework of the continuum of care, for the most part with a monitoring system and approximately half of them with a specific budget allocation. In Latin America and the Caribbean, neonatal mortality declined 4% from 2008 to 2010, according to 2012 estimates by the Institute for Health Metrics and Evaluation. It accounts for 61.1% of under-1 mortality and 47.8% of under-5 mortality; the proportion of neonatal deaths is increasing as under-5 mortality declines. Reductions in neonatal mortality are slower than those for older children. The above-mentioned evaluation recommended (a) improving the quality of maternal and newborn care within the framework of the continuum of care, while simultaneously aiming at the principal identified causes of newborn deaths and ensuring adequate coverage in geographical areas where vulnerability and exclusion are highest; (b) strengthening community systems ; (c) strengthening information systems.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.4.1	Number of countries with at least 50% of selected districts implementing interventions for neonatal survival and health	4	18	Yes
Comments: 21 countries achieved this indicator: ARG, BOL, BRA, COL, CUB, DOR, ECU, ELS, GRA, GUT, GUY, HON, NIC, PAN, PAR, PER, SAL, SAV, TRT, URU, and VEN. These countries are implementing interventions for neonatal survival and health in at least 50% of selected districts. Over the period 2008-2013, efforts were focused on capacity-building, as the number of neonatologist is still low in LAC. A number of countries have also updated their neonatal care manuals and protocols.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.4.2	Number of guidelines and tools developed and disseminated to improve neonatal care and survival	4	9	Yes
Comments: A total of 14 guidelines were developed. 11 countries published guidelines on neonatal care and survival. At the regional level, CLAP developed and disseminated three guidelines on the following topics: neonatal transportation, prevention and control of neonatal infection, and prevention of medical error.				

RER 4.5 Member States supported through technical cooperation to improve child health and development taking into consideration international agreements	Fully Achieved

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

45. The Region of the Americas will achieve MDG-4 in 2014 if current trends continue in all the countries. A number of countries in this Region were among the first to demonstrate that it is possible to sharply lower child mortality, even from high initial rates, when concerted action, sound strategies, adequate resources, and political will are consistently applied in support of child and maternal mortality.

46. Implementation of the Integrated Management of Childhood Illness (IMCI) strategy, an integrated approach to child health that focuses on the well-being of the whole child instead of on single-condition approaches has allowed for a significant reduction in under-5 mortality and an improvement in child nutritional status in countries where is well implemented and with large-scale coverage. Thanks to the IMCI, health worker performance and quality of care improved. The community component, in combination with WHO/PAHO Key Family Practices, was particularly useful in allowing for task-shifting and the formation of multisectoral teams of health service providers and community leaders.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.5.1	Number of countries that have expanded coverage of the integrated management of childhood illness to more than 75% of target districts	8	13	Yes
Comments: 14 countries achieved this indicator: BAR, BOL, COL, CUB, ECU, ELS, GUT, GUY, HON, NIC, PAN, PAR, PER, and VEN. These countries expanded the coverage of integrated management of childhood illness to more than 75% of target districts.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.5.2	Number of countries implementing the WHO/PAHO Key Family Practices approach at the community level to strengthen primary health care	9	13	Yes
Comments: 13 countries achieved this indicator: BOL, COL, ELS, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, URU, and VEN. Of note, BOL is implementing the Key Family Practices in all districts targeted by the Zero malnutrition Initiative. Best Practices with community educators in the department of San Marcos were being scaled up in GUT. PAR has also piloted a very positive experience in Alto Paraguay. ECU has already trained 60% of community workers on the Key Practices.				

RER 4.6 Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development	Fully Achieved

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

47. Eighteen countries in Latin American and the Caribbean have moved forward on development and implementation of adolescent health policies, programs, norms, and standards. However, there are many others that have still not put sufficient emphasis on the special needs of adolescents. While adolescents are central to every major current challenge in global health, they are either treated the same as children or expected to share facilities with adults. Indeed, there are various shortcomings within the health system: adolescents' lack of access to primary health care; concerns about confidentiality, consent, and privacy; insufficient education of health professionals; and absence of dedicated hospital wards.

48. Over 2008-2013, technical cooperation was provided to: (a) scale up interventions across sectors (health, education, labor, and local communities) to promote adolescent health and reduce inequities, (b) skill the health workforce to enable health service systems to reach their potential by engaging young people, (c) disaggregate and improve information on adolescent health, and lastly, (d) develop partnership models with young people themselves.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.6.1	Number of countries with a functioning adolescent and youth health and development program	10	17	Yes
Comments: 18 countries achieved this indicator: ARG, BAH, BLZ, BOL, BRA, COR, CUB, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PER, SUR, and VEN. These programs focus on ensuring an integrated and integral approach for adolescent health. The most common constraint highlighted by countries is the absence of specific allocated budget to support existing programs.				
Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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])	3	15	Yes
Comments: 22 countries/territories achieved this indictor: ABM, ARG, BOL, CHI, COR, CUB, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, NIC, PAN, PAR, PER, SCN, SAL, SAV, and VEN. 22 countries/territories are today implementing youth-friendly health services thanks to efforts made in				

the revision, adoption, and adaptation of existing national packages of norms and standards on adolescent health, capacity-building of human resources in health, and the collection and dissemination of best practices, lessons learned, and current evidence,. Although many countries are reporting the implementation of youth-friendly services, little monitoring and evaluation is being done in terms of measuring the quality of said services. In order to support countries in this effort, capacity-building efforts in the area of monitoring and evaluation need to be prioritized and supported in the upcoming year.

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	Fully Achieved

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

49. As a result of advocacy efforts over many years, countries in the Region of the Americas have expanded access to comprehensive sexual and reproductive health (SRH) services and commodities in the context of women's rights. Some of the countries made substantial progress in improving the coverage of family planning. Remaining challenges include continued improvement of the quality of care and limited, out-of-date, or non-standardized information in some of the countries. The politically and culturally sensitive nature of SRH topics (unsafe abortion, adolescent sexual health, and reproductive health in general) must be considered in order to achieve full implementation of the reproductive health strategy.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.7.1	Number of countries that have adopted strategies to provide comprehensive reproductive health care	5	15	Yes
Comments: 20 countries achieved this indicator: ARG, BAR, BOL, COR, CUB, DOR, ECU, ELS, GRA, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, TRT, URU, and VEN.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
4.7.2	Number of countries that have reviewed their public health policies related to sexual and reproductive health	7	12	Yes
Comments: 16 countries achieved this indicator: ARG, BLZ, BOL, CAN, CHI, CUB, COR, ELS, ECU, GUY, HON, JAM, PER, SUR, URU, and VEN. Given the progress made by the countries in developing and implementing comprehensive sexual and reproductive health policies, strategies, and programs, as reported under Indicators 4.1.2 (universal access to sexual and reproductive health policies) and 4.7.1 (comprehensive reproductive health policies), this indicator target has been achieved.				

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 life course	Fully Achieved

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

50. The Plan of Action on the Health of Older Persons, including active and healthy aging (2009-2018), has been cornerstone to setting consensus on ways to address the various determinants of healthy aging and to bringing together the different sectors that play a role. The most significant advances have occurred in: (1) promoting supportive environments for older persons at home, in the community, and in long-term care facilities, and (2) reorienting the primary health care model to expand its focus on services for the elderly.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	5	12	Yes

Comments:
18 countries/territories achieved this indicator: ABM, ANI, ARG, BOL, CHI, CUB, DOM, ECU, GRA, HON, MEX, NIC, PAN, PAR, PER, SCN, SAL, and SAV.

This achievement is the result of advocacy efforts to include health of the elderly in public policy. Country actions were largely focused on training the human resources needed to meet the challenges associated with the steady increase in life expectancy, including self-care training. Trainings in health management for older persons in primary care were conducted in BAR, GUY, and NIC for interdisciplinary health teams to improve the quality of primary care for older persons. The curriculum for the training programs was guided by the revised edition of the Primary Health Care Guide for Older Persons.

SO5: To reduce the health consequences of emergencies, disasters, crises, and conflicts and minimize their social and economic impact						Fully Achieved[11] (100% of indicator targets achieved)	
RER Status[12]	5.1	5.2	5.3	5.4	5.5	5.6	5.7

SO5 Budget Overview

Approved Budget (PB 08-13)	**Funds Available (in US$ millions)**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
102.9	12.9	92.7	105.6	90%	103%

SO5 Programmatic Assessment

51. During the past six years, the Member States, with PASB technical cooperation, improved their health sector disaster preparedness, better protected health services from the impact of hazardous events, responded more efficiently and effectively to disasters, and forged stronger strategic partnerships at national, subregional and global levels, as reflected in achievements under the seven RERs in this SO. All the RER indicators were achieved.

52. While progress was not even across countries and there are still gaps to be filled and achievements to be maintained, thanks to this collaborative work between the PASB, the Member States, and other partners, the health sector as a whole in Latin America and the Caribbean is more resilient to disasters than it was six years ago. Most of the Latin American and Caribbean countries now have the capacity to respond to minor and moderate events that affect the health of their population with a single-hazard approach and without

[11] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[12] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

international support. The challenge arises when responding to large and/or multi-hazard emergencies, a situation that is further exacerbated by overwhelming external cooperation.
Commitment on the part of governments towards disaster management has also increased, especially following approval of the Plan of Action for Safe Hospitals 2010–2015, the participation of governments in the Regional Disaster Response Team, and the release of government staff to develop guidelines and support training.

53. 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 health disaster programs, mainstream the topic in their institutions, establish clear priorities, and mobilize funds for national disaster management in order to meet the population's demands, as well as international expectations.
This SO was achieved thanks to years of constant investments made by the Member States, the PASB, and other partners in disaster reduction.

SO5 Main Achievements

a) With approval of the Plan of Action for Safe Hospitals by the PAHO 50th Directing Council, the health sector became the first sector to have a regional plan of action in place for improving the safety of health facilities (among those contributing to the Hyogo Framework for Action for Building Disaster Resilience).

b) With approval Resolution CSP28.R19 of the 28th Pan American Sanitary Conference, which reconciles national and international interest in the coordination of international humanitarian assistance and health clusters in case of disasters, the Region of the Americas became the first region to adopt a resolution that integrates the principle of the United Nations humanitarian reform while respecting the needs and priorities of sovereign countries. This resolution calls for practical national and intercountry institutional arrangements, which will be supported by PAHO.

c) An innovative initiative was implemented that integrates climate change and disaster risk reduction considerations into the health sector (SMART Hospitals Initiative). Among the key outputs were a toolkit to guide the implementation of climate change mitigation measures in existing health care facilities (the Smart Hospital Toolkit); a cost-benefit analysis of "climate-smartening a hospital," which provides evidence of the cost-effectiveness of instituting environmentally friendly and disaster-resilient measures in hospitals; and two pilot/demonstration projects for health facilities. This initiative has already being a catalyzing force for interest and involvement in the issue from both partners and national authorities. It is noteworthy that the Georgetown Hospital, one of the pilots, which was implemented in Saint Vincent and the Grenadines, was unscathed by the impact of the 2013 Christmas Eve low-level trough system, which affected the country and almost paralyzed functions at the main referral hospital, the Milton Cato Hospital.

d) A new Emergency Operations Center (EOC) was inaugurated at PAHO headquarters, coupled with adoption of a new policy outlining the Organization's institutional response to emergencies and disasters.

e) Disaster management technical materials and publications developed by PAHO were integrated into a new Knowledge Center for Public Health and Disasters (an online learning portal), launched in 2012. This new site provides a one-stop shop where users can access practical information and test their knowledge on all aspects of health disaster management. During the six-year period, PAHO developed a great deal of technical material and guidelines on a variety of critical topics. These have been broadly adopted and used by Member States as well as by countries in other regions of the world.

f) All responses to emergencies were initiated within 24 hours of the request, including the major disasters that impacted the Region during 2008-2013: the earthquakes in Haiti and Chile in 2010; the H1N1 Influenza pandemic in 2009; cholera outbreaks in Haiti and the Dominican Republic; Hurricane Sandy in Jamaica, Haiti, the Bahamas, and Cuba in 2012; earthquakes in Guatemala and Costa Rica in 2012; floods in Bolivia, Colombia, and Central America (El Salvador, Guatemala, Honduras, Nicaragua, and Panama); and volcanic eruptions in South America. In addition, technical support was provided to the countries

following the Tsunami in Japan and the subsequent radiological emergency. In addition, PAHO continued to support the ministries of health in Colombia and Haiti in managing their health clusters.

g) The Alert and Response system in Haiti was strengthened to go beyond epidemics and encompass all hazards, such as floods and mass casualty events. This initiative included the development of SISCLOR, an early warning and rapid response system for water quality control in health facilities and emergency shelters. It is a short message service-based water quality control system that was developed with the support of the PASB and other partners. SISCLOR has also been expanded to Colombia and the Dominican Republic.

h) Health disaster risk reduction (DRR) and response was included on the agenda of a number of subregional intergovernmental mechanisms, including the Central American Plan for Comprehensive Risk Management of Public Health Disasters and Emergencies, 2013 -2018, prepared by the Technical Commission for Risk Management in Central America and the Dominican Republic and approved by the Executive Secretariat of the Commission of Ministers of Health of Central America and the Dominican Republic (COMISCA) and the individual Ministries of Health; the Andean Strategic Plan for Disaster Risk Management 2013-2017, approved by the Andean Ministries of Health; the Andean guide for mutual cooperation between countries, updated and approved by the member countries of the Andean Committee for Disaster Prevention and Response;and the draft Caribbean Comprehensive Disaster Management Strategy and Framework beyond 2012.

i) The Hospital Safety Index (HSI) was developed and applied in more than 2,900 hospitals and other health facilities in 33 countries and territories, most of which are implementing corrective measures in priority health facilities. The HSI, developed by the PASB to assess the probability of a health facility remaining operational in emergency situations, is also utilized by more than 20 countries in other WHO regions. The development and use of this tool has enabled countries to transition from a purely qualitative approach to a semi-quantitative index or score that provides national authorities with an overall view of the level of safety of their health services so that they can prioritize interventions and update their health disaster response plans.

j) Preparation and publication of the book *Earthquake in Haiti—January 2010: Lessons to Be Learned for the Next Massive Sudden-Onset Disaster* involved the participation of high-level international researchers and writers, more than 150 interviews, and review by a group of high-level experts. This book shares lessons to be learned from Haiti with a view to improving 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 the health services in Haiti.

SO5 Main Challenges

a) There are concerns regarding difficulties in mobilizing funding for preparedness and risk reduction, which have been exacerbated by the financial crisis. Many humanitarian donors that traditionally funded preparedness and mitigation programs are now focusing more on readiness and response. This shift has negatively affected the staff cadre and impacted the pace of progress on technical cooperation issues.

b) The ability to attract emergency response funding depends largely on demonstrated ability to deliver agreed commitments on time, which in most cases is six months. However, routine administrative procedures can affect capacity to implement funds and activities in a timely and efficient manner.

c) The number of disaster related projects increased during the period, but they represented smaller budgets, which generated a tremendous amount of administrative and reporting work. Over all, there were more donors, but there was also less funding per donor.

d) One of the greatest challenges is to maintain a team of experts for the Regional Disaster Response Team with up-to-date knowledge and skills while at the same time coping with a high turnover of members and/or their unavailability for immediate deployment. This team, established upon request from the PAHO Directing Council (Resolution CD45.R8 [2004]), facilitates international health coordination and provides public health assistance to the affected countries.

e) Despite efforts to provide disaster management training for human assets in the Region in the past, human and institutional resources continue to be insufficient to respond to these events, especially emerging threats such as chemical or radionuclear disasters at a level that conforms to national and international expectations.

f) Sustainability of interventions in light of attrition in the Ministries of Health is yet another challenge.

g) The health sector in Latin America and the Caribbean is still ill-prepared to face large-scale chemical, radiological, or other technological disasters. Technological disasters constitute a significant potential risk to countries that have reached a certain level of industrial development but have done little in terms of regulation and/or prevention.

h) Despite progress in the Safe Hospitals initiative, ensuring that all new health facilities are safe from disasters and improving the safety of existing ones remains a major challenge. While there are a number of factors contributing to this situation, financial limitations and insufficient political will are among the most important.

i) Access to evidence-based information that supports decision-making continues to be one of the needs in the field of risk reduction and health. Searching for evidence, such as investment in hospital safety versus the cost of a disaster's impact on health facilities or the health network continues to be a key issue in convincing governments, the public, and donors about DRR.

j) The H1N1 pandemic influenza in 2009 and the earthquake in Haiti in 2010 triggered the largest and most challenging emergency response operations for the PASB during this reporting period. Because of their magnitude, these events were challenges not only for the affected countries and those providing support to the response, but also for the entire international community. All three levels of WHO had to be activated at the same time, the main challenge being the overwhelming number of actors that responded and their differing levels of expertise and capacities.

SO5 Lessons Learned

a) 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, many Member States are just staring to initiate health disaster mitigation measures and a few are yet to begin. However, the development of a simple tool, like 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 transform theory into practice.

b) Considerations for preparedness and risk reduction should be mainstreamed into all Organization-wide resource mobilization efforts as part of the development agenda.

c) The prevalence of disasters (both in number and magnitude) increases interest in the subject, as reflected in the level of commitment shown by PAHO Country Offices and Member States.

d) An overwhelming number of response/humanitarian actors (sometimes ill prepared to provide aid) could have a negative effect on the health response. A mechanism to ensure more effective participation of health cluster actors must be implemented. The 28th Pan American Sanitary Conference approved Resolution CSP28.R19, which reconciles national and international interest in the coordination of international humanitarian assistance and health clusters in case of disasters as the first step to addressing this issue.

e) Building on existing structures facilitates project/program implementation. For example, 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. Also, capitalizing on events in the countries and coupling related activities facilitates the technical cooperation process. Examples are application of 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.

f) The important country efforts in disaster preparedness need to be complemented with the development of standardized tools to better assess and monitor progress and identify critical aspects that need to be implemented.

g) The SMART Hospital Initiative has reinforced the positive impact of sharing efficient and effective results through demonstration/pilot projects on gaining buy-in and commitment to new approaches/interventions. This example augers well for their scaling up and long-term sustainability.

Progress towards Impact Results

SO5 Indicator 1: Crude daily mortality
Target: Daily mortality of populations affected by major emergencies maintained below 1 per 10,000 during the initial emergency response phase

This indicator was achieved. In all the emergencies assessed during 2008-2013, the daily mortality was below 1 per 10,000 during the initial emergency response phase. In Haiti, although the mortality rate due to the collapse of physical infrastructure was higher than this ratio, the daily mortality rate was below 1 per 10,000 inhabitants during the initial emergency response phase, which is what the indicator measures.

SO5 Indicator 2: Access to functioning health services
Target: Affected health networks become operational within one month following a natural disaster

This indicator was achieved. Where affected, all health networks were operational within one month following disasters that occurred during implementation of the Strategic Plan. In Haiti, access to health care during the initial response phase to the 2010 earthquake was above the pre-disaster level.

Substantial progress has been accomplished in relation to rehabilitation and reconstruction. 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 recovery capacity of the health system in that country. In other cases, such as in Saint Vincent and the Grenadines after the 2013 Christmas Eve floods, the health networks remained operational, though at a reduced capacity.

Assessment of the Region-wide Expected Results

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	Fully Achieved

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

54. The target values for all indicators in this RER were exceeded. This RER reflects most of the Organization's preparedness and mitigation work, and the fact that all indicators were exceeded—even after having to respond to the unprecedented events in Haiti (both the massive earthquake and the cholera epidemic) and many other major disasters within and outside the Region, while working with a progressively declining staff complement—is clear evidence of the commitment to disaster risk reduction on the part of both the PASB and the Member States.

55. The PAHO 50th Directing Council approved Resolution CD50.R15 (2010), Plan of Action for Safe Hospitals 2010-2015, thus facilitating the Member States as they go about adopting a national risk reduction policy and working towards achieving the goal that all new hospitals will continue their operations during disasters. A total of 32 Latin American and Caribbean (LAC) countries/territories have broadly and successfully applied the Hospital Safety Index in more than 2,900 hospitals and other health facilities with leadership and technical support from PAHO. Most of them are also implementing corrective measures in priority health facilities.

56. While some countries have advanced in the development of independent and operational health disaster programs, maintaining these programs with funding, credible leadership, and the ability to

coordinate at the national level is an ongoing challenge. This challenge is compounded by the high turnover and migration of trained health personnel in many LAC countries and the limited budgetary capacity of some governments. Existing programs must be strengthened and new ones developed in the countries that lag behind.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.1.1	Number of countries that have developed and evaluated disaster preparedness plans for the health sector	23	35	Yes
Comments: 38 countries/territories achieved this target: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, FEP, GUT, GUY, GRA, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SAL, SAV, SCN, SUR, TRT, URU, and USA. Preparedness, readiness, and response related to the many large emergencies that occurred in the Region during the period of the Strategic Plan undoubtedly accelerated national processes related to updating and/or developing disaster preparedness plans for the health sector. Work will need to be sustained to continuously update disaster preparedness plans and include the missing countries.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.1.2	Number of countries implementing programs for reducing the vulnerability of health infrastructure	9	30	Yes
Comments: 39 countries/territories achieved this indicator: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, NCA, PAN, PAR, PER, SAL, SCN, SAV, SUR, TCA, TRT, URU, USA, and VEN. The majority of the countries have been implementing their health facilities' vulnerability reduction programs within the context of the Safe Hospitals Initiative and the framework of the Regional Plan of Action on Safe Hospitals 2010-2015, approved by the PAHO 50th Directing Council. In addition to this political commitment, there has been strong support from donor organizations, which has greatly facilitated implementation of actions in many countries, such as in Haiti, via the World Bank/Ministry of Health/PAHO Disaster Risk Reduction initiative for Reconstruction after the earthquake.Safe hospital actions have also stimulated expansion of the initiative beyond the health sector to include schools (Safe Schools) and hotels (Safe Hotels). In addition, the organization implemented an innovative initiative that integrates climate change and disaster risk reduction considerations into the health sector (Safe + Green = SMART Hospitals Initiative). Among the key outputs are a toolkit to guide implementation of climate change mitigation measures in existing health care facilities (SMART Hospital Toolkit); cost-benefit analysis of climate-smartening a hospital, which provides evidence of the cost-effectiveness of instituting environmentally friendly and disaster-resilient measures in hospitals; and two pilot/demonstration projects in health facilities. This initiative has already being a catalyzing force for interest and involvement on the issue on the part of both donors and national authorities.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.1.3	Number of countries that report having a health disaster program with full-time staff and specific budget	10	15	Yes

Comments:
20 countries/territories achieved this indicator: ARG, BOL, BRA, CAN, CHI, COL, CUB, ECU, FDA, FEP, HON, JAM, MEX, NIC, PAN, PAR, PER, URU, USA, and VEN.

Two countries fell from the baseline (BLZ and TRT). The concept of a health disaster program is finally fully ingrained in all Member States as a requirement for proper emergency planning and response. All LAC countries have established disaster management functions within their ministries of health. While 27 of them have formally created a disaster program, only 20 are staffed full-time and have a dedicated budget, which again illustrates how the situation varies from country to country and why it requires sustained support from the PASB in terms of advocacy and human resource capacity-building. At the institutional level, new guidelines for the organization of health disaster programs were finalized and published online at the Knowledge Center on Public Health and Disasters.

RER 5.2 Timely and appropriate support provided to Member States for immediate assistance to populations affected by crisis	Fully Achieved

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

57. This RER originally corresponded to response activities, as reflected in the title. However, with the adoption of a new RER (5.7, Outbreak Crisis and Response funding) that encompassed humanitarian response in the 2010-2011 biennium, it was left to reflect readiness activities.

58. With improved country capacity to deal with disasters, there is a growing demand for a different level of technical cooperation with increased specificity to countries' particular realities at both the strategic and operational levels. The PASB has therefore been strengthening its own capacity to assist countries in preparing and responding to disasters according to this new reality, despite the high level of response operations in the Region of the Americas (in terms of both number and magnitude). This approach has included development of its new EOC and adoption of a policy outlining the Organization's institutional response to emergencies and disasters, together with an increase in its surge response capacity. A total of 21 PAHO/WHO Country Offices (PWRs, Administrators, and Disaster Focal Points) participated in face-to-face workshops, and an e-learning course was developed in both English and Spanish to facilitate continuous learning on this topic.

59. The capacity of PASB staff was further strengthened through training in other areas, such as cholera preparedness and response, health cluster operations, and Response Team topics (logistics, information management/communications, epidemics, mental health, and water, sanitation, and hygiene (WASH)). 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.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.2.1	Number of regional training programs on emergency response operations	4	7	Yes

Comments:
This indicator was exceeded. PAHO provided several regional training programs on response operations. These included:

- Training for regional disaster response teams, including the following subdisciplines: Epidemiology and surveillance, information management and communication, health logistics, mental health and psychosocial support, WASH;
- Training for health cluster coordinators (one for each subregion);
- Pre-deployment course for disaster response teams;
- Preparedness and response to cholera outbreaks for the Caribbean and Central America;
- Supply Management and Logistics Support System.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.2.2	Percentage of emergencies where a response to emergencies is initiated within 24 hours of the request	100%	100%	Yes

Comments:
All responses to emergencies were initiated within the 24 hours of receipt of requests including the major disasters that impacted the Region during 2008-2013: the H1N1 influenza pandemic, cholera outbreaks in the Caribbean and Central America, earthquakes in Haiti and Chile in 2010; Hurricane Sandy in BAH, CUB, HAI, and JAM in 2012; earthquakes in COR and GUT, floods in BOL, COL, and Central America (ELS, GUT, HON, NIC, and PAN), and volcanic eruptions in South America. In addition, technical support was provided to the countries following the nuclear accident and tsunami in Japan, in collaboration with PASB's Health Systems and Services (HSS).

During the last semester of 2013, response was provided for an outbreak of acute respiratory infections in PER; dengue outbreaks in HON and NIC, where resources were mobilized and technical support provided for prevention and control; flooding in SAL and SAV, where resources were mobilized and technical support provided for emergency coordination, rapid assessment, WASH, and restoration of health care delivery; and drought in BOL, where resources were mobilized and technical support provided for WASH and health care delivery. In COL and HAI, PAHO continued to support the ministries of health in managing the health clusters.

RER 5.3 Member States supported through technical cooperation for reducing health sector risk in disasters and ensuring the quickest recovery of affected populations	Fully Achieved

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

60. PAHO involvement in post-disaster recovery efforts increased over the period. During the implementation of the SP, recovery operations were supported for the August 2007 Earthquake in Pisco, Peru and the 2008 Noel Tropical Storm in the Dominican Republic. An agreement was also signed with the World Bank for funding from the United Kingdom to ensure that mitigation measures were incorporated into all new hospitals in Haiti after the 2010 earthquake. With this funding, one expert/professional was seconded to the Haitian Ministry of Health's Infrastructure Unit following the earthquake. PAHO also participated in development of the post-disaster needs assessment (PDNA) for Haiti, with the recruitment of a high-level expert. This PDNA had an operational component for health. A number of consolidated appeal processes were launched for Haiti and Colombia, in which the health sector was well represented.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.3.1	Percentage of post-conflict and post-disaster needs assessments conducted that contain a gender-responsive health component	100%	100%	Yes

Comments:
This indicator was achieved. All the post-disaster needs assessments carried out during the SP period included a gender component to varying extents. Disaster needs assessment templates integrate criteria targeting gender and vulnerable population, and all PDNAs contain disaggregated data. Training in needs assessments with inclusion of specific criteria for gender were carried out in BOL and ECU to ensure disaggregation of data and particular attention to the special needs of women and other vulnerable populations.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.3.2	Percentage of humanitarian action plans for complex emergencies and consolidated appeals with strategic and operational components for health included	100%	100%	Yes
Comments: This indicator was achieved. All United Nations humanitarian action plans and/or consolidated appeals included a health component. These documents were prepared mainly for COL and HAI (since 2010) on an annual basis. There were also others, such as a flash appeal for flooding in ELS and a Humanitarian Action Plan for CUB following Hurricane Sandy.				

RER 5.4 Member States supported through coordinated technical cooperation for strengthening preparedness, recovery, and risk reduction in areas such as communicable diseases, mental health, health services, food safety, and nuclear radiation	Fully Achieved

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

61. This is the RER in which the inter-programmatic activities of the PASB in disaster management are best reflected. From the response to the H1N1 influenza pandemic in 2009, through the response to the Haiti earthquake and cholera, to the recent floods in Central America, collaboration between different technical areas—especially between Areas of Emergency Preparedness and Disaster Relief (PED), Sustainable Development and Environmental Health (SDE), and Health Surveillance and Disease Control (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; coordination to provide technical advice to the countries of the Region following the Japan radiation disaster (HSS and PED); coordination to prepare the Caribbean and Central America for potential cholera outbreaks (PED, HSD, HSS); and the participation of different technical areas in the health cluster—to mention a few. Also—in coordination with HSD, Knowledge Management and Communication (KMC), and PED—an institutional response strategy was developed and approved establishing three levels of activation, and a new EOC was inaugurated.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	90%	100%	Yes
Comments: All the countries affected by emergencies had a communicable disease risk assessment conducted whenever needed. Examples included risk assessment toolkits developed for cholera reintroduction in Mesoamerica after the outbreak in MEX in 2013; risk assessments of the reemergence of cholera in 2010, carried out in HAI and DOR in the context of the rainy season; risk assessments following the 2010-2011 floods in Central America and the 2012 dengue outbreak in Ucayali Department, PER. In addition, comprehensive risk assessments of the cholera situation following Hurricane Sandy were conducted in CUB, DOR, and HAI.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.4.2	Percentage of emergencies where coordinated technical cooperation (PASB task force) is provided when needed	100%	100%	Yes

Comments:
The PASB task force was convened to coordinate the secretariat's response to emergencies when needed. This included the response to floods in Central America, the response to the earthquake and cholera epidemic in HAI, the earthquake in CHI, response to the H1N1 influenza pandemic in 2009, and the oil spill in the Gulf of Mexico.
On other occasions, although the PASB task force was not convened, special meetings were held, such as in relation to the 2013 cholera outbreak in MEX and two 2013 emergencies outside the Region: the Syria crisis and he typhoon in the Philippines. In addition, at the suggestion of PAHO, the Organization of American States (OAS) convened a special meeting of the Inter-American Disaster Committee regarding Hurricane Sandy, in which PAHO participated as the inter-American system's specialized organization in health matters.

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	Fully Achieved

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

62. At differing points during the six-year period, up to 32 countries had focal points for the International Food Safety Authorities Network (INFOSAN). However as of end of 2013, 10 countries fell from the baseline, having not updated their point of contact information in the INFOSAN secure site or communicated updates to Geneva .Nevertheless, since RER indicator 5.5.3 ties into the larger goal of ensuring the countries' capacity to address food safety emergencies, which was an indicator in itself (5.5.1) for which the target was exceeded, the RER is considered fully achieved.

63. The challenge remains to have additional countries appoint formal focal points for INFOSAN and keep their information updated. Food safety-related emergencies were included in the Event Management System during the period.

64. Thanks to strong interprogrammatic work between PED and SDE, indicator 5.5.2 was achieved. However, while most of the countries have made great strides in facing natural hazards, the health sector in Latin America and the Caribbean still has more work to be done to face large-scale chemical, radiological, or other technological disasters. Because of other competing demands and the multisectoral aspect of chemical emergency prevention, preparedness, and response, it seems that these are not perceived as a priority in the health sector. However, the training and capacity-building activities that the PASB supported have been helpful in raising awareness and mobilizing additional resources to develop national action plans. Technological disasters pose a significant potential risk for countries that have reached a certain level of industrial development but have done little in terms of regulation and/or prevention.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.5.1	Number of countries with capacity to respond to food safety emergencies	15	30	Yes

Comments:
33 countries/territories achieved this indicator: ARG, BAH, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SAL, SUR, TRT, URU, USA, and VEN.

This indicator was included because it was part of the original WHO General Programme of Work (GPW), but WHO subsequently deleted it from their work plan. Nonetheless, PAHO maintained it and continued provision of technical cooperation, particularly within the context of strengthening IHR core capacities.

Among the technical cooperation activities was a workshop conducted for Coordinators of Emergency

Response Management in the Area of Food Safety and Nutrition in the English-speaking Caribbean, With the participation of 30 senior officers from 10 countries, and each country developed an action plan to incorporate food safety and nutrition into their national health emergency plans. Work for Central America and South America was done in coordination with the Food and Agricultural Organization (FAO) and Regional International Organization for Plant Protection and Animal Health (RIOPPAH).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.5.2	Number of countries with national plans for preparedness, and alert and response activities in respect to chemical, radiological, and environmental health emergencies	20	28	Yes

Comments:
28 countries/territories achieved this indicator: ABM, ARG, BAR, BOL, BRA, CAN, CHI, COR, CUB, DOR, ECU, ELS, FDA, FEP, GUT, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, and USA.

This indicator was included because it was part of the original WHO General Programme of Work, but WHO subsequently deleted it from their work plan. Nonetheless, PAHO maintained it and continued provision of technical cooperation, particularly within the context of strengthening IHR core capacities.

Among the most recent activities was an interprogrammatic workshop for 15 English-speaking Caribbean countries to strengthen their capacity to detect, report, and control chemical emergencies and direct technical support to MEX. A guidance document based on the WHO manual for the public health management of chemical incidents is currently being developed.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.5.3	Number of countries with focal points for the International Food Safety Authorities Network	28	32	Yes

Comments:
At different times during the six-year period, up to 32 countries had focal points in the International Food Safety Authorities Network (INFOSAN).

However, by the end of 2013, 22 countries/territories had updated information for their focal points by registering in the INFOSAN secure site: ABM, ANI, ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, ECU, HON, JAM, MEX, NIC, PAN, SCN, SAV, TNT, USA, and VEN. 10 countries fell from the baseline, having not updated their information on the INFOSAN secure site or communicated any updates to WHO.

Participants from 23 countries were trained through webinars on the IHR and its relationship to INFOSAN. Two webinars were conducted in Spanish and English, with 216 participants from 20 countries and 53 participants from 14 countries, respectively.

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	Fully Achieved

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

65. PAHO has developed solid, long-lasting relationships with many organizations involved in disaster management, which will continue to be strengthened to improve the resilience of the health sector and reduce the impact of disasters on health. The PASB also published appropriate and timely reports following all emergencies in the Region, as well as a number of materials on lesson learned, such as an assessment of

the health response to the earthquake in Haiti and external evaluations of the regional response to the H1N1 influenza pandemic. The PASB continues to provide health cluster reports for HAI and played an important role in the Global Health Cluster by providing a cluster leader for operations in Pakistan (earthquake), the Philippines after Typhoon Haiyan and Mali and Syria (civil conflict crises).

66. Despite the significant advances in information management, many countries in the Region lag behind in creating and empowering health sector teams to collect, assess, and make health information available in the first 48 hours of an emergency. The task of collecting post-disaster data (including gender disaggregated data), analyzing and interpreting it in operational terms, and transforming it into action for disaster response is complex and not always carried out properly following a major event. The health sector generally relies on health situation rooms for the ongoing collection and analysis of information on epidemiology, communicable diseases, and other public health data. Yet these situation rooms are not always linked to EOCs, which are the coordination hubs for response actions. In fact, some countries are actually limited in their capacity to organize and run EOCs. The PASB must also strengthen the capacity of its EOC at PAHO headquarters and the subregional level to analyze information and coordinate operational needs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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%	Yes
Comments: The United Nations Health Cluster, as defined by the United Nations Humanitarian Reform, was operational in all emergencies for which it was called upon. It is currently active in COL and HAI, where PAHO is supporting the MoH in the management of health clusters. Two virtual meetings were held with health cluster partners in Latin America and the Caribbean on the reintroduction of cholera in Central America in 2013. The PASB also supported coordination of the health cluster in the Philippines after Typhoon Haiyan and in the Syrian and Mali civil conflicts. Health clusters were also activated for response to Hurricane Tomas in 2010 in the Eastern Caribbean, the earthquake in DOM and GUT in 2013, and DOM after the Haiti earthquake in 2010.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.6.2	Number of emergency-related regional interagency mechanisms and working groups where PAHO/WHO is actively involved	4	10	Yes
Comments: PAHO is actively involved in more than 10 ongoing partnerships and working groups: the Andean Committee for Disaster Prevention and Response; the Coordinating Center for the Prevention of Natural Disasters in Central America; the Global Health Cluster, the Caribbean Disaster Emergency Management Agency; the Disaster Mitigation Advisory Group; the Regional Disaster Information Center; the Latin American and Caribbean Humanitarian Information Network; the Regional Inter-Agency Task Force on Risk, Emergency, and Disasters in Latin America and the Caribbean; the United Nations International Strategy for Disaster Reduction; the Inter-American Mechanism for Humanitarian Assistance; the OAS Inter-American Committee on Natural Disaster Reduction; the Regional Coalition for Water and Sanitation to Eliminate Cholera in the Island of Hispaniola; the Eastern Caribbean Donor Group for Disaster Management; the International Structure Engineering Association Caribbean Chapter; and the Specialized Meeting on Social and Natural Disaster Risk Reduction, Civil Defense, Civil Protection, and Humanitarian Aid.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.6.3	Percentage of disasters in which UN and country-originated reports include health information	100%	100%	Yes
Comments: Health information was provided in the United Nations and country-originated disaster reports, including the reports on the complex emergencies in COL and HAI, as well as acute emergencies such as the H1N1 influenza pandemic; earthquakes in CHI and HAI; floods in Central America, BOL, and COL; Hurricanes Irene in BAH, Sandy in BAH, CUB, HAI, and JAM, Isaac in Dominica and HAI; and earthquakes in COR and GUT. The countries were also informed about 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	Fully Achieved

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

67. The 2010 earthquake in Haiti constituted the most massive humanitarian response effort ever made by PAHO and by the humanitarian community in general. Record numbers of experts 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 massive response was followed by an additional surge in activities due to the cholera epidemic in October 2010, in which a decentralized approach, based on field teams, proved to be successful.

68. Many Member States have started to review how they approach the management of international assistance to obtain greater benefits from the new opportunities offered by humanitarian assistance and, at the same time, overcome the challenges posed by a greater international response. The Americas is the first region to have adopted a resolution that integrates the principle of United Nations humanitarian reform with respecting the needs and priorities of sovereign countries (Resolution CSP28.R19 of the 28th Pan American Sanitary Conference). This resolution calls for practical national and intercountry institutional arrangements that will be supported by the PASB for humanitarian operations.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.7.1	Percentage of emergencies for which PAHO/WHO mobilizes national and international resources for operations when needed	100%	100%	Yes
Comments: The PASB actively mobilized national and international resources for operations in all emergencies, when needed, including the major disasters that impacted the Region between 2008 and 2013: earthquakes in CHI and HAI in 2010; the H1N1 influenza pandemic in 2009; cholera outbreaks in the Caribbean; Hurricane Sandy in BAH, CUB, HAI, and JAM in 2012; earthquakes in COR and GUY in 2012, floods in BOL, COL, and Central America (ELS, GUT, HON, NIC, and PAN) in 2010-2011; and volcanic eruptions in South America. In addition, technical support was provided to the countries following the tsunami and nuclear accident in Japan. During the last semester of 2013, support was provided in response to an acute respiratory illness outbreak in PER and dengue outbreaks in HON and NIC, where resources were mobilized and technical support provided for prevention and control; flooding in SAL and SAV, where resources were mobilized and technical support provided for emergency coordination, rapid assessment, water, sanitation and hygiene (WASH), and restoration of health care delivery; drought in BOL, where resources were mobilized and technical support provided for WASH and health care delivery. In COL and HAI, PAHO also continued to support the ministries of health in managing the health clusters.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
5.7.2	Percentage of recovery operations for which health interventions are implemented when needed	100%	100%	Yes
Comments: Health interventions were part of all recovery operations, including the protracted emergencies in COL and HAI and acute major disasters that impacted the Region between 2008 and 2013, such as the earthquake in HAI in 2010; Hurricane Sandy in BAH, CUB, HAI, and JAM in 2012; earthquakes in COR and GUT in 2012; Hurricane Tomas in 2010, and flooding in SAL and SAV in 2013.				
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				Partially Achieved[13] (79% of indicator targets achieved)

RER Status[14]	6.1	6.2	6.3	6.4	6.5	6.6

SO6 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
48.0	21.7	18.4	40.1	94%	84%

SO6 Programmatic Assessment Summary

69. Considerable progress was made in the effort to prevent and reduce noncommunicable disease risk factors in the Region. Member States and Territories led efforts that have influenced regional and global initiatives to reduce NCD risk factors and have highlighted the importance of health promotion. Surveillance systems in the Region have grown in number and complexity, sometimes leading to duplication of effort. This duplication is a cause for concern and merits attention. The political discourse has slowly recognized the need for integrated, multisectoral, and equitable policies and interventions to improve health and address its determinants. Recent advances led to political commitments at the United Nations High Level Meeting (UNHLM) on NCDs in 2011 and to the WHO Global Action Plan on NCDs. Accordingly, countries now have an obligation to implement regulations aimed at tackling risk factors such as tobacco, alcohol, and unhealthy diet (including sugary drinks and ultraprocessed food). However, interference from the tobacco, alcohol, and relevant food and beverage industries might hinder the significant progress and political will already achieved, as litigation by these industries based on commercial and investment grounds is currently in progress, with an expectation that more lawsuits might follow. Should any of the current cases succeed, the result would be major reversals in effective public health policies. PAHO therefore needs to continue to strongly support country efforts in tackling NCD risk factors and emerging challenges that threaten the achievements to date.

SO6 Main Achievements

a) Significant advances on surveillance of risk factors are noted: 25 countries adopted Pan Am STEPS studies or aligned with this surveillance system; 27 participated in the Global School Health Survey; 30 updated at least one of the components of the Global Tobacco Surveillance System (30 updated their

[13] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[14] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

Global Youth Tobacco Survey, 5 developed the Global Adult Tobacco Survey, and 19 developed the Global Health Professional Student Survey). Surveillance of risk factors is key to building a strong case on best-buys and evidence-based policies that help to curb the NCD epidemic in the Region.

b) Significant progress was made in regional implementation of the WHO Framework Convention on Tobacco Control (FCTC): 29 Member States are Parties to the Convention; 17 countries have a 100% smoke-free policy in enclosed public places, enclosed workplaces, and public transportation; 13 countries have a total or a very comprehensive ban on tobacco advertisement, promotion, and sponsorship; and 19 countries comply with the minimum requirements of FCTC Art 11 on regulations on packaging and labeling of tobacco products. At least 6 countries have modified their tobacco tax structure to reduce accessibility; and 2 countries approved using tobacco revenues to finance public health.

c) There was considerable achievement in the implementation of national policies or norms to promote healthy diet and physical activity: 9 countries improved their school food environments; 1 country enacted taxes on sugary drinks and energy-dense snacks; and laws or regulations on marketing were enacted in 4 countries. The Region is leading efforts related to fighting the obesity epidemic, especially in children.

d) For the 8th Global Conference on Health Promotion, 25 case studies from 15 countries were compiled and analyzed for development of a Global Health in All Policies (HiAP) Framework, which was presented in Helsinki.

e) 17 countries have well established Health Promoting School Networks.

f) Following adoption of Regional Plans of Action on Harmful Use of Alcohol and Substance Use, there has been an increase in awareness, engagement, and allocation of resources to tackle alcohol and substance use that has resulted in improved policies, programs, and interventions in alcohol and/or substance use in various countries of the Region.

g) Strong regional positioning of the topic of substance abuse as a public health matter is influencing decision-making processes by main stakeholders in the Region.

h) Concrete actions have been taken in several countries to provide safe environments such as bike paths to promote a healthy lifestyle and physical activity.

i) 16 countries of the Region significantly expanded access to preventive technology for safer sex (mostly condoms and water-based lubricants) for youth in key populations.

j) The Region led the inclusion of health promotion at the Global NCD Consultation.

SO6 Main Challenges

a) Ensuring the sustainability of risk factor surveillance systems by collecting good information and using it for country risk factor reduction interventions is a particular challenge. NCD and risk factor surveillance should be maintained as a priority within health information systems, and resources must be directed towards this important activity. Also, to improve efficiency, surveillance of risk factors needs to have a more integrated and coordinated approach; this is a major factor that still needs to be addressed at both regional and country levels.

b) Another challenge is interference of the tobacco, alcohol, sugar, and ultraprocessed food industries, which undermines the progress achieved by countries towards the reduction of NCD risk factors. The litigation and disputes, based on commercial and investment grounds, that are taking place with regard to tobacco control, if successful, could threaten or even reverse some of the public health achievements already made and slow down progress in tackling other risk factors. Regional and bilateral trade agreements are a great area of concern if they do not clearly protect the public health.

c) Multisectoral work is challenging at the country level. Efforts to tackle risk factors are not the exclusive responsibility of the Ministries of Health. Efforts to implement Health in All policies should continue at PAHO and at the country level.

d) There has been uneven progress on policies for diet and physical activity, and public efforts have been modest in combating adult obesity. Nevertheless, attention towards combating childhood obesity has been

gaining traction throughout the Americas. This is considered the right way to go in terms of protective actions by governments and legislators.

e) PAHO faces the major challenge of developing a high-quality regional plan on childhood obesity and reaching consensus among the Member States on its adoption and implementation. Member States should take the big step of implementing actions recommended in the plan in their national health systems.

f) The challenge of increased alcohol consumption in the Region continues. Slow progress was noted in the implementation cost-effective policies related to reducing harmful use of alcohol, despite the adoption of a global strategy and regional plan of action. Investments made by the alcohol industry to increase their market share in Latin American and Caribbean countries may threaten public health.

g) There continues to be a lack of emphasis in the prevention agenda on the promotion of safer sex, especially in at risk populations, and incomplete application of state-of-the art approaches to address the specific needs of at risk populations.

h) Further integration of health promotion and prevention in health care systems is needed, particularly in primary health care, to address NCDs and their risk factors. There is a need for more training and human resources, as well as an improved understanding of the impact of these factors and conditions on the overall health burden at national and regional levels.

SO6 Lessons Learned

a) Consolidation of the HP School Networks requires both time and technical cooperation. Global agendas revolving around the social determinants of health and noncommunicable diseases call for delivery channels, such as the existing HP networks, to reach the settings where people work, live, and learn.

b) While countries have proven their ability to establish NCD and risk factor surveillance, sustainability continues to be a challenge, since it requires well-trained professionals and sustainable financial resources.

c) A human rights approach has been key to defending tobacco control regulations from tobacco industry claims and litigation efforts, though litigation promoted by the tobacco industry at the domestic level has overwhelmingly ended up in favor of public health.

d) Alcohol use is still not recognized as a major risk factor that requires a multisectoral approach, free of conflicts of interest. This is critical to protect individuals and public health.

e) Technical cooperation on promoting safer sexual behaviors is a component that requires closer articulation with other United Nations agencies—the United Nations Population Fund (UNFPA), the United Nations Development Fund (UNDP), the United Nations Educational, Cultural, and Scientific Organization (UNESCO), and the United Nations Children's Fund (UNICEF)—as well as with other stakeholders.

Progress towards Impact Results

SO6 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)

8 countries presented a 10% reduction in the prevalence of tobacco use (ARG, BRA, CAN, CUB, MEX, PAN, URU, USA). But it should be noted that 7 countries (COR, DOR, ELS, GUT, PAR, SAL, and SAV) either do not have a new survey for comparison or else their new survey is not comparable with the previous one.

SO6 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)

Despite evidence from the United States of America that childhood obesity is leveling off in some states and adult obesity rates are not increasing as rapidly, in general it can be said that no country in the Region has been able to reduce the rate of adult obesity. This stalemate might partly be the result of very modest public efforts to combat the problem. Conversely, attention on childhood obesity is gaining traction throughout the Americas and at least 9 countries are already taking practical measures to tackle the situation, including the use of laws and regulations.

SO6 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 proposed impact indicator should have been based on the estimated number of new cases of HIV infection in the target age group. Prevalence data are usually not disaggregated by age group, which hampers the utilization of this indicator. Moreover, the effects of the interventions intended to promote safer sex and measured as prevalence may be more conspicuous in older age groups who benefited from those interventions when they were much younger.

In the case of the Caribbean, UNAIDS estimates that in this age group there has been a decline of around 50%, while the decline in Latin America has been only around 15%. As mentioned before, data are not sufficiently disaggregated and further research and surveillance are necessary to improve the quality of strategic information. Nevertheless, there is clear indication that among youth in key populations (MSM, trans persons, sex workers, drug users) there might be no decline at all, which demands a much more targeted strategy to deal with the HIV epidemic in this segment of the population.

Assessment of the Region-wide Expected Results

RER 6.1 Member states supported through technical cooperation to strengthen their capacity for health promotion across all relevant programs and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors	Fully Achieved

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

70. Substantial progress was achieved Region-wide during the period 2008-2013 in promoting health in the Americas. During this period, countries in the Region reviewed and adopted policies and plans, the information from which was captured during preparation for the 8th Global Conference on Health Promotion, where the experiences of 15 countries of the Region was compiled and presented at Helsinki. The health-promoting school network approach is now being used in 17 countries and has been a key instrument for channeling a number of health-promoting activities, including prevention of communicable and noncommunicable diseases, as well as healthy lifestyles. New modalities of health promotion, such as the urban health concept, have been widely adopted in the Region, including implementation of the conclusions of the Second Regional Forum on Urban Health and the Third Forum on Health Promotion. Also, the participation of youth organizations in health promotion activities, particularly national parks, have proved to be effective in promoting health. Multisectoral collaboration has been a key factor in the progress made in the Region in these areas.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.1.1	Number of countries that have health promotion policies and plans with resources allocated	11	20	Yes

Comments:
29 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, FEP, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAV, TRT, URU, and USA.

These countries/territories reported having health promotion programs in place with resources allocated at the national level. Certainly, many countries in the Region are responding to the call for action following the 8th Global Conference on Health Promotion held in Helsinki in June 2013. As part of preparations for the Conference, 25 cases studies, representing 15 countries, were compiled and analyzed for the development of a Global Health in All Policies (HiAP) Framework, which was presented in Helsinki. In addition, funding in support of the HiAP initiative was made available through Spanish Agency for International Development Cooperation (AECID), the Rockefeller Foundation, and the Kobe Center.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.1.2	Number of countries with Healthy Schools Networks (or equivalent)	7	15	Yes

Comments:
17 countries achieved this indicator: ARG, BAH, BLZ, BRA, CAN, CHI, COL, CUB, DOR, ECU, ELS, FEP, GUT, GUY, MEX, NIC, and PER.

The number of countries with well-functioning national Health Promoting School Networks has increased from 10 in 2009 to 17 as of 2013. In addition to well-established networks with almost a decade of collaboration such as the ones in ARG, CHI, CUB, and MEX, it is important to note that newcomers like NIC and BRA will have a strategic impact in the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.1.3	Number of countries that adopt the PAHO/WHO urban health conceptual framework	0	5	Yes

Comments:
6 countries achieved this indicator: BRA, CHI, COL, ELS, MEX, and SUR.

The Urban Health Equity Assessment and Response Tool Urban HEART (UH) has been used as a health equity component, explicitly including conceptual, methodological, and metrical elements that can better support equity-oriented decision-making at the local urban level. COL developed pilot projects in Bosa District, Medellin, and Cali, and the Ministry of Health will use the methodology throughout the country. ELS has taken action in urban health, which is now included in its policies and being addressed through primary care, as well as programs aimed at people living in slums. BRA, CHI, and MEX have been active in implementing the healthy municipality initiative at the subnational level. BRA tested a pilot project in Porto Alegre (Vila Restinga) that addressed two areas: (i) metrics for measuring and monitoring inequalities in intraurban health, and (ii) governance, through work with local authorities and community leaders, to collect and validate data, define local sustainable development indicators, generate information, establish the Hospital Moinhos de Vento to serve as promoter of local development and "health for all". ARG also advanced towards achievement of this indicator: it has an active network of healthy municipalities and has been developing policies on urban health; however, the urban health conceptual framework was not implemented, as first it must be developed, piloted, and tested in urban settings.

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 and their dissemination	Partially Achieved

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

71. The technical cooperation provided by PAHO resulted in strengthening countries' capacity to obtain data related to NCDs and risk factors, including epidemiological data on adults and adolescents. Countries have shown steady improvement in their capacity in this area. Of special mention is the Caribbean subregion, which has succeeded in having the first data on risk factor (RF) levels in 13 countries or territories which have used them in developing their national NCD plans. The area of NCD surveillance requires constant attention and support in order to expand the countries' capacity to conduct more sophisticated analysis, dissemination, and use of data for advocacy.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.2.1	Number of countries that have developed a functioning national surveillance system using Pan Am STEPs (Pan American Stepwise approach to chronic disease risk factor surveillance) methodology for regular reports on major health risk factors in adults	6	20	Yes
Comments: 23 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BRA, CHI, COL, COR, GUT, DOM, GRA, JAM, NEA, NCA, PAN, PAR, SCN, SAL, SAV, SUR, TRT, and URU. 23 countries in the Region developed PanAm STEPs studies or aligned with PanAm STEPs. These studies served as a basis for developing country reporting systems on main risk factors and diseases. The methodology was useful in introducing RF surveillance and disease prevalence data, particularly in smaller countries with less developed capacity for NCD surveillance, like ABM, BLZ, GRA, NCA, PAN, PAR, SAL, and SAV. For larger countries that have well-developed NCD surveillance, it helped to standardize anthropometric measurements and blood tests and facilitated international comparability (ARG, BRA, CHI, COL, and COR). Still, capacity in the countries varies, and they usually rely on a single professional or a very small team, so further support in capacity-building and encouraging countries to disseminate information to a broader audience is vital, particularly now that there are global targets for NCDs.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.2.2	Number of countries that have developed a functioning national surveillance system using a school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	30	Yes
Comments: 27 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, CHI, COL, COR, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, NCA, PER, SAL, SAV, SCN, SUR, TRT, URU, and VEN This indicator recorded a steady increase in the number of countries joining the Global School Health Survey (GSHS), from 11 countries in 2010 to 16 in 2011, and 27 by the end of 2013. In addition to the 27 countries and territories, 5 others (BRA, CUB, DOR, PAN, and PAR) were at various stages of GSHS implementation. Work is under way and funding has been secured for GSHS implementation in HAI in early 2014.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	3	12	Yes

Comments:
12 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BRA, CAN, CHI, DOM, JAM, PAR, and USA.

Two PAHO statistical publications, (i) Basic Health Indicators and (ii) *Basic Health Indicators on NCDs*, include data on NCDs. The PAHO minimum dataset helped the countries to organize their data on NCDs, secure annual reporting from different sources, and produce annual NCD reports. It also served to guide the first comprehensive compilation of NCD information, including socioeconomic indicators, specific mortality, prevalence of diseases, and risk factors in adults and adolescents, as well as the information on the response of health systems and intersectoral policies. Published under the title *Basic Health Indicators on NCDs*, it was prepared for the UNHLM. The exercise will be repeated in 2015.

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	Partially Achieved

RER Assessment Summary (2 out of 4 RER indicator targets achieved; 2 not achieved)

72. Even though the RER was partially achieved, it should be noted that the Americas have progressed substantially towards implementation of the WHO Framework Convention on Tobacco Control (FCTC). Unfortunately there is still a lot to do, especially because the WHO FCTC articles measured here imply minimum cost for the government and are based much more on political will. The deadlines established in the WHO FCTC for Articles 11 (packaging and labeling of tobacco products) and 13 (tobacco advertising, promotion, and sponsorship) have not been met by many countries that are Parties to the Convention. With regard to the Surveillance System, the five countries that did not complete at least one component of the GTSS are in the process to do so during 2014.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.3.1	Number of countries that have adopted smoke-free legislation which includes all public places and all workplaces (public and private), consistent with the WHO Framework Convention on Tobacco Control	1	7	Yes

Comments:
17 countries achieved this indicator: ARG, BAR, BRA, CAN, CHI, COL, COR, ECU, GUT, HON, JAM, PAN, PER, SUR, TRT, URU, and VEN.

These countries are 100% smoke-free in enclosed public places, enclosed workplaces, and public transportation. The work done by SUR was outstanding: it passed the most comprehensive law of the Region by a unanimous vote of its Parliament. MEX has legislation which, even though it allows for smoking in designated areas, has been regulated in such a strict way that the requirements are almost impossible to meet. Many CARICOM countries are working on bills in this area (ANI, BAH, GUY, and SAL), as well as BOL which is preparing a decree.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	0	4	Yes

Comments:
13 countries achieved this indicator: BRA, CHI, COL, PAN, SUR, ARG, BOL, CAN, COR, HON, ECU, ELS, and URU.

These 13 countries have a comprehensive ban on tobacco advertisement, promotion, and sponsorship. Five of them have a complete ban (BRA, CHI, COL, PAN, and SUR) and 8 have a comprehensive ban (ARG, BOL, CAN, COR, HON, ECU, ELS, and URU). Some of the countries have banned the display of the tobacco products at the point of sale (COL, PAN, SUR, and URU partially) since the packet itself is the ultimate means of promotion for the tobacco industry, especially if the rest of the media are banned. Four countries (BAH, BOL, PER and VEN) have prepared draft legislation aimed at achieving or strengthening this indicator. In the case of BOL, their goal is to expand the ban from comprehensive to complete.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.3.3	Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control	8	23	No

Comments:
19 countries achieved this indicator: ARG, BOL, BRA, CAN, CHI, COR, ECU, ELS, HON, JAM, MEX, PAN, PER, SUR, TRT, URU, and VEN.

These Member States comply with the minimum requirements of Art. 11 of the WHO FCTC in that they use graphic warnings occupying 50% or more of the main surfaces. COL had graphic warnings at 30% of size, and CUB was using text-only warnings at 30%. Two more countries (NIC and USA) have passed legislation, but in NIC the law has not been regulated yet, and in USA there has been litigation against the rulings by the tobacco industry. URU and CAN are the countries with the largest warnings, at 80% and 75%, respectively, followed by ECU, at 60%. JAM has approved warnings at 75% of size, but there are not in circulation yet.

Basically, if all the countries had complied with the WHO FCTC mandate on time (3 years after ratification), the indicator would have been reached. The major obstacles for countries achieving this indicator are the need for more political will and strong interference from the tobacco industry, which delay decision-making.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.3.4	Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	9	35	No

Comments:
30 countries//territories achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COR, CUB, DOM, DOR, ELS, GRA, GUT, GUY, HON, JAM, MEX, PAN, PAR, SCN, SAL, SAV, SUR, TRT, USA, URU, and VEN.

The Global Youth Survey (GYTS) was completed by 28 countries or territories, as follows:
2008 (BLZ, CHI, GUT, PAR); 2009 (ANI, BRA, DOM, ELS, GRA, SUR); 2010 (CUB, GUY, JAM,

SCN, VEN); 2011 (DOR, MEX, SAL, SAV, TRT, USA); 2012 (ARG, BOL, and PAN); and 2013 (BAH, BAR, CAN [although it is not part of the Surveillance System], and COR).

The Global Adult Tobacco Survey GATS was completed by 5 countries: BRA (2008), MEX, URU (2009), ARG (2012), and PAN (2013).

The Global Health Professions Student Survey (GHPSS) was completed by 18 countries: CHI, CUB, GUT, JAM, PAN, PAR, SAL, TRT, URU (2008), BAH, BAR, BLZ, GRA, GUY, SUR (2009), ELS, HON, VEN (2011), and COR (2013).

Of the 30 countries that updated at least one of the 3 GTSS components, 23 of them implemented at least 2 of them (GYTS, GATS, GHPSS). Even though the indicator was not met in numerical terms, the progress made was a tremendous success for the Region. The regional tobacco surveillance system is regular and systematic, and therefore it provides sound and reliable data that monitors implementation of the WHO FCTC and supports decision-making to curb the tobacco epidemic.

Five countries of the Region (COL, ECU, HAI, NIC, and PER) were not able to update any GTSS survey. These countries have been already trained and are expected to conduct GYTS in 2014. The issues that contributed to the countries not achieving the proposed targets were, among others: review of the GYTS protocol by WHO and CDC, which postponed implementation of the survey; internal difficulties at the country level regarding coordination among partners (COL, ECU, and HAI); and shortage of funds, which kept the survey from being implemented in 2013 (PER).

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 psychoactive substance use and related problems	Fully Achieved

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

73. The level of achievement of this RER may be attributed to the adoption of a regional plan of action on reducing harmful use of alcohol, pursuant to the WHO strategy adopted in 2010, as well as the development of a regional strategy and plan of action on substance use in 2011. Technical cooperation increased as a result; research initiatives were supported in several countries; and countries started to dedicate time and funding to strengthen the capacity of health professionals to deal with alcohol and other problems in PHC with the support of 4 virtual courses that became available in the PAHO Virtual Campus for Public Health. In addition, books, scientific papers, and other materials were published and disseminated, thus increasing the knowledge base for alcohol and drug policy action. Regional meetings and awareness events organized by PAHO allowed for better exchange of information, experiences, and expertise across the Region. Despite limited resources and a strong alcohol industry trying to influence public health policy-making, the results achieved were significant and created the basis for stronger and more effective technical cooperation in the next five years.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	11	20	Yes
Comments: 28 countries/territories achieved this indicator: ANI, ARG, BAR, BOL, BRA, CAN CHI, COL, COR, DOM, DOR, ELS, GRA, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, TRT, URU, USA and VEN.				

During 2008-2013, regional plans of action on alcohol and on substance abuse were adopted, and a network of national counterparts on alcohol and public health was formed and became active. BRA, CHI, MEX, and USA launched large programs to strengthen the health system response in PHC to respond to alcohol and other drug problems.

Research was undertaken both separately and jointly in ARG, BRA, CAN, COR, DOR, GUT, GUY, MEX, NIC, PAN, PER, USA, and VEN,, the results of which informed programs and policies on alcohol and injuries and violence against women. In addition, several publications were prepared and disseminated in the Region. Alcohol policies to reduce the harmful use of alcohol were approved and implemented (taxation, drink driving laws, restrictions on the sale of alcohol), resulting in a measurable decline in mortality in BRA, CAN, CHI PER, USA, and VEN. PAHO translated and disseminated a book on alcohol policy and public health that included cost-effectiveness data, and the Organization also participated in research with WHO on a cost-effectiveness analysis of alcohol policies by region and globally (WHO-CHOICE), which was later used in MEX.

The Ministries of Health of GUT, PER, and URU are implementing drug policy changes and interventions at the country level. There has been a steady increase in technical cooperation related to alcohol and drug issues over the last six years, reflecting the extent of the problem and recognition of the capacity and role of public health in dealing with alcohol and drug problems. An atlas on the resources for prevention and management of alcohol and substance use is being developed.

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, physical inactivity, and related problems	Partially Achieved

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

74. Although the goal of stopping further increments in adult obesity rates was not achieved, in the last six years the Region has made considerable improvements in facing the obesity epidemic, particularly in children. It is clear now that the focus on childhood obesity is the appropriate way to go, as children and adolescents have become the subject of protective action by governments and legislators over the past few years. Much has been learned in the promotion of healthy eating and the regulation of snacks high in salt, sugar, and fat. In the area of physical activity, the evident progress made by several governments in their policies on transportation and public spaces is an additional asset that is helping to create a solid public health platform to curtail and reverse obesity trends in the coming years.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.5.1	Number of countries that have implemented national policies to promote healthy diet and physical activity according to PAHO/WHO guidelines	8	20	No

Comments:
9 countries achieved this indicator: BRA, CAN, CHI, COL, COR, ECU, MEX, PER, and URU.

Major achievements over the last six years can be summarized as follows:

1. National policies (binding norms) were introduced to improve school food environment/programs and promote physical activity in BRA, CAN, CHI, COR, ECU, MEX, PER, USA (at the state and local level and also in the Supplemental Nutrition Assistance Program (SNAP) preschool program), and URU.
2. A tax was approved on sugary drinks and energy-dense snacks in MEX.
3. Laws were passed to regulate the marketing of snacks and sugar-sweetened beverages; set limits on sugar, salt, and fat content in these products; and require "front-of-package labels" in CHI, COL, ECU, and PER (regulations for some of these laws are in the process of being implemented).

Public policies that favor and promote healthy food go beyond the health sector. The political will of governments to develop and implement policies in this area is often undermined by arguments from related industries that often are better represented in the government than public health. The multisectoral nature of the problem, weak political will, and the influence of the industry are the major roadblocks standing in the way of faster achievement levels for this indicator.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	7	18	Yes

Comments:
18 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, ELS, FEP, GUT, JAM, MEX, NEA, PAN, PAR, TRT, URU, and USA.

In general, the Region is committed to provide safe environments for physical activities. Many countries have implemented bike paths and other spaces for physical activity. Bike use for transportation is improving in BRA, CAN, COL, ECU, MEX, and USA, and BRA, MEX, and USA have bike-sharing programs. Most countries in the Region have established Sunday streets/open streets (*ciclovías recreativas*); ELS offers physical activity programs, URU has developed active plazas. ECU made a contest of best local practices for health promotion in Cuenca and has created settings for pedestrians, bikes, and physical activity. Also, many of the countries are implementing health promotion actions to raise awareness of the importance of healthy lifestyles and physical activity.

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

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

75. Despite the progress achieved in expanding access to preventive technology (mostly condoms and water-based lubricants) by youth in key populations, there is still an urgent need to monitor the actual impact of interventions, such as the value of vicarious learning, comprehensive sexuality education, negotiation skills, and sustainability in the mid-term of interventions that seem to have a short-term effect. A thorough document to guide Member States on preventive practices in key populations is under development. Also, a training manual for peer educators of HIV+ youth has been completed in English, and a Spanish version of this manual is being finalized.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
6.6.1	Number of countries that have implemented new or improved interventions at the individual, family, and community levels to promote safer sexual behaviors	7	11	Yes

Comments:
15 countries achieved this indicator: BAH, BAR, BLZ, CHI, COL, COR, ELS, GUY, JAM, HON, MEX, NIC, PER, SUR, and TRT.

While progress has been made, a number of important challenges were identified during the last 6 years: lack of emphasis on the prevention agenda; insufficient emphasis on new generations that require effective interventions; and incomplete application of state-of-the art approaches to address the specific needs of most at-risk youth.

SO7: To address the underlying social and economic determinants of health through policies and programs that enhances health equity and integrates pro-poor, gender-responsive, and human rights-based approaches					Fully Achieved[15] (100% of indicator targets achieved)	
RER Status[16]	7.1	7.2	7.3	7.4	7.5	7.6

SO7 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
60.0	23.6	24.4	48.0	92%	80%

SO7 Programmatic Assessment Summary

76. The SO networks have been very active. The communication and collaboration among its members have facilitated sound teamwork, as well as successful cooperation with PAHO/WHO Representatives (PWRs) and country officials. A total of seven case studies from the Region of the Americas (two from Brazil, Canada, Chile, and Costa Rica, and two from the United States) were documented and published on the 2011 World Conference on the Social Determinants of Health website as background material. These case studies formed the evidence used at the Conference to illustrate the systematic and practical aspects (the "how") of implementing the social determinants of health (SDH) approach at the country level. Different strategies have been adopted to promote the SDH approach. Among others, it is important to highlight the leadership of the health sector in adopting its strategy of intersectoral collaboration at national and international levels to address the social and economic determinants of health in their efforts to encourage poverty reduction and sustainable development. At the Global Conference on Health Promotion, where the central theme was Health in All Polices (HiAP), PAHO presented a summary of experiences in the Americas, a collection of 25 case studies from 15 countries in the Americas and one case study from Spain. The local actions, implemented through the Faces, Voices, and Places (FVP) Initiative, were recognized in an evaluation conducted in San Cristóbal de las Casas, Mexico, in 2013, with the participation of Argentina, Belize, Brazil, Chile, Costa Rica, Colombia, Ecuador, and Mexico, together with ECLAC, UNDP, and the International Federation of Medical Students (IFMSA). The meeting highlighted the contribution of the FVP Initiative to addressing health inequities and achieving Millennium Development Goals. As part of a number of important initiatives to improve the comprehension and advancement of Human Rights, PAHO collaborated with the United Nations Special Rapporteur on the Right to Health in his visit to Peru. Gender equality and equity remain global, regional, and national pillars for health and development, and intercultural health has become a stronger agenda in the Region.

SO7 Main Achievements

a) The PAHO 50th Directing Council approved Resolution CD50.R8, Health and Human Rights, which consolidated all the results accomplished in 19 countries and by the PASB with regard to Indicator 7.4.1.

b) A special issue of the *Pan American Journal of Public Health* was devoted to the social determinants of health.

[15] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[16] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

c) Following the Regional Consultation on HiAP, which had the participation of 15 countries in the Region, 26 case studies on Health in All Policies (HiAP) were published and disseminated.

d) The Member States achieved considerable improvement in the development of axiomatic, methodological, and instrumental approaches to generate and analyze data for monitoring the socioeconomic inequalities in health outcomes. Particular emphasis was placed on the need to make subnationally disaggregated data available by geographic, demographic, socioeconomic, and health dimensions, in synergy with technical cooperation activities aimed at strengthening national capacities for health situation analysis (RER 11.3) within the SDH framework.

e) The Regional Gender Equality Plan of Action 2009-2014 was approved, and a midpoint monitoring report on 36 countries was produced. Important political and technical agreements were reached with the Central American Integration System (SICA) and the Andean Community of Nations (CAN) on gender equality in health. Technical presence in the area of cultural diversity and health is growing in the countries and with partners, with strong participation of ethnic/racial groups.

f) A Regional Consultation on the Social Determinants of Health was held in preparation for the 2011 World Conference on the Social Determinants of Health in Rio de Janeiro, contributing specific regional case studies on how to operationalize SDH.

g) In 2011, PAHO spearheaded a multistakeholder collaboration in consultation with the South American Institute of Government in Health and the Oswaldo Cruz Foundation (FIOCRUZ) in São Paulo, Brazil, along with the participation of Anguilla, Antigua, Barbados, Bolivia, Brazil, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, Grenada, Jamaica, Panama, Suriname, Saint Kitts and Nevis, and Saint Lucia, which contributed to the inclusion of health inequity and the social determinants of health in the outcome document of the United Nations Conference on Sustainable Development.

h) In September 2011, following the Rio World Conference on the Social Determinants of Health, PAHO convened a meeting of Collaborating Centers in North Carolina, USA, to discuss, among others, the recommendations that emerged from the Rio Conference. Collaborating Centers from Brazil, Canada, Chile, Colombia, Cuba, Puerto Rico, and the United States, working in the Health Promotion and Healthy Settings group, participated and contributed in smaller group discussions to this analysis.

i) In May 2011, PAHO provided training in the use of two tools: the Health Impact Assessment, and the Urban Health Equity Assessment and Response Tool (Urban HEART). These training initiatives were joint collaborations with the University of New South Wales, Australia, and the Kobe Center, Japan. The Urban HEART training took place in Bogotá, Colombia, and three countries, Argentina, Colombia, and Suriname, successfully conducted a pilot initiative using this tool as a direct result of the training.

j) The designation of health inequities and determinants of health as the overarching theme of the *Health in the Americas 2012 Edition – Regional Outlook and Country Profiles* and inclusion of the social determinants of health as a key priority area in the PAHO Strategic Plan 2014-2019 were achievements that recognized the growing emphasis on this area. Member States such as Argentina, Brazil, and Mexico have specifically discussed the need to address health inequities using the social determinants of health approach, and this is specifically reflected in the new PAHO Strategic Plan, which features the social determinants of health as a core pillar, as well as in Category 3. The PAHO flagship publication, *Health in the Americas 2012 Edition*, gives key examples of what the countries have done over the most recent five-year period (2006-2010) to address health inequities using the social determinants of health approach. Examples include *Crece Contigo* in Chile and Peru's national CRECER Strategy.

k) SDH Focal Points from all six of the WHO Regional Offices (Europe, Eastern Mediterranean, Americas, Africa, South-East Asia, and Western Pacific) met in Geneva in January 2012 to discuss implementation of the Rio Political Declaration on the Social Determinants of Health. Each region took responsibility for overseeing implementation of one or two of the five key pillars of the Rio Declaration. PAHO agreed to oversee implementation of the pillar that refers to Participation, given the Region's solid experience in this area and its ability to share best practices with other regions, including participatory budgeting and participatory management in the health sector.

SO7 Main Challenges

a) Complex issues such as gender identities/expressions, reproductive rights, sexual orientation, and legal capacity of adolescents, persons with disabilities, and older persons remains a challenge, since they are regulated by national laws (including criminal and civil codes) that have not been reviewed in a manner consistent with universal and regional human rights treaties and standards.

b) There continues to be a need to actively promote and advocate for the inclusion of the social determinants of health in the Post-2015 Development Agenda.

c) Considerable additional efforts are required to institutionalize both the ongoing collection of internally consistent disaggregated data, as well as microdata from surveys, and the periodic assessment of action on the social determinants of health through benchmarking and monitoring of socioeconomic inequalities in health.

d) There is a need to reach outside the public health community and convince other professionals how health inequities can be reduced through action on the social determinants of health.

e) Publication of "new knowledge" on the social determinants of health within the Region in Portuguese, French and Spanish is important to effectively disseminate the Region's knowledge base.

f) It will be important to ensure that equity is "hard-wired" into the goals of the Post-2015 Development Agenda through disaggregated indicators and targets at all levels.

g) Disaggregated data needs to be collected, monitored, and evaluated.

h) A monitoring report of 36 countries identified lack of sustained political will and insufficient budgets as the main challenges in achieving gender equity in health.

i) Intercultural health initiatives are often fragile within larger development plans, with limited statistical information and major gaps that undermine true participation in the design of interventions that are responsive to the specific needs of ethnic/racial groups.

SO7 Lessons Learned

a) Many solutions to health problems fall outside of the health sector. Therefore, it is essential to involve the legislative and judiciary branches through human rights law initiatives and capacity-building as urged by Resolution CD50.R8 of the PAHO 50th Directing Council, Health and Human Rights.

b) Development of a critical mass of advocates in the public health workforce for using the most current methods, techniques, and instruments to measure, analyze, and monitor health inequalities, as well as to assess potential impact attributable to political action taken to address the social determinants of health, can only be achieved and strengthened by sustaining ongoing Region-wide efforts and investments in the public health workforce and in interinstitutional collaboration.

c) Sound policies across the economic, environmental, and social dimensions contribute directly and indirectly to improved health.

d) Policy coordination among sectors like education, environment, employment, or transportation is a must in order to address the social determinants of health and achieve equity.

e) Achieving health equity will require not only the acknowledgement that health is determined by a variety of factors but also the commitment of government, private, academic, and civil society resources.

f) While there is evidence for the effectiveness of acting on social determinants to reduce health inequities, more research and knowledge are needed to better inform policy-makers of what works best in their particular context.

g) The social determinants approach cannot be a "program" that is rolled out. Instead, it requires systematic implementation and learning from experience in each context.

h) When corporate policies exist, organizational changes respect the institution more readily and civil society plays an important role in advocacy for accountability.

i) The unaccompanied or rapidly changing presence of technical cooperation on intercultural health has a significant impact on progress in the Region.

Progress towards Impact Results

SO7 Indicator 1: Number of countries with national health indicators disaggregated by sex and age, including the Gini coefficient and the Lorenz curve
Baseline: 3 countries in 2007
Target: 6 countries by 2013

All baseline and targeted countries have made important strides in generating evidence on the magnitude and trends of social inequalities in health outcomes, informing the pro-equity public health policies that are adopted. Six countries in the Region met this goal with national health indicators disaggregated by sex and socioeconomic status, including the Gini coefficient, Lorenz curves, concentration curves, and equity-gap measures.

SO7 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

A number of the countries in the Region have made strides in developing public policies for the non-health sector, including Brazil, Canada, Chile, and Costa Rica. Costa Rica has had a long-standing commitment to social development and to universal access to core social programs in education and health. This commitment has been demonstrated by Costa Rica's level of public spending on social sectors. Brazil's most famous and effective Conditional Cash Transfers program (Bolsa Família) aims at eliminating both short- and long-term poverty through immediate cash transfers and long-term investment in the country's human development. Evidence suggests that the Bolsa Família program has played a significant role in reducing under-5 mortality rates from malnutrition and diarrhea. Moreover, educational equality in Brazil has been on the rise over the past decade as a result of increased public spending on education, along with greater enrollment numbers. The reduction of inequality in education, along with the expansion of enrollment in schools, has been a direct result of these social policies. Moreover, Chile's strong economic growth, combined with robust social spending, has contributed to some of the lowest levels of inequality, inequity, and poverty in Latin America.

SO7 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

A total of 20 countries in the Region have developed initiatives that stress the need to strengthen local coordination around joint health strategies to ensure that public health measures reach the entire population. Through the Faces, Voices and Places Initiative, national and local agencies collaborated on an intersectoral plan that stressed active local participation. PAHO/WHO provided technical cooperation for programs in maternal and child health, malnutrition, and neglected infectious diseases, as well as for initiatives to improve water quality and strengthen food security.

Assessment of the Region-wide Expected Results

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

RER Assessment Summary (1 out of 1 RER indicator target achieved)

77. Countries in the Region have made concrete progress in reducing health inequities. Different strategies have been adopted to promote the SDH approach, as seen in Brazil, where a National Commission on SDH

was established, and in Argentina and Chile, where structures were created to promote this approach in the Ministries of Health or at high levels of the national government. The overarching purpose of these strategies has been to further the SDH agenda within their respective countries through action at the local and national level. Similarly, in South America, the Council of Ministers of Health of the Union of South American Nations (UNASUR) identified SDH as one of the five priorities in the Organization's 2010-2015 Plan of Action. MERCOSUR, for its part, created an Intergovernmental Commission on Health Promotion and Social Determinants of Health, and most recently, in the development of PAHO's Strategic Plan 2014-2019, the Region's Member States ensured that SDH is an integral part of the Organization's six-year plan. Other programs and policies that address one or more key social determinants of health have similarly been implemented in the Region.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.1.1	Number of countries that have implemented a national strategy for addressing key policy recommendations of the Commission on the Social Determinants of Health	0	12	Yes
Comments: 13 countries and territories achieved this indicator: ARG, BLZ, BRA, CHI, COL, COR, CUB, ECU, ELS, FEP, GUT, PAR, and PER. Different strategies have been adopted to promote the SDH approach, as seen in BRA, where a National Commission on the Social Determinants of Health was established, and in ARG and CHI, where structures were created to promote this approach in the Ministries of Health or at high levels of the national government. The overarching purpose of these strategies has been to further the Social Determinants of Health agenda within their respective countries through action at the local and national level.				

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	Fully Achieved

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

78. Member States took a number of steps to strengthen intersectoral collaboration at national and local levels in order to address the social and economic determinants of health in efforts to encourage poverty reduction and sustainable development. PAHO played an instrumental role in preparations for the Global Conference on Health Promotion, which had Health in All Policies (HiAP) as its central theme. The Region presented a total of 26 case studies on HiAP, highlighting the connection between policy development, implementation, and oversight. All the HiAP studies demonstrated the benefit of public participation and intersectoral action and served as examples for other countries wishing to implement an HiAP approach. The special issue of the *Pan American Journal of Public Health* on the social determinants of health, published in December 2013, served as a platform for enhancing dialogue and sharing best practices on SDH throughout the Region. The HiAP strategy proved to be an effective tool for countries to sustain South-South cooperation and encourage concrete action on the social determinants of health among governments and policy-makers. PAHO's Faces Voices and Places Initiative was rolled out in 18 countries, where networks of municipalities continue to work with their most vulnerable communities. PAHO also supported national and local governments in their efforts to move forward in achieving the MDGs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.2.1	Number of published country experiences on tackling social determinants for health equity	6	12	Yes

Comments:
16 countries achieved this indicator: ARG, BOL, BRA, CHI, COL, COR, ECU, FEP, GUT, MEX, NIC, PAN, PER, SUR, TRT, and URU.

During the Global Conference on Health Promotion, where the central theme was Health in All Policies, PAHO presented a summary of the experiences of the Americas, a collection of 25 case studies from 15 countries in the Americas and one case study from Spain. These studies focused on specific government programs that incorporated some of the core principles of HiAP, highlighting mechanisms to address the social and economic determinants of health through intersectoral action. Moreover, a special issue of the *Pan American Journal of Public Health* featured the topic of social determinants of health. This publication was largely a product of the countries' overwhelming interest in more fully grasping the concept of social determinants and making SDH a priority on national health agendas.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.2.2	Number of countries implementing at least one systematized intervention for the most vulnerable communities, as defined by the PASB MDG Cross-Organizational Team	0	12	Yes

Comments:
16 countries achieved this indicator: ARG, BLZ, BOL, CHI, COL, COR, DOR, ECU, ELS, GUT, HON, FEP, MEX, PAN, PAR. and PER.

The PAHO Cross-Organizational Team on MDGs allowed collaborative work to be done between different technical areas and teams, specifically emphasizing the need to work with Member States in responding to the social determinants of health and "health for all" towards achievement of the MDGs.

ARG, COL and PAR carried out activities at the local level to address the needs of indigenous and Afro-descendant populations. MEX completed work on a healthy housing training center in Chiapas. ARG, COR, DOR, and ECU implemented healthy municipalities projects. BOL and HON created the National Healthy Housing Network.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.2.3	Number of countries that have implemented the Faces, Voices, and Places initiative	6	15	Yes

Comments:
18 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, ECU, ELS, GUT, HON, JAM, NIC, PAN, PAR, PER, and URU.

Expansion of the FVP initiative included the development of networks of municipalities to exchange information and promote cross-collaboration. BRA developed a project on good practices associated with Afro-Brazilian religion. CUB and ECU applied FVP in projects on child and mother health. PAR developed a FVP focus in work with indigenous populations. All these activities received direct technical support from PAHO, as well as national and local governments, in their efforts to advance toward achievement of the MDGs.

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)	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

79. A considerable improvement in the development of axiomatic, methodological, and instrumental approaches for generating and analyzing data to monitor the socioeconomic inequalities in health outcomes was achieved in the Member States. Particular emphasis was placed on the need to make subnationally disaggregated data available by geographic, demographic, socioeconomic, and health dimensions, in synergy with technical cooperation activities aimed at strengthening national capacity for health situation analysis (RER 11.3) within the SDH framework.

80. Considerable additional efforts are required in order to institutionalize the ongoing collection of disaggregated data that are internally consistent, as well as microdata from surveys and the periodic assessment of action on the social determinants of health through benchmarking and monitoring of socioeconomic inequalities in health. A critical mass of advocates in the public health workforce for using the most current methods, techniques, and instruments to measure, analyze, and monitor health inequalities, as well as to assess potential impact attributable to the political action taken to address the social determinants of health, can only be achieved and strengthened by sustaining ongoing Region-wide efforts and investments in the public health workforce and in interinstitutional collaboration.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.3.1	Number of countries that have published reports incorporating disaggregated health data at the subnational level to analyze and evaluate health equity	2	9	Yes
Comments: 12 countries achieved this indicator: BOL, BRA, CHI, COL, COR, ECU, ELS, GUT, NIC, PAN, PER, and VEN. These countries made significant efforts in generating evidence at the subnational level on the magnitude and trends of social inequalities in health outcomes. At least 9 countries circulated summary reports on social inequalities in health following an exploratory data analysis technical workshop carried out with the corresponding Epidemiology Unit teams. In BRA, for instance, these results, presented at an important scientific gathering (Expo-Epi) showed the positive impact of income redistributive measures on the reduction of inequalities in infant and child mortality across states.				

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

RER Assessment Summary (1 out of 1 RER indicator target achieved)

81. Member States, with the support of the PASB, approved a Directing Council resolution on barriers to health for Lesbian, Gay, Bisexual and Trans (LGBT) Persons, based on human rights norms and standards and expansion of gender equity to include gender identity, gender expression, and sexual orientation. In addition, the PASB collaborated with the Inter-American Commission on Human Rights and the government of Costa Rica to reform the national law on in vitro insemination so that it will be consistent with international human rights norms and standards. PAHO collaborated with the United Nations Special Rapporteur during his visit to Peru on the subjects of reproductive rights, the right to health in the context of universal health coverage, and other areas of public health law, including gender identity, access to medicines, and protection of persons with disability.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	18	Yes
Comments: 18 countries/territories achieved this indicator: BAH, BAR, BOL, COR, DOR, GUY, HAI, HON, JAM, MEX, NIC, NCA, PAR, SAL, SAV, SCN, TRT, and VEN. Worth noting: JAM incorporated human rights norms into a draft national mental health law, as did the Cayman Islands; BAH completed the reform of its national tobacco law based on human rights and the FCTC; VEN included similar criteria in its law on HIV; and COR incorporated human rights norms/standards into its national law on in vitro insemination through a process of technical collaboration between PAHO and the Inter-American Commission on Human Rights.			
RER 7.5 Gender analysis and responsive actions incorporated into PAHO/WHO normative work and technical cooperation provided to Member States for formulation of gender-sensitive policies and programs				Fully Achieved

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

82. The PASB made important advances in mainstreaming gender perspectives in health. The strategy to work closely with the ministers of health, women's machineries, and civil society within the countries, combined with the subregional integration processes and the internal work of the PASB, showed well-documented gains in a midpoint monitoring report developed in collaboration with the countries, which was noted by the Pan American Sanitary Conference (Document CSP28/INF/3 [2012]). Progress, however, is uneven and countries agree that there is a need for stronger budgetary and sustainable efforts within the Ministries of Health to consolidate efforts beyond the MDGs. Gender equality and equity are essential pillars for health and development at the global, regional, and national levels. The PASB has led the process to ensure that a cross-cutting approach to addressing these issues is at the core of the new PAHO Strategic Plan 2014-2019. The PASB also supported scaling up capacity-building efforts with countries, fully integrated into the virtual campus with online self - tutored and tutored short courses on gender and health within a framework of diversity and human rights. The future must embrace evolving gender identity needs and expressions in order to truly promote and achieve gender equity in health (resolution CD52.R6 [2013] on LGBT).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.5.1	Number of countries that are implementing plans for advancing gender in the health sector	0	18	Yes
Comments: 33 countries/territories achieved this indicator: ABM, ANI, ARG, BAR, BRA, BLZ, BOL, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SUR, TRT, URU, and VEN. The countries have made varied degrees of progress in mainstreaming gender perspectives in health (assessed in a monitoring report of 36 countries presented to the Directing Council), as reflected in training courses and curricula, gender policies in health, new legislation, documents that report gender statistics, budget, national commissions to promote gender monitoring, gender observatories, gender			

mainstreaming best practices, etc. More information is available at the following link: Monitoring PAHO's Gender Equality Plan of Action: Interim Report 2009-2011.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	8	28	Yes

Comments:
30 documents were generated.

Examples of these regional, subregional, and national guidance documents include educational materials on gender and health, statistical brochures, gender and health profiles, experiences with best practices in gender mainstreaming in health, fact sheets on gender and health topics, and specific studies on gender and health (e.g., diabetes management in TRT and physical activity among school-aged girls in NIC).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.5.3	Number of PASB entities that include gender perspectives in their situation analysis, plans, or monitoring mechanisms	3	20	Yes

Comments:
21 entities included gender perspectives in their situation analysis, plans, or monitoring mechanisms.

Technical collaboration with regional entities has been established and monitoring has been conducted. Ongoing cooperation exists. This collaboration is with the five technical areas and the many entities within them, including entities with enabling functions (Human Resources Development, Planning and Budgeting, Knowledge Management and Communication). This achievement is a measurable way to include gender into the normative work of PAHO (mainstreaming) with the Member States. It implies that the entities' Biennial Work Plans (BWPs) include gender analysis their situation analyses and that specific products and services have been designed to address gender mainstreaming activities (data disaggregation, training, gender and health profiles, etc.). Thirty-three country entities also are a part of this effort.

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	Fully Achieved

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

83. Countries have made tremendous strides in advancing the agenda to protect and promote the health and human rights of indigenous peoples, Afro-descendants, and other ethnic/racial groups. During the period, intercultural health became a stronger agenda in the Region, with the involvement of Ministries, interagency groups, civil society, and leaders of ethnic/racial groups. Within the PASB there is need to further unify the framework for technical cooperation on all ethnic/racial groups. A special paper with guidance on intercultural health will be consolidated in 2014. An ongoing area of work for countries and the PASB is the generation, analysis, and use of health-related data with appropriate disaggregation by ethnicity. Finally, all work in this area must strengthen the participation of ethnic/racial groups and leaders.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.6.1	Number of countries that implement policies, plans, or programs to improve the health of indigenous peoples	3/21	19/21	Yes

Comments:
20 countries/territories achieved this indicator. ARG, BRA, BLZ, BOL, CHI, COL, CUB, DOM, ECU, ELS, FEP, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, and VEN.

During 2008-2013, country efforts to integrate indigenous health into national programming were focused in many instances on specific health projects involving indigenous peoples. These efforts have opened the way for several national responses, including the creation of offices, designation of technical staff, and the development of health policies and plans. Within the PASB, renewed commitment to the 2006 resolution (CD47.R18) included a structural change to place technical cooperation in the Office of Gender and Ethnicity, with greater emphasis on policy development.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.6.2	Number of countries that include ethnic variables within their health information systems	3	15	Yes

Comments:
18 countries achieved this indicator: 10 countries (ARG, BOL, ECU, GUT, GUY, MEX, PAR, PAN, PER, and VEN) have fully integrated ethnic variables into their health information systems, and 8 (BLZ, BRA, CAN, CHI, COR, COL, HON, and USA) have accomplished efforts towards achieving this indicator.

Very few countries have had national responses to include the ethnicity variable in health information systems. However, many countries generate ad hoc reports on specific health conditions disaggregated by ethnic/racial groups.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
7.6.3	Number of countries that implement policies, plans, or programs to improve the health of specific ethnic/racial groups	10	16	Yes

Comments:
16 countries achieved this indicator: ARG, BOL, BRA, CAN, COL, CHI, CUB, ECU, ELS, GUT, GUY, MEX, NIC, PAN, PER, and USA.

Specific attention to ethnic/racial health programming has benefited from the framework of the World Summit of Afro-descendants, held in Honduras in 2011. Whereas the technical cooperation for indigenous peoples places strong emphasis on intercultural health models, this is not an identified priority for Afro-descendants. There is, however, a clear agenda for inclusive policies that respect cultural heritage and identity and the elimination of racial discrimination.

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					Fully Achieved[17] (100% of indicator targets achieved)	
RER Status[18]	8.1	8.2	8.3	8.4	8.5	8.6

SO8 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
75.2	37.2	24.0	61.3	91%	81%

SO8 Programmatic Assessment

84. SO8 includes responses to several of the PAHO mandates, multiple strategies, action plans, and projects aimed at promoting a healthier environment through intensification of primary prevention and programs to address the root causes of environmental threats to health and strengthen and improve sustainable development. During the period, the PASB, in close collaboration with WHO and other United Nations agencies, including ECLAC, ILO, UNDP, and UNEP, consistently promoted regional advocacy, actions and joint efforts, and support for countries to lead intersectoral efforts to address the regional expected results in public health and the environment. This collaboration is key, since SO8 relies on actions taken by other sectors, including the environment, agriculture, water, energy, transportation, urban planning, the private sector, and civil society.

85. The PASB supported countries in the implementation of guidelines, such as those for Water Safety Plans and the WHO Guidelines for Drinking Water Quality, contributing to the attainment of MDG-7 and the elimination of water-borne diseases. It also contributed to development of the new WHO Air Quality Guidelines and established the bases for their implementation in the Region. The PASB, including the Collaborating Centers, focused on supporting countries to promote actions in specific settings and vulnerable populations, spearheading initiatives such as workers' health protection, children's environmental health, consumers' health, and child work elimination, inter alia, aimed at optimizing the use of resources through integrated actions by the health sector.

86. Other important results were aimed at strengthening occupational and environmental health policy-making. Interventions were achieved on the area of workers' health, with organization of the Interagency Group on Child Labor in the Region in collaboration with the International Labor Organization; inclusion of a plan of action on workers' health and well-being on the agenda of the Inter-American Conference of Ministers of Labor, sponsored by the Organization of American States; implementation of initiatives to protect the health of health workers in 19 countries; and development of a road map to prevent occupational cancers in five countries.

87. To address the need of the health sector leadership to influence other public policies, particularly in urban settings, the 51st Directing Council approved the Strategy and Plan of Action on Urban Health (CD51.R4), which calls for assessing health impact and harnessing non-health sector actions to improve health. The Organization promoted implementation of the Plan through regional forums on urban health.

[17] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[18] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

88. Evaluation of progress in the Region under Agenda 21, promoted by PAHO, emphasized that the health sector is positioned in a leadership role to make a substantial contribution towards achieving The Future We Want, as enshrined in the Declaration of the United Nations Conference on Sustainable Development (Rio+20).

89. To implement the Strategy and Plan of Action on Climate Change, approved by the Member States at the PAHO 51st Directing Council (Resolution CD51.R15), a global vulnerability guide was developed, which will be instrumental for the countries as they take stock of their situation and prepare to implement the measures called for in the Plan of Action.

90. The Organization worked closely with WHO/HQ and WHO/Regional Office for Africa on developing a Biodiversity and Health Framework similar to the regional scope of collaboration established for the Secretariat of the United Nations Convention on Biological Diversity.

91. In response to the United Nations appeal in the area of human security, PAHO, in collaboration with the United Nations Development Program, prepared a concept paper that was presented to the Directing Council (Document CD50/17 and Resolution CD50.R16). Also, in collaboration with the Government of Japan, it developed a framework for action to address populations under highly vulnerable social and environmental conditions.

92. PAHO led by the governments of Colombia and Uruguay, joined the global alliance and the regional effort to include a specific public health objective aimed at increasing chemical safety in the Region, for the first time, in an international chemical convention—namely, the Minamata Convention on Mercury.

SO8 Main Achievements

a) Attainment of the MDG 7 target on access to improved drinking water services (94% in 2012).

b) Approval and implementation of a Strategy and Plan of Action on Climate Change (51st Directing Council).

c) Inclusion of health in the final declaration of the United Nations Conference on Sustainable Development (Rio+20), with 17 countries participating in a regional evaluation of progress made by the countries under Agenda 21 towards Rio+20.

d) Inclusion of a specific article on health in the recently approved United Nations Minamata Convention on Mercury to strengthen health sector participation in implementation of the convention, in collaboration with the United Nations Environment Program (UNEP).

e) Adoption of a strategy to strengthen health within the Strategic Approach to International Chemicals Management.

f) Establishment of the Interagency Group on Child Labor, in collaboration with the International Labor Organization and nine other agencies operating in the Americas, to eliminate child domestic work in the Region.

g) Implementation of Water Safety Plans and WHO Guidelines for Drinking Water Quality in 25 countries, including participation in the development and implementation of WHO surveys on water and sanitation as part of the Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS), in 17 countries.

h) Completion of a Region-wide exercise to review and update the technical cooperation framework on water and sanitation in the Region, resulting in a series of publications on new paradigms for the Americas, initiatives to address human rights in the area of water and sanitation, and measures to address water and sanitation in disasters and emergencies.

i) Implementation of the Children's Environmental Health Initiative in the Region by building up knowledge on the situation and on the challenges identified by the Atlas of Children's Health and the Environment in the Americas.

j) Development and implementation of a virtual training tutorial on the public health assessment of hazardous waste sites in Brazil, Mexico, Paraguay, and Central American countries to strengthen the capacity of Member States in public health and the environment (available in Portuguese and Spanish).

SO8 Main Challenges

a) Mobilization of financial and human resources to implement the convention clause on the use of mercury in the health sector.

b) Formulation of an adequate technical cooperation framework on migration and health, incorporating the concepts of universal health coverage and health equity.

c) Insufficient availability of tools and institutional capacity for monitoring and analyzing inequalities in exposure to environmental and occupational risks.

d) Limited capacity and resources to enable national health authorities in the Region to implement and strengthen a health strategy on the environment and occupational health, including chemical safety.

e) Lack of national awareness about utilizing and implementing the United Nations concept of human security in health programs that focus on sustainable development.

f) Lack of a model of composite indicators to monitor sustainable development and health based on the PAHO core indicators.

g) Weakness of intersectoral integration at the country level to increase awareness and implement WHO Air Quality Guidelines in order to systematically address air pollution in the Region.

h) Limited participation by the health sector at the national level in formulation of the sustainable development goals to be incorporated in the United Nations Post-2015 Development Agenda and an open working group process.

i) Lack of health sector implementation of initiatives aimed at decreasing the carbon footprint, such as the WHO Greening the Health Sector policy.

j) Limited response of the United States-Mexico Border Health Commission on issues associated with the social and environmental determinants of health.

SO8 Lessons Learned

a) Regional leadership can be very effective contributing to a global process when aligned with WHO, countries, and inter-agency collaboration.

b) The use of virtual tools for webinars, with simultaneous translation, proved to be extremely effective not only as a communication tool but also as a means of delivering technical cooperation. This method is now embodied in PAHO general practice for knowledge-sharing, thus assuring regional outreach and broader communication.

c) Building new alliances outside the "traditional partners" has proven to be a very effective alternative for implementing PAHO policies on other sectors.

d) Mobilization of the Collaborating Centers has proven to be an efficient way to incorporate scientific evidence into the PAHO work plan, as well as to deliver technical cooperation and engage other sectors in implementation of the Strategic Plan.

Progress towards Impact Results

SO8 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 population in 2002
Target: 96% of urban and 77% of rural population by 2013 (per MDGs)

According to data from the WHO report "Progress on Sanitation and Drinking-Water 2013 Update," at the end of 2011 there was 97% coverage in urban areas, 82% in rural areas, and an overall coverage of 97%; therefore the target was achieved.

SO8 Indicator 2: Proportion of urban and rural populations with access to improved sanitation in the Region
Baseline: 84% of urban and 44% of rural population in 2002
Target: 90% of urban and 48% of rural population by 2013 (per MDG)

According to data from the WHO report "Progress Report on Sanitation Drinking-Water 2013 Update," at the end of 2011 there was 94% coverage in urban areas, 62% coverage in rural areas, and an overall coverage of 88%. Therefore, the target was achieved.

SO8 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

National plans have been carried out to implement several important initiatives in workers' health in Argentina, Bahamas, Barbados, Belize, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Honduras, Nicaragua, Panama, Trinidad and Tobago, United States, Uruguay, and Venezuela. Initiatives included protection of health workers, prevention of needle-stick injuries, vaccination against hepatitis B, prevention of occupational diseases (including silicosis, asbestos-related diseases, occupational cancer, musculoskeletal disorders, and work-related mental illness), and measures to address working conditions in high-risk sectors (informal, health services, mining, agriculture). Strengthening the practice of occupational health sciences was carried out with regional and country associations of industrial hygienists, ergonomists, and occupational physicians in an effort to make the burden occupational diseases visible and promote strong activities to prevent them. Therefore, the target was achieved.

SO8 Indicator 4: Number of countries with toxicological information centers
Baseline: 14 countries in 2006 (estimated).
Target: 24 countries by 2013

Subregional initiatives included a Central American proposal for a network of toxicology information centers (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama); strengthening role of toxicology information centers in chemical emergencies (Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Martinique, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Turks and Caicos Islands); and capacity-building through an online review course on acute pesticide poisoning (Argentina, Guatemala, Nicaragua, Panama, and Uruguay). Therefore, the target was achieved.

SO8 Indicator 5: Reduction in the attributable factor of the burden of diarrheal diseases among children/adolescents aged 0–19 years due to environmental causes
Baseline: 94% in 2002 (estimated)
Target: 84% by 2013 (following the WHO Methodology for Assessment of Environmental Burden of Disease, measured by the factors attributable to disability-adjusted life years

Since WHO has not updated its global estimates of the environmental burden of disease, which produced the (baseline) figure of 94% a global average figure for the developing countries, without these estimates

we can only assume there was a reduction of at least 84% as the attributable fraction for the burden of diarrheal diseases based on the following information:

- As noted for SO Indicator 1, the proportion of population with access to improved water went from 95% in urban areas and 69% in rural areas in 2002 to 97% in urban areas and 82% in rural areas in 2011. This figure is higher (better) than the target for 2013.
- As noted for SO Indicator 2, the proportion of the population with access to improved sanitation went from 84% in urban areas and 44% in rural areas in 2002 to 94% in urban areas and 62% in rural areas. Both figures are higher (better) than the 2013 target.
- If it is assumed that most of the environmental fraction of diarrheal disease is related to access to water and sanitation, and that both these latter targets were achieved and surpassed, then it is also safe to assume that the target for the SO8 indicator 5 was achieved or surpassed.
- Deaths from diarrheal disease in children 1 to 59 months of age dropped from 27,600 in 2002 to 9,940 in 2011, for a reduction of 64%. That said, mortality from diarrheal disease accounted for only 7% of all causes of mortality in children aged < 5 years in 2002 and only 4% in 2011. The large fraction attributed to the environment coupled with the sizable reduction in deaths during the period, reinforces the conclusion that the observed reduction is related to environmental changes. The exact fraction will only be known when a future comprehensive assessment of risk factors is done by WHO.

SO8 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

Twenty countries have a legal framework for pesticides, with differences in terms of public health protection. Ten countries have national air quality programs, with the majority of Member States not following the WHO Air Quality Guidelines on annual average exposure to the inhalable fraction of air pollution. Mexico is reviewing its current legislation in this regard. Fifteen countries have included the right to water in their national legislation. Eight countries sharing borders in the Amazon region have received support from PAHO to harmonize, diagnose, and monitor mercury intoxication systems in the Amazon region. A progress report on the PAHO Regional Action Plan on Workers' Health was presented to the Directing Council, including the status of workers' health in the Americas and progress in implementation of the plan in 25 countries.

Assessment of the Region-wide Expected Results

RER 8.1 Evidence-based assessments, norms, and guidance on priority environmental health risks (e.g., air quality, chemical substances, electromagnetic fields (EMFs), radon, drinking water, waste water re-use) disseminated	Fully Achieved

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

93. This RER was achieved as a result of the commitment of Member States and PAHO technical cooperation to tackle priority environmental health risks and implement international environmental and occupational health agreements. Sensitization was strengthened in occupational and environmental health programs in the Region, but there are large differences in capacity to implement national environmental and occupational health strategies, plans of action, and programs. The assessment done to update information on air pollution indicates the need to strengthen the work in this area.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.1.1	Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year	2	7	Yes

Comments:

- Six trainings on public health risk assessment of hazardous waste sites were conducted in BRA, CHI, COL, ECU, GUY, and VEN.
- Public health risks were assessed in GUT.
- A Region-wide risk assessment on lead levels in children in LAC was conducted.
- A Region-wide risk assessment on the use of biomass for cooking and heating was completed.
- Risks associated with pesticide management were assessed.
- Regional information on the environmental burden of diseases in air pollution was updated in the database of the Global Burden of Disease Attributable to Air Pollution.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.1.2	Number of international environmental agreements with implementation is supported by PASB	5	6	Yes

Comments:
The target was achieved, with 6 environmental agreements supported. PAHO supported the following agreements on environmental health at the subregional level: in Central America, the Regional Sanitation Strategy of the Central America and Dominican Republic Forum for Water and Sanitation and the Central America and Dominican Republic Meeting on Health, through SICA; in BRA, the Convention on Biological Diversity; and in ARG, HON, PER, and SUR, the Global Alliance to Eliminate Lead in Paint. The Region of the Americas had the largest number of health representatives (ANI, BLZ, BOL, BRA, CAN, CHI, DOM, ECU, HON, NIC, SAL, SAV, SUR, and URU) at the 3rd SAICM International Conference on Chemicals Management (Nairobi, 2012), which adopted the Strategy for Strengthening the Engagement of the Health Sector in the Implementation of the Strategic Approach to International Chemicals Management.

The MERCOSUR ministers of health declared their commitment to proactive action to strengthen the role of the health sector in chemical safety for the implementation of multilateral environmental conventions.

The Region of the Americas succeeded in including a chapter on health in the Minamata Convention on Mercury, which incorporated contributions by the PASB and Member States to the analysis that supported the proposal.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.1.3	Number of countries implementing WHO norms, standards, or guidelines on occupational or environmental health	13	24	Yes

Comments:
25 countries/territories achieved this indicator: ANI, ARG, BAH, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, TRT, URU, and VEN.

A progress report on fulfillment of the Regional Plan of Action on Workers' Health was presented to the Directing Council, and a report on the status of workers' health in the Americas was presented at the Inter-American Conference of Ministers of Labor. As a result of these interventions, actions to give greater visibility to the subject and to improve the reporting and diagnosis of occupational diseases will

be carried out jointly by the Ministries of Health and Labor in the Region of the Americas.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.1.4	Number of countries implementing WHO guidelines on drinking water towards MDG 7	6	14	Yes

Comments:
25 countries/territories achieved this indicator: ABM, ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUT, GUY, HAI, JAM, MEX, NIC, PAN, PAR, SAV, SUR, TRT, and URU.

25 countries promoted WHO guidelines towards achievement of the MDGs. A methodology for water safety plans and local pilots were implemented in ARG, GRA, MEX, and PAR.

Institutional strengthening and governance of the water and sanitation sector was promoted in BRA, ECU, PAN, and SAV. Water monitoring and surveillance at the local level was improved in BRA. Water quality guidelines were promoted in ABM, ANI, BOL, ELS, and GUY. BLZ completed the revision of its drinking water guidelines. ECU implemented regulations on the management of water quality. HAI promoted new water and sanitation guidelines and surveillance mechanisms, created a group of sanitary officers, and promoted hygiene at health centers. Fourteen countries conducted WHO surveys on water and sanitation (GLAAS).

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)	Fully Achieved

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

94. Technical cooperation to support several initiatives was carried out in various fields: healthy housing, water safety and sanitation, workers' health (with an action plan), community involvement, and vulnerable populations (domestic child work) through the Interagency Group on Child Labor, protection of health workers from needle-stick injuries, prevention of hepatitis B, prevention of occupational and environmental cancers. Initiatives are now in place in 7 countries and will soon be extended to the entire Region. Also, actions were initiated with the Ministries of Health and public health surveillance agencies to create awareness about consumer health.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.2.1	Number of countries implementing primary prevention interventions for reducing environmental risks to health in workplaces, homes, or urban settings	4	10	Yes

Comments:
19 countries/territories achieved this indicator: ABM, ANI, ARG, BLZ, BOL, BRA, CHI, COL, CUB, DOR, ECU, ELS, GUT, HAI, HON, JAM, NIC, PAN, PAR, PER, SAV, TRT, URU, and VEN.

Most of the countries achieved their targets related to sanitary landfills, housing, water, and sanitation in workplaces and health care settings. Actions to create awareness about the impact of hazardous products on consumer health involving Ministry of Health and public health surveillance agencies were initiated through the Consumers' Safety and Health Network of OAS/PAHO.

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	Fully Achieved

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

95. Thirty-two countries in the Region developed or strengthened policies and programs related to occupational and/or environmental health. The support of the Collaborating Centers has been essential to this accomplishment. Although the targets were met, the level of accomplishment varies between countries. The results show there was significant progress and willingness on the part of Member States to progress in the implementation of environmental and occupational policies and programs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.3.1	Number of countries receiving technical and logistic support for developing and implementing policies for strengthening the delivery of occupational and environmental health services and surveillance	10	20	Yes
Comments: 20 countries/territories achieved this indicator: ABM, BAH, BOL, BRA, CHI, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, HAI, HON, MEX, NIC, PAR, PER, and TRT. The Member States received technical support in the following areas: training in the development of plans for workers' health; training in public health risk assessment of hazardous waste sites; training in situation analysis of public health pesticides and chemical safety; public health risk assessment of burning solid waste containing tires in BAR; development of a SAICM project in BAH; the development of national plans on pesticides; and the development of the plan for the elimination of cholera in the Island of Hispaniola.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.3.2	Number of national organizations or collaborating or reference centers implementing PAHO/WHO-led initiatives at the country level to reduce occupational risks	2	6	Yes
Comments: This indicator was fully achieved. The network of PAHO Collaborating Centers (CCs) on occupational health (OH) is Region-wide, with 20 active CCs. Of this number, 15 are designated Centers (2 BRA, 4 CAN, 1 CHI, 1 COR, 1 CUB, 1 GRA, and 5 USA); 5 are postulated institutions currently working with PAHO (1 CHI, 1 COL, 2 MEX, and 1 PER). Three ceased to collaborate: 1 CAN and 2 USA. The activities of the OH Network rendered excellent results for PAHO/WHO action plans. A global CC meeting was held in MEX (2012) and two PAHO CC meetings were held, one in North Carolina, USA (2011) and the other one in Rio de Janeiro, BRA (2013). Contributions and follow-up yielded multiple actions and concrete results: protection of health workers in 20 countries, programs to eradicate silicosis in 5 countries, awareness raised about silent epidemics of regional occupational diseases, intensification of the initiative to prevent occupational cancer, discussions with the informal and mining sectors to address and improve working conditions, among others.				

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	Fully Achieved

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

96. PAHO led and guided intersectoral technical work to mainstream and promote an integrated, corporative and logistic approach towards the resolution of complex problems. The Declaration of the Regional Coalition for Water and Sanitation to Eliminate Cholera in the Island of Hispaniola was signed by 16 agencies from different sectors, including Ministries and departments of public works, the Haiti National Directorate of Potable Water and Sanitation (DINEPA) among them. A policy brief on water and sanitation was prepared to promote this fundamental human right with universities, centers and justice and human rights institutions. This document highlights the need for countries to create laws, norms, and procedures to assure water and sanitation for all. The regional review on the use of pesticides in the health sector has led to new avenues of interaction between the health sector and providers to increase chemical safety. The analysis emerging from GLAAS also helped to identify the reasons behind the disparities in access to water and sanitation between different countries, communities, and income groups.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	2	4	Yes

Comments:
5 initiatives were implemented:

1) The Initiative of the Regional Coalition for Water and Sanitation to Eliminate Cholera in the Island of Hispaniola was very active, moving from cholera control to cholera elimination through essential investments in water, sanitation, and hygiene infrastructure.
2) The Healthy Housing Initiative promoted a regional network involving universities, WHO Collaborating Centers, municipalities, and Ministries of Education. This initiative was strengthened by PAHO through webinars and meetings such as the 9th biennial seminar Health in Housing, held in Rio.
3) The Urban HEART Initiative was implemented in Colombia (Bosa, Barranquilla, and Bogotá) and Brazil (Porto Alegre and Vila Restinga). PAHO supported implementation of a methodology of metrics and governance to identify gaps and opportunities in addressing health inequities.
4) A regional policy brief on water, sanitation, and human rights was prepared for the purpose of making the connections between water for human consumption, basic sanitation, public health, and human rights.
5) A regional review on the safe use of public health pesticides was conducted in the Region and the results were discussed with Member States.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.4.2	Number of PAHO/WHO guidelines and tools produced intersectorally for global environmental health protection	0	4	Yes

Comments:
4 tools and guidelines were produced:

1) WHO guidelines on assessing the need for the reporting and control of public health pesticides was translated into Spanish and used in ECU and GUT.
2) A questionnaire on the status of legislation and management of public health pesticides was developed at the global level and used for risk assessment in 32 countries in the Region (report published).
3) Water Safety Plans and WHO Guidelines on Drinking-Water have been implemented in 25 countries.
4) WHO surveys on water and sanitation (GLAAS) were developed with a view to promoting new policies on water and sanitation.

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 re-emerging environmental health concerns from development, evolving technologies, other global environmental changes, and consumption and production patterns	Fully Achieved

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

97. The most significant achievements included PAHO support for overall health sector leadership in contributing to the United Nations Conference on Sustainable Development (Rio+20). This health sector leadership was exercised based on agreements reached at several preparatory regional meetings and reports that were brought to the attention of the foreign affairs representatives responsible for the Rio+20 Declaration. Also, the health sector made important contributions to the Post-2015 Development Agenda. In particular, the interaction between the environmental sector and the health sector resulted in an enhanced contribution towards greater inclusion of health in the United Nations Minamata Convention on Mercury and the United Nations Convention on Biological Diversity in collaboration with the labor sector, the health sector has been able to implement joint actions through the Inter-Agency Group for the Elimination of Child Labor.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.5.1	Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB	1	4	Yes

Comments:
The target was exceeded, with PASB support, through the following 9 forums:

1) United Nations Conference on Sustainable Development (Rio de Janeiro, 20-22 June 2012).
2) Regional meeting of Directors of WHO Collaborating Centers (Rio de Janeiro, Brazil, November 2013).
3) International Seminar on Climate Change and Health (Mexico City, 4-6 September 2013), with UNEP, to review advances in implementation of the Strategy on Climate Change and Health.
4) Regional Workshop on the Inter-Linkages between Human Health and Biodiversity in the Americas, (Manaus, 4-7 September 2012), with the Secretariat of the Convention on Biodiversity.
5) 4th Latin American and Caribbean regional meeting on the Strategic Approach to International Chemicals Management (SAICM) and related consultations (Mexico City, 19- 22 August 2013).
6) Second Global Forum on Mercury Use in Artisanal and Small-scale Gold Mining (Lima, 3-5 September 2013).
7) Regional Workshop to Introduce Health Impact Assessment into the Peruvian and Chilean National Institutes of Health (2013).
8) III Global Conference on Child Labor (Brasília, 8-10 October 2013).
9) Participation in the18th Inter-American Conference of Ministers of Labor (IACML) of the Organization of American States (Medellín, 11-12 November 2013) to include actions to protect workers' health.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
8.5.2	Number of current PASB five-year reports on environmental health available, including key health drivers and trends and their implications	1	2	Yes

Comments:
Target was exceeded with the following 3 reports:

1) PAHO. The Environment and Human Security, in *Health in the Americas.* Washington, DC: PAHO, 2012.

2) PAHO. Health, Environment and Sustainable Development: Towards the Future We Want. Washington, DC: PAHO, 2013.
3) Progress Report on the Regional Plan on Workers' Health, presented to the 52nd Directing Council of PAHO, 2013 (Document CD52/INF/4).

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	Fully Achieved

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

98. The Strategy and Plan of Action and Resolution on climate change and health approved by the PAHO 51st Directing Council has been gradually implemented in the countries. Progress was reviewed at a regional workshop in Mexico. Several countries are including health information in their national climate change strategies. Since approval of the Strategy, 10 countries have reported under the United Nations Convention on Climate Change and have included health aspects related to climate change impacts and adaptation.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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 by authors/institutions based in Latin America and the Caribbean	N/A	2	Yes

Comments:
The target was fully achieved with the following 3 studies and reports on climate change and health:
- Progress Report on Climate Change and Impacts to Health in Argentina, Brazil, Chile, Paraguay and Uruguay
- Protecting Health from Climate Change: Vulnerability and Adaptation Assessment. Papers co-published with two Collaborating Centers, FIOCRUZ (BRA) and NIPH, Mexican Institute of Health (MEX);
- Analyses of health aspects of climate change reported by 10 countries, presented at the United Nations Convention on Climate Change. Other reports will be published in 2014 related to PAHO-sponsored pilot studies on adaptation to climate change.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	5	Yes

Comments:
15 countries/territories achieved this indicator: ABM, BAR, BOL, BRA, CHI, COL, COR, ECU, ELS, GUY, HON, NIC, PAN, PER, and SAV.

The countries reported their progress in implementing plans to enable the health sector to respond to the health effects of climate change at a regional meeting in Mexico (2013). The findings of this meeting will be used in the preparation of the report to be presented to the Directing Council in 2014.

SO9: To improve nutrition, food safety, and food security throughout the life course in support of public health and sustainable development					Partially Achieved[19] (93% of indicator targets achieved)	
RER Status[20]	9.1	9.2	9.3	9.4	9.5	9.6

SO9 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
63.4	33.9	28.4	62.3	95%	98%

SO9 Programmatic Assessment

99. Over the course of the Strategic Plan 2008-2013, PAHO provided technical cooperation to improve nutrition, food safety, and food security throughout the life course in support of public health and sustainable development. Region-wide expected results were established to create alliances, partnerships, coordination mechanisms; promote leadership at the country, regional, and global levels; and stimulate intersectoral actions. Technical cooperation was provided to build country capacity to assess and respond to all forms of malnutrition and zoonotic and non-zoonotic food-borne diseases (FBDs); promote appropriate infant and young child feeding practices; prevent micronutrient deficiencies; promote healthy dietary practices; improve clinical management of HIV patients; incorporate nutrition interventions in national response plans to emergencies; strengthen nutrition surveillance; and build country capacity in operational research.

100. As in other regions, the chronic malnutrition, wasting, underweight, and anemia have been declining since 1990 in the Americas. On the other hand, obesity among children and adolescents has reached epidemic proportions in the regions, such that many countries face the double burden of malnutrition with a high risk for noncommunicable diseases. Even though the Region has shown important progress, there are important differences between and within countries.

101. The countries have made significant progress in implementing nutrition policies, programs, and interventions, but additional effort is required to address the social determinants of health and reduce health inequities. Program and intervention sustainability depends on the allocation of financial and human resources for implementation and monitoring and evaluation.

SO9 Main Achievements

a) 30 countries have intersectoral policies, legislative and regulatory frameworks, coordination mechanisms, and programs in place to promote and implement comprehensive interventions in the area of food safety, food security, and nutrition, including nutrition and food safety norms and guidelines according to global and regional mandates.

b) 30 countries have implemented the WHO Child Growth Standards.

c) Most countries in the Region have made great progress in implementing programs and interventions to promote breastfeeding, prevent micronutrient deficiencies, and promote healthy diets and lifestyles.

[19] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[20] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

d) For the first time since the introduction of foot-and-mouth disease (FMD) in the Americas in 1870, there have been 33 months without any reported cases. This is an historical achievement for the Pan American Foot-and-Mouth Disease Center (PANAFTOSA/PAHO/WHO) and the countries of the entire hemisphere.

e) The Inter-American Network of Food Analysis Laboratories (INFAL), which has been in operation since 1997, now has 154 food laboratories in 30 countries. The Global Food-borne Disease Network (GFN) includes all clinical reference laboratories of the Region. PulseNet Latin America and the Caribbean was selected to receive the IHRC PulseNet Innovations Award in 2013 "in recognition of innovative use of instructional technology with the potential to significantly enhance the functionality of PulseNet in outbreak investigations."

f) All the LAC countries have national Codex Alimentarius Committees and are actively collaborating with the FAO/WHO Coordinating Committee for Latin America and the Caribbean (CCLAC).

SO9 Main Challenges

a) Issues still to be resolved include ensuring delivery of health systems and services to populations without access, allocation of human and financial resources, staff training, skills development for planning and program management, procurement of materials and supplies needed for use by the services, and adherence to the recommendations.

b) While acute malnutrition is not a major problem in the Region, outbreaks of acute malnutrition are periodically observed in specific population groups.

c) Overweight and obesity are increasing in the Region, Mexico and the United States being the countries with the highest prevalence.

d) Greater efforts are needed to incorporate specific nutritional interventions into the management of HIV patients and into plans for emergency response. In neither of these cases are nutritional interventions perceived as a priority.

e) With regard to food-borne diseases, the challenge is to maintain PAHO excellence in the current context of budget cuts.

f) Work yet to be done includes achievement of FMD-free status without vaccination, introduction of surveillance and emergency response tools, and strengthening of the FMD eradication policy, strategy, and plan in Venezuela.

SO9 Lessons Learned

Over the past six years, combined efforts of the PASB and Member States have been instrumental in fostering discussion leading to improved planning, comparison of policy commitments with implemented action, collection of key data and mapping of action and policy against indicators, and promotion of good practices to improve nutrition, food safety, and food security. As a result, the proportion of children under 5 years of age who are underweight, stunted, or with anemia has significantly decreased. The burden associated with food-borne disease has also notably decreased. However, the proportion of overweight or obese children is stable or, in a number of countries, on the rise. The main challenge going forward is to turn the tide in the epidemic of obesity in children and adolescents.

Progress towards Impact Results

SO9 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 1995-2002)
Target: 4.7% by 2013

In 2010, the proportion of underweight children under 5 years of age in Latin America and the Caribbean was 1.4%. (Source: Black RE, Victora CG, Walker SP, et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet. 2013 Aug 3; 382(9890):427-51)

SO9 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 2010, the proportion of stunted children under 5 years of age in Latin America and the Caribbean was 7.4%. (Source: Ibid.)

SO9 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

In 2011, the proportion of children under 5 with anemia was 24.9 % in LAC. (Source: Ibid.)

SO9 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 period 2000–2003)
Target: 4% or less by 2013

The proportion is stable at 3.8%. (Source: Ibid.)

SO9 Indicator 5: Reduction in the number of food-borne diarrheal disease cases per 100,000 inhabitants in the Region
Baseline: 4,467 in 2006
Target: 4,020 by 2013

According to the numbers above, the 2013 goal implies a 10% decline. PANAFTOSA estimates that during the period 2008-2013 the average decline was 18% compared with the 2006 baseline. This estimate is based on the disease burden studies conducted during the period in the Region (Argentina, Barbados, Cuba, Chile, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, and Trinidad and Tobago) and also in the numbers reported by the Member States participating in the annual meetings of PulseNet Latin America and Caribbean networks and the WHO Global Food-borne Infections Network.

Assessment of Region-wide Expected Results

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

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

102. Although countries have implemented policies and programs, efforts to reduce social inequities and ensure sustainability of interventions are needed. At the regional level, chronic malnutrition shows a decreasing trend, with marked differences internally between the countries. Guatemala is the country with the highest prevalence. Acute malnutrition is not a major problem in the Region, but periodic outbreaks of acute malnutrition are observed in specific population groups. Overweight and obesity are increasing in the Region: Mexico and the United States are the countries with the highest prevalence. PAHO is developing an action plan for the prevention of overweight and obesity in children and adolescents, which will be submitted to the Directing Council in 2014.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.1.1	Number of countries that have coordination mechanisms to promote intersectoral approaches and actions in the area of food safety, food security, and nutrition	18	30	Yes
Comments: 30 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUY, GUT, JAM, HAI, HON, MEX, NIC, PAN, PER, SAL, TRT, USA, and VEN. All the countries have developed policies, legislative and regulatory frameworks, and coordination mechanisms to prevent chronic malnutrition or micronutrient deficiencies or to promote food and nutrition security. More recently, intersectoral actions have also focused on the prevention of overweight and obesity.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.1.2	Number of countries that have implemented nutrition, food-safety, and food security interventions	10	25	Yes
Comments: 30 countries and territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUY, GUT, JAM, HAI, HON, MEX, NIC, PAN, PER, SAL, TRT, USA, and VEN. All the countries have implemented intersectoral programs or interventions, including breastfeeding, complementary feeding, micronutrient supplementation, food fortification, water and sanitation, agricultural policies, and social protection policies, including conditional cash transfers programs. However, they still need to allocate resources to ensure the sustainability of this work and the comprehensive and simultaneous delivery of programs.			

RER 9.2 Member States supported through technical cooperation to increase their capacity to assess and respond to all forms of malnutrition and zoonotic and non-zoonotic food-borne diseases and to promote healthy dietary practices	Fully Achieved

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

103. During the period 2008-2013, countries have developed, adapted, and implemented nutrition norms and guidelines, food safety standards, and healthy dietary practices, pursuant to regional/mandates. A major challenge is to ensure financial and human resources, the availability of sustainable distribution channels, motivated health personnel to deliver the interventions, and public compliance with health recommendations. It is therefore necessary to promote actions to achieve better coverage.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.2.1	Number of countries implementing nutrition and food safety norms and guidelines according to global and regional mandates	15	30	Yes
Comments: 30 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUY, GUT, JAM, HAI, HON, MEX, NIC, PAN, PER, SAL, TRT, USA, and VEN. All the countries have developed and implemented nutrition norms and guidelines, food safety standards, and healthy dietary practices pursuant to regional/global mandates, and a nutritional epidemiological			

profile that addresses breastfeeding, complementary feeding, micronutrient supplementation, and food fortification. However, most of the programs have achieved only low coverage.

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	Fully Achieved

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

104. Countries made progress in achieving the expected result, especially in adopting the WHO Child Growth Standards. Although the countries periodically collect nationally representative data on major forms of malnutrition (stunting, wasting, overweight and obesity, anemia in children under 5, malnutrition in pregnant and nonpregnant women) through demographic and health or nutrition surveys, additional efforts are needed to integrate nutrition information with the analysis of social determinants and timely decision-making. Results of technical and operational research are frequently published by the Ministries of Health, universities, cooperating agencies, and NGOs.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.3.1	Number of countries that have adopted and implemented the WHO Child Growth Standards	0	25	Yes
Comments: 30 countries/territories achieved this indicator: ABM, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PER, SAL, TRT, USA, and VEN. All the countries have adopted and implemented the WHO Child Growth Standards.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.3.2	Number of countries that have nationally representative surveillance data on one major form of malnutrition	12	22	Yes
Comments: 22 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, MEX, NIC, PAN, PER, USA, and VEN. All the countries published nationally representative data on major forms of malnutrition (stunting, wasting, overweight and obesity, anemia in children under 5, malnutrition in pregnant women and nonpregnant women). However, additional efforts are needed to incorporate nutritional indicators into national public health surveillance systems and integrate nutrition information with the analysis of social determinants for timely decision-making.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.3.3	Number of countries that produce evidence-based information in nutrition and food security	11	22	Yes
Comments: 23 countries achieved this indicator: ARG, BAR, BLZ, BRA, CAN, CHI, COR, COL, CUB, DOR, ECU, ELS, GUT, HON, JAM, MEX, NIC, PAN, PER, SUR, TRT, USA, and VEN. All the countries published results of technical and operational research related with nutrition, food security, food safety, poverty reduction, and social development or social protection, usually prepared by Ministries of Health, universities, cooperation agencies, the PAHO Country Offices, or NGOs. However,				

the PAHO nutrition program does not have the resources to encourage and support specific research in this area.

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 life course in stable and emergency situations	Partially Achieved

RER Assessment Summary (4 out of 5 RER indicator targets achieved; 1 partially achieved)

105. Countries have made progress in implementing programs and interventions to improve infant and young child feeding practices, prevent micronutrient deficiencies, promote healthy diets and lifestyles, include nutritional guidelines in management protocols for HIV/AI patients, and incorporate food and nutrition security into their emergency response plans. However, major changes are still needed to increase the prevalence of exclusive breastfeeding until 6 months, reduce the prevalence of anemia, and achieve healthy eating habits. Additional efforts are also needed to incorporate specific nutritional interventions into clinical protocols for the management of the HIV patients and food and nutrition security into emergency response plans.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.4.1	Number of countries that have implemented at least 3 high-priority actions recommended by the Global Strategy for Infant and Young Child Feeding	5	20	Yes
Comments: 20 countries/territories achieved this indicator: ARG, BLZ, BOL, CHI, COL, COR, DOR, ECU, ELS, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SAV, TRT, and VEN. All the countries have implemented at least three high-priority practices under the Global Strategy for Infant and Young Child Feeding. In order to effectively promote exclusive breastfeeding until 6 months, countries need to redouble their efforts to implement and monitor the International Code of Marketing of Breastmilk Substitutes and revitalize implementation of the Baby-Friendly Hospital Initiative.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.4.2	Number of countries that have implemented strategies to prevent and control micronutrient malnutrition	11	25	Yes
Comments: 27 countries/territories achieved this indicator: ABM, ARG, BAH, BLZ, BOL, BRA, CAN, CHI, COL, COR, DOM, DOR, ECU, ELS, GUY, GUT, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, USA, and VEN, All the countries have national norms in place on micronutrient supplementation in children under 5 and pregnant and nonpregnant women of childbearing age. All the countries in the Region have programs for universal salt iodization or the fortification of wheat flour with iron, folic acid, and B vitamins. In addition, some of the countries have programs in place for the fortification of pasta, rice, sugar, or oil. The countries should make efforts to allocate financial and human resources to establish sustainable monitoring and evaluation systems. Efforts to ensure compliance and increase the coverage of micronutrient supplementation interventions are also needed.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	11	25	Yes

Comments:
25 countries/territories achieved this indicator: ANI, ARG, BAH, BOL, BRA, CHI, COL, COR, DOM, DOR, ECU, ELS, FEP, GUT, GUY, HON, JAM, NIC, PAN, PAR, PER, SAL, SUR, URU, and VEN.

All the countries are considering policies to reduce the consumption of sugary foods and drinks, fats, trans-fats, and sodium. They have also updated their food-based dietary guidelines and are promoting physical activity. Implementation of these policies requires an intersectoral approach involving environment, agriculture, trade, education, health, infrastructure and urban planning, legislative and regulatory frameworks, etc.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.4.4	Number of countries that have incorporated nutritional interventions in their comprehensive response programs for HIV/AIDS and other epidemics	11	25	No

Comments:
21 countries achieved this indicator: ANI, ARG, BAH, BAR, BLZ, BRA, CHI, COL, COR, DOR, ELS, GUT, GUY, JAM, NIC, PAN, PER, SCN, SAV, SUR, and TRT.

The countries have incorporated nutrition interventions in the management protocols for HIV/AIDS patients. However, it is necessary to reposition the importance of nutrition in the treatment of patients with HIV. Improvement of interprogramatic and interdisciplinary coordination is also required.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.4.5	Number of countries that have national preparedness and response plans for food and nutrition emergencies	11	25	Yes

Comments:
25 countries achieved this indicator: ANI, BAH, BAR, BRA, BLZ, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GUT, GUY, GRA, HON, JAM, NIC, PAN, PAR, PER, SAV, SCN, and TRT.

The countries have incorporated food issues, food safety, and nutrition and health into their emergency response plans. However, the scope of this indicator should be reviewed, since the Region does not suffer from famines, nor does it have refugee camps, as do some of the other WHO regions. Specified interventions, such as the management of acute malnutrition, should focus on populations at high risk (e.g., the dry corridor in GUT, the Mosquitía region in HON and NIC, the Chocó region in COL, and the Titicaca and Amazon regions in ARG, BRA, BOL (Chaco), ECU, PAR, and PER).

RER 9.5 Zoonotic and non-zoonotic food-borne diseases, and foot-and-mouth disease surveillance, prevention, and control systems strengthened and food hazard monitoring programs established	Fully Achieved

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

106. There have been many achievements by the food safety networks managed by PAHO in collaboration with other national and international partners. The Inter-American Network of Food Analysis Laboratories (INFAL), operating since 1997, now has 154 food laboratories in 30 countries. The Global Food-borne

Disease Network includes all the clinical reference laboratories in the Region. The PulseNet Latin America and the Caribbean network was selected to receive the IHRC PulseNet Innovations Award in 2013 "in recognition of innovative use of instructional technology with the potential to significantly enhance the functionality of PulseNet in outbreak investigations." The challenge is now to maintain PAHO excellence and relevance within the context of budgetary reductions in this area. The recommendation is to increase innovation and resource mobilization. With regard to FMD, for the first time since its introduction in this hemisphere in 1870, there have been 33 months without any reported cases. This is an historical achievement for PANAFTOSA/PAHO/OMS and the countries of the entire hemisphere. The challenges are to maintain this accomplishment and move towards achieving hemisphere-wide FMD-free status without vaccination; to continue supporting the countries, particularly in introducing new surveillance and emergency response tools and mechanisms in the face of increasing population susceptibility to the FMD virus; and to strengthen the national FMD eradication policy, strategy, and plan in VEN.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.5.1	Number of countries that have established or strengthened intersectoral collaboration for the prevention, control and surveillance of food-borne diseases	16	30	Yes
Comments: 30 countries achieved this indicator: ANI, ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, USA, and VEN. All the countries participate actively in the three regional networks involved in the surveillance of FBDs in the sectors of health, agriculture, and the environment (WHO-GFN, PulseNet, and INFAL). Several countries have pilot projects on integrated surveillance of antimicrobial resistance (BRA, COL, COR, ECU, PAR, URU, and VEN.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.5.2	Number of South American countries that have achieved at least 75% of the Hemispheric Foot-and-Mouth Disease Eradication Plan objectives	4/11	11/11	Yes
Comments: 11 countries and territories achieved this indicator: ARG, BOL, BRA, CHI, COL, ECU, GUY, PAR, PER, URU, VEN About 95% of the cattle population is under international certification that it is FMD-free with or without vaccination. The last reported outbreak of FMD was on 2 January 2012. VEN remains as the only South American country that has not yet established an effective control program and eradication.				

RER 9.6 Technical cooperation provided to National Codex Alimentarius Committees and the Codex Commission of Latin America and the Caribbean	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

107. In a joint initiative with FAO, PAHO was engaged in organizing the CCLAC 2009, 2011 and 2013 meetings and provided training in the countries through pre-CCLAC technical seminars. In collaboration with WHO, regional experts were identified to serve on the technical committees and experts from the Region were selected and recruited to participate in the respective meetings. The main achievement is that all the LAC countries now have national Codex Committees and are actively participating in the CCLAC, but the challenge is for them to remain engaged and continue the work of these national committees. Training for participating Member States, developed by the Codex Alimentarius or WHO/FAO, on current

topics such as risk analysis, emergency response to food safety events, and risk-based inspection was important in promoting adherence to Codex standards. Funding for the CCLAC technical seminars is basic to accomplishing the latter task. Furthermore, grants from the Codex Trust Fund to selected Member States to participate in Codex meetings continue to be fundamental in promoting active participation in this food safety standards-setting body.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
9.6.1	Number of countries adopting Codex Alimentarius Meeting resolutions	40	40	Yes
Comments: 40 countries/territories achieved this indicator: 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. The 40 countries and territories have all adopted Codex resolutions that are important to strengthening the food safety system in their countries. Countries participate continuously in the Codex through CCLAC. Mainly efforts were made to maintain and consolidate achievements. 4 countries received training in the Codex tool for managing Salmonella risk in the poultry chain (BLZ, CUB, DOR, and MEX).				

SO10: To improve the organization, management, and delivery of health services			Partially Achieved[21] (86% of indicator targets achieved)
RER Status[22]	10.1	10.2	10.3

SO10 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
109.7	29.3	56.0	85.2	89%	79%

SO10 Programmatic Assessment Summary

108. Member States made important progress in the organization, management, and delivery of health services. Within the framework of PHC-based health systems, important reforms continued to be implemented throughout the Region, with 31 countries and territories (see list under RER indicator 10.1.1) documenting achievements in the strengthening of their health systems. These reforms, which include progress at the systems levels with new legislative frameworks and national plans and at the health service levels, with approaches to integrated health care, also included important commitments toward universal health coverage (UHC) in the last two years of the period. Of equal significance are the results reported on the adoption and implementation of integrated health service delivery network (IHSDN) strategy in the reform and reorganization of health services with the goal of improving quality, efficiency, and equity in the delivery of care. This progress is reflected in the consistent increase in the number of Member States

[21] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[22] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

(17, see list of countries under RER indicator 10.2.2) incorporating the IHSDN strategy. Initiatives to integrate priority programs in order to improve health outcomes in the context of IHSDNs continues to move forward through efforts to integrate programs into a comprehensive model of care that is patient-centered and life course-focused.

109. Improving the management of health care delivery organizations is seen by the Member States as a key element in the overall improvement of health systems, as reflected in the increased attention and demand for technical cooperation in the form of management training and tools. The PAHO Productive Management Methodology for Health Services (PMMHS) continues to be an important technical cooperation program requested by the Member States. Five countries have successfully implemented PMMHS tools for analysis of the essential conditions for providing health services and for costing the services provided and have integrated the PMMHS into the health services management framework. In addition, over 200 health service managers have been trained in the PMMHS.

110. Despite important developments in many countries and territories, quality of care in all its ramifications continues to challenge most health systems in the Region, demanding of the PASB renewed efforts and approaches to assist countries. However, during the period, studies on the prevalence of adverse events in hospitals were conducted in five countries (ARG, COL, COR, MEX and PER), while a pilot study on adverse events in primary care settings was concluded in four countries (BRA, COL, MEX, and PER).

111. Seventeen Member States report improvement in health system governance, as reflected in assessments of essential public health functions (EPHF). In many other countries, however, the transition from assessment to action and specific plans for strengthening public health are still lacking.

SO10 Main Achievements

a) During the period, the Governing Bodies approved resolutions on the following topics: (a) Regional Policy and Strategy for Ensuring Quality of Health Care, including Patient Safety (CSP27.R10) in 2007; and (b) Integrated Health Services Delivery Networks based on Primary Health Care (CD49.R22) in 2009.

b) 23 Member States documented important reforms based on the PHC Strategy. The renewal of PHC in the Americas surpassed the number of countries required to meet the indicator. Improving the performance of national health systems using the PHC Strategy is an ongoing process that will necessarily span more than one strategic plan.

c) The document Integrated Health Service Delivery Networks: Concepts, Policy Options, and a Road Map for implementation in the Americas," was published and disseminated in 2011, a direct follow-up to the approval of Resolution CD49.R22in 2009. This publication has been widely used and consulted throughout the region becoming the main point of reference for building integrated health services.

d) 18 countries and territories implemented initiatives to integrate priority programs into a comprehensive model of care that includes strengthening the first level of care and improving the family and community approach to health care.

e) PMMHS continues to be an important technical cooperation program for improving management efficiency, and demand for it is growing in the Member States. Five countries (COL, DOR, ELS, GUY, HAI, and PAN) began implementing new training programs and tools based on PMMHS, and two virtual courses were conducted with participants from various Member States.

f) The number of countries adopting and implementing policies and plans for IHSDNs based on the PAHO position paper has increased consistently. IHSDNs have become the framework that most Member States are choosing to use in reforming the organization of their health care delivery services.

SO10 Main Challenges

a) Thirty percent of the Region's population cannot obtain access to care for financing reasons, and 21% are dissuaded from seeking because of geographical barriers.

b) In the Region, with its epidemiological profile of rising rates of chronic noncommunicable diseases and progressively aging population, fragmented health services are poorly suited to provide for the current health care needs of the populations. This fragmentation by itself, or combined with other factors, resulted in difficult access to services, services of poor technical quality, irrational and inefficient use of available resources, unnecessary increases in production costs, and poor user satisfaction.

c) The predominant model of care in most countries of the Region tends to be acute and episodic, provided mostly in hospitals, with excessive use of health technologies and specialized physicians. This situation creates an unbalanced investment in hospital-based services in urban areas to the detriment of first-level ambulatory care, with alarming neglect of health services in rural areas and for vulnerable populations.

d) The distribution of health service infrastructures, especially hospitals, is mainly concentrated in large urban centers, which negatively affects access and worsens inequities. Health facilities that are farther removed from cities tend to have a greater lack of inputs and competent personnel. The dearth of adequate infrastructure at the first level of care in terms of number of facilities, geographic distribution, and response capacity generates, among other adverse phenomena, excessive use of emergency services. Fragmentation and hospital-centered care and the commercialization of the health services undermine the capacity of health systems to serve the needs of populations in an equitable manner.

SO10 Lessons Learned

a) The need to reinforce an integrated vision of health systems development and reforms by clarifying the links between PHC-based health systems, integrated health care delivery networks, universal health coverage, and other strategic areas of health systems development (determinants of health, governance, EPHFs, etc.). The individual presentation of these topics leads to the impression of jumping from one thing to another without any coherent strategy and, ultimately, to major confusion. This integrated vision needs to be reinforced with both the Member States and the PASB.

b) The development of a comprehensive, updated, and strategic approach to quality of care that goes beyond the current vertical and instrumental efforts is an urgent task that the Secretariat must undertake. Such a strategic approach must include overall policies for quality of care from a systems point of view that provide coherence and sustenance to the many piecemeal projects and approaches currently in place (Patient Safety, Safe Surgery, Hand-Washing, Safe Hospitals, Infection Control, etc.). This process will demand close inter programmatic and interdepartmental collaboration.

c) An important lesson to be extracted from the experience during the period is the need to clearly define measurable indicators at all levels of the Strategic Plan. The assignment of indicators taken from very specific research or studies and that are not routinely collected by health statistics pose the risk of not being replicable (because of complexity, cost, or difficulty in obtaining data), as seen in SO Indicators 1 and 2.

Progress towards Impact Results

SO10 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

Latin America and the Caribbean is the most urbanized region of the world: 77% of its inhabitants reside in urban areas, and this percentage is expected to continue to rise in the coming years, creating increased challenges for the delivery of health care services in these cities. In general, access to health care services has improved significantly in both the number and proportion of the population utilizing the health services and in their availability and efficacy. This improvement in access to care has contributed to better health outcomes, high immunization rates, and successful disease eradication in the Americas (PAHO, *Health in*

the Americas 2012). That said, for purposes of the present evaluative exercise, it is not possible to determine achievement of the impact indicator with rigor because the necessary information for analysis is not available and the studies conducted in 2004 to determine the baseline have not been updated.

SO10 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

As with the previous indicator, the information required for this analysis is not available. However, it is to note that 13 Member States have reported the implementation of policies and progress in population coverage using integrated health service delivery networks.

Assessment of the Region-wide Expected Results

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	Partially Achieved

RER Assessment Summary (3 out of 4 RER indicator targets achieved; 1 not achieved)

112. The majority of countries have reported progress towards reforms based on the PHC regional policy—namely, the renewal of PHC in the Americas. Many countries have also made progress in the integration of priority health programs (i.e., mental health and NCDs) into a more comprehensive model of care. These reforms include the development and approval of strategic plans for PHC-based systems, pilot implementation thereof, and assessment of health services delivery based on the PHC strategy. Improving the performance of national health systems using the PHC Strategy is an ongoing process; documenting and disseminating country experiences provides Member States with policy guidance in their quest for equitable access to health services of good quality with solidarity.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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 the PAHO/WHO Position Paper	14	23	Yes

Comments:
31 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BRA, CHI, COR, CUB, DOM, ECU, ELS, GRA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, TCA, URU, and VEN.

Countries have documented different levels of reforms based on the PHC regional policy of renewal of PHC in the Americas. 10 countries (BAH, BLZ, ELS, GUY, HAI, HON, MEX, SUR, TCA, and TRT) documented PHC interventions to strengthen their health systems. In addition, COL reported strengthening its health services with a PHC approach in various departments and municipalities. PER is implementing IHSDNs based on a strong PHC approach. Other Member States reported development of plans and policies based on PHC.

Improving the performance of national health systems using the PHC Strategy is an ongoing process; documenting and disseminating country experiences provides the Member States with policy guidance in their quest to improve health results with quality, equity, and solidarity.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	3	14	Yes

Comments:
17 countries achieved this indicator: ARG, BAR, BOL, CHI, COR, COL, DOR, ECU, ELS, HON, GUT, MEX, NIC, PAN, PER, PAR, and URU.

14 countries conducted new evaluation exercises for EPHFs. In addition, NIC developed an EPHF Improvement Plan for the local level. In GRA, reassessment of the EPHFs led to the development of a new Strategic Health Sector Plan. PAN conducted an evaluation of a decade of health policies, including EPHFs, that lead to new approaches to strengthening the public health and governance functions of the Ministry of Health. TRT conducted an evaluation of EPHFs among regional health authorities in the country.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
10.1.3	Number of countries that integrate an intercultural approach in the development of policies and health systems based on PHC	0	8	No

Comments:
5 countries achieved this indicator: BRA, ECU, HON, PAN, and VEN.

Although 5 countries reported actions to integrate ethnic diversity into their PHC initiatives, these efforts are often introductory. Many changes occurred at the Regional level to redirect priorities in models of care for intercultural ethnic/racial groups. The countries' efforts must be commended and supported within the new PAHO Strategic Plan, with emphasis on UHC.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
10.1.4	Number of countries that use the Renewed Primary Health Care strategy in their population-based programs and priority disease control initiatives	0	12	Yes

Comments:
18 countries achieved this indicator: BLZ, BRA, CHI, COR, CUB, DOR, ECU, ELS, GUT, HON, JAM, MEX, PAN, PAR, PER, SUR, URU, and VEN.

Countries implemented initiatives to integrate priority health programs in order to improve health outcomes: strengthen the first level of care; improve the family and community approach to health care; and integrate programs such as EPI, maternal and child health, mental health, and NCDs into a comprehensive model of care.

RER 10.2 Member States supported through technical cooperation to strengthen organizational and managerial practices in health service institutions and networks, to improve performance, and to achieve collaboration and synergy between public and private providers	Fully Achieved

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

113. Twenty countries made significant progress in implementing strategies to strengthen the management of health care services, while 18 countries are now actively designing plans or have begun implementation of integrated health services projects.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
10.2.1	Number of countries that have implemented strategies to strengthen health services management	3	20	Yes
Comments: 20 countries/territories achieved this indicator: BAH, BLZ, BRA, COL, CUB, DOR, ECU, ELS, FDA, GUT, HON, MEX, NEA, NIC, PAR, PER, SUR, TRT, URU, and VEN. Five countries (COL, DOR, ELS, GUY, HAI, and PAN) reported that are implementing training programs and tools based on the PMMHS. ELS, also using PMMHS, made very important advances in the improvement of health care organization and management in five networks of the Ministry of Health and nine centers of the National Rehabilitation Institute. PER also implemented programs for strengthening capacity in health care management at the subnational level.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
10.2.2	Number of countries that have adopted PAHO/WHO policy recommendations to integrate health services networks, including public and nonpublic providers	3	13	Yes
Comments: 18 countries/territories achieved this indicator: ARG, BOL, BRA, CHI, COL, COR, CUB, DOR, ELS, JAM, MEX, PAN, PAR, SUR, TCA, TRT, and URU. The number of countries adopting and implementing policies and plans for IHSDNs based on the PAHO position paper has steadily increased. Some outstanding examples include: CHI, application of the IHSDN technical and conceptual framework in the country's health regions; COR, development of a road map for strengthening its health service networks based on IHSDNs; PAN, incorporation of the IHSDN approach into the development of a new model of care for both public and nonpublic providers; and PAR, development of a proposal for implementation of an IHSDN in the region of Alto Paraná as a joint project with the IDB.				

RER 10.3 Member States supported through technical cooperation to strengthen programs for the improvement of quality of care and patient safety	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

114. At the country level, improvement of quality of care and patient safety continued to be high on the agenda of national and local authorities and the Country Offices. At the regional level, studies on prevalence of adverse events in hospitals were conducted in five countries (ARG, COL, COR, MEX, and PER), and the pilot phase of a study on adverse events in primary care settings was concluded in four countries (BRA, COL, MEX, and PER). In addition, through interprogramatic collaborative work within the PASB, manuals were developed on infection control in health services.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
10.3.1	Number of countries that show progress in programs for the improvement of quality of care, including patient safety	11	24	Yes

Comments:
25 countries/territories achieved this indicator: ABM, ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GUY, HAI, HON, JAM, MEX, NIC, PAR, SAL, SAV, SCN, URU, and VEN.

Some important examples included advances in the development and approval of policy documents and tools (DOR, ELS, MEX, URU, and VEN); new organizational structures dedicated to quality at the level of the Ministry of Health (COL); and advances in quality of care in national programs (CHI, GUY, HAI, NIC, PAR, SAV, SCN) and specific to hospitals (ANI, HON, and NIC).

SO11: To strengthen leadership, governance, and the evidence base of health systems				Partially Achieved[23] (79% of indicator targets achieved)	
RER Status[24]	11.1	11.2	11.3	11.4	11.5

SO11 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
119.2	75.2	33.4	108.7	96%	91%

SO11 Programmatic Assessment Summary

115. All the countries made efforts to strengthen their health systems in order to provide people-centered and comprehensive health services to everyone. Efforts were focused on strengthening national health policies, strategies, and plans and health information systems, analysis, and databases, as well as creating and/or maintaining different platforms to access and exchange health information at all levels. Countries in the Region made progress in improving the coverage and quality of health information systems and developed plans to strengthen weak areas. A notable improvement in vital statistics was observed. Seventeen of 25 countries met the targets for improved birth registration, and 11 reached the target for improved death registration.

SO11 Main Achievements

a) Improvements in strengthening the national health authority were noted. In particular, through the implementation of national plans and the upgrade or enactment of health legislation to move forward in the realization of the right to health and the expansion of access to health care.

b) An improvement in the quality of data on mortality and births was achieved.

c) The Latin American and Caribbean Network was consolidated to strength health information systems (RELACSIS), with recent incorporation of the English-speaking Caribbean countries. National plans were developed to strength health information systems, and the Regional Health Observatory was implemented.

d) There has been sustained progress in regional knowledge-sharing and online discussion of health-relevant issues with the development of open-access platforms.

[23] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[24] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

SO11 Main Challenges

a) Limited institutional capacity to assess and evaluate health system performance, particularly in the area of health policies implementation, and to exercise the stewardship role of the national health authority for adequate implementation of legislation and regulation is one of the main challenges in the Region.

b) Reliability, quality, and systematic production of data remain a challenge at the national and sub-national levels, and some countries still have fragmented information systems**.**

c) There is limited capacity for analysis and the use of evidence for decision-making in health management and health system governance.

d) Implementation of sound policies and resources for research to improve health care delivery is an area that needs to be addressed.

SO11 Lessons Learned

a) There is growing consensus that striving for the global goal of UHC based on the right to health, with particular attention to improvement and strengthening of national health legislation, has contributed to accelerated health system reforms in the countries.

b) Many experiences in health system transformation are ongoing, some of them with important investments and huge expectations in terms of broader coverage and potential health gains. The most successful experiences have been those that established mechanisms for national dialogue with broad social participation and the involvement of all key stakeholders, including civil society.

c) The role of PAHO role as an authoritative source and broker of evidence-based public health information and knowledge should be maintained and strengthened, where necessary, since it is essential to face the overload of health information and the diffusion of social networks.

d) Building alliances with countries and agencies played a key role in the regional process of supporting national health system strengthening. These efforts need to be intensified, since in many countries, especially key countries, the lack of quality of health information jeopardizes any effort to improve health information systems.

Progress towards Impact Results

SO11 Indicator 1: Number of countries with legislation aimed at increasing access to health (nonpersonal services and public health) and health care
Baseline: 5 countries in 2007
Target: 15 by 2013

The indicator was achieved. During the period there was an important effort to update and upgrade health legislation in order to respond to the right to health and reach universal health coverage. The following countries reported changes in legislation aimed at increasing access to health and health care: ARG, BLZ, BOL, BRA, FDA, COL, COR, CUB, DOR, ECU, ELS, FDA, HON, PER, TRT, and URU.

SO11 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 was exceeded. All 35 Member States formulated policies, strategies, and mid- and long-term plans and defined national health objectives with measurable targets. This progress was clearly outlined in the Mid-Term Evaluation of the Health Agenda for the Americas, which reported that by 2011, 30 countries had implemented a national health plan with specific goals and strategies, and of those, 20 had used the Agenda and its various areas of action.

SO11 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

This indicator was achieved. The countries targeted (ARG, BLZ, BOL, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PAN, PAR, PER, and URU) implemented processes to improve the coverage and quality of their health information systems using PAHO/WHO standards and the Health Metrics Network. These evaluations allowed countries to develop a strategic plan, which many of them have been following to adjust the problems detected.

SO11 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

Member States were supported in facilitating the generation and transfer of knowledge in priority areas, including public health and health systems research. A substantial number of countries have had tangible achievements, even if this work is still in progress and a number of milestones need to be completed or enhanced in order to meet the objectives presented by the Member States.

SO11 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

Countries made progress with the Policy on Research for Health (CD49/10). In addition to the Latin American Conferences on Research and Innovation for Health, where basic data were collected, Health Research Web (https://www.healthresearchweb.org/common/country_details.php?id=206) enabled the sharing of information about national health research systems and led to published analyses. There is a paucity of recent information about financial flows. PAHO contributes to WHO efforts to have an observatory monitoring (http://www.who.int/phi/cewg/en/) resources on research for health.

Assessment of the Region-wide Expected Results

RER 11.1 Member States supported through technical cooperation to strengthen the capacity of the national health authority to perform its steering role; to improve policy analysis, formulation, regulation, strategic planning, and implementation of health system changes; and to enhance intersectoral and interinstitutional coordination at the national and local levels	Fully Achieved

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

116. The RER was fully achieved. All indicator targets were met. All countries in the Region have formulated policies or plans or defined national health objectives and 13 countries and territories have updated their legislations and regulatory frameworks.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.1.1	Number of countries that have updated their legislations and regulatory frameworks	5	12	Yes
Comments: 13 countries/territories achieved this indicator: ARG, BLZ, BOL, BRA, COL, CUB, DOR, ECU, ELS, FDA, HON, TRT, and URU.				

This assessment is based on the PAHO regional analysis of the legal framework supporting UHC, the right to health, and equity.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.1.2	Number of countries that have formulated policies, mid-term and long-term plans, or defined national health objectives	9	35	Yes
Comments: 35 countries achieved this indicator: 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, and VEN.				

RER 11.2 Member States supported through technical cooperation for improving health information systems at the regional and national level	Partially Achieved

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

117. The RER was partially achieved. Countries implemented processes to improve the quality and coverage of health information systems, whether assessing their information systems, training health personnel, implementing tools to improve processes, strengthening the diagnosis, and/or reducing underreporting, among other achievements. There were some difficulties with the English Caribbean countries. On a positive note, 15 of the 19 countries in the baseline and four additional countries continued their efforts to maintain and strengthen their national initiatives. They also published brochures and made the brochures available to the public through the Internet and/or databases, with information on indicators, and they promoted health analysis at subnational levels, among other activities.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.2.1	Number of countries that have implemented processes to strengthen the quality and coverage of their health information systems	3	15	Yes
Comments: 15 countries/territories achieved this indicator: ARG, BLZ, BOL, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PAR, PAN, PER, and URU. Countries implemented processes to improve the quality and coverage of health information systems by assessing their information systems, training health personnel, implementing tools to improve processes, strengthening the diagnosis, and/or reducing underreporting, among other measures.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.2.2	Number of countries that have implemented the PAHO Regional Core Health Data	9	27	No
Comments: 19 countries/territories achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, PER, DOR, ECU, ELS, GUT, HON, MEX, NIC, PAN, PAR, PER, and PUR. The Caribbean countries (ANI, DOM, GRA, GUY, SAL, SAV, SCN, and TRT) are pending because they were not able to implement their national initiatives. Four additional countries/territories (HAI, JAM, NEA, and VEN) implemented other activities related to this indicator but did not develop the brochure of basic data.				

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	Partially Achieved

RER Assessment Summary (3 out of 4 RER indicator targets achieved; 1 not achieved)

118. All the countries continued to update their health situation analyses by improving their health information systems and/or publishing periodic updates of their basic health indicators. The generation and use of evidence drawn from the WHO Evidence-informed Policy Network (EVIPNet) and national program guidelines is reflected in network coordination, the definition of standards, training activities, policy briefs, and the production and implementation of guidelines in the Region. Access to the Virtual Campus of Public Health regional portal improved significantly during the biennium, with widely disseminated information. Countries continued to monitor fulfillment of the MDGs using a variety of strategies. Given that they have two years in which to meet the target deadline, they will most likely intensify their efforts to achieve them.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.3.1	Number of countries that update their health situation analysis at least every two years	5	10	Yes
Comments: 42 countries/territories achieved this indicator: 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, NCA, NIC, PAN, PAR, PER, PUR, SCN, SAL, SAV, SUR, TRT, TCA, USA, URU, VEN. In the last biennium, these countries prepared country chapters for Health in the Americas 2012 Edition. During this process, every country updated its health situation analysis.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	0	8	Yes
Comments: 12 countries achieved this indicator: ARG, BOL, BRA, COR, COL, CUB, DOR, ECU, ELS, FEP, PAR, and PER. The generation and use of evidence by EVIPNet teams and national programs is reflected in network coordination, standards definition, training activities, policy briefs, and the production and implementation of guidelines in the Region.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.3.3	Number of countries that have access to essential scientific information and knowledge as measured by access to Virtual Health Libraries (VHL) at national and regional levels	10	25	Yes
Comments: 36 countries achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BRA, BOL, COR, COL, CHI, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, HAI, HON, JAM, MEX, NCA, NEA, NIC, PER, PAR, PAN, PUR, SAL,SAV, SCN TRT, URU, and VEN. The 25 Caribbean countries and territories had access to the VHL Regional Portal and search services and represented 92.6% of all registered visits.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.3.4	Number of countries monitoring the health-related Millennium Development Goals	23	36	No

Comments:
The countries continued to monitor MDGs achievements using different strategies. Given two years to meet the targets, the countries will most likely intensify their efforts to achieve them. Of 33 countries, 12 documented their monitoring of the health-related MDGs.

13/36 countries continued to monitor their MDGs achievements by publishing specific reports, supporting improvements in their national health information systems, and/or developing coordination activities with different national political entities and international agencies (BAH, BLZ, COL, CUB, GUT, GUY, JAM, NEA, PAN, PAR, PER, TRT, and VEN). CAN and USA 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	Fully Achieved

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

119. The RER was fully achieved. Member States were supported in facilitating the generation and transfer of knowledge in priority areas, including public health and health systems research, and information was organized and collected in openly accessible databases, where it prompted analysis and provided an understanding of the structure, policies, and resources in place, leading to actionable information to guide improvements in national health research systems, as documented in reports and publications. A substantial number of countries have reached tangible achievements, and yet this work is still in progress. The countries' appropriation of the research governance process and their systematic use of research governance tools to enable them to systematically integrate evidence from ethical and sound scientific research with the engagement of society is patchy and a work in progress. Fostering the different government sectors' appreciation of the value of ethical and thoughtful research for health will require sustained support until countries can fully realize and benefit from the returns that research brings for social and economic development, as a tool to address the determinants of health, and as a driver of progress in communities.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.4.1	Number of countries that have a national health research system with the characteristics (indicators) defined by PAHO	0	5	Yes

Comments:
12 countries/territories achieved this indicator: BRA, COL, CUB, DOR, ECU, FEP, GUT, GUY, JAM, MEX, PAR, and PER.

Meaningful progress requires assessing aspects of quality, including structure, process, and consistent and sustained results towards the achievement of health and development.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.4.2	Number of countries with national commissions aimed at monitoring compliance with ethical standards in scientific research	12	20	Yes
Comments: 22 countries and territories achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, ECU, ELS, GUT, HON, JAM, MEX, PAN, PAR, PER, SUR, TRT, URU, and VEN. The work towards achieving this indicator has been very difficult, insofar as it conflicts with the agreement between WHO and UNESCO on the support of National Ethics Committees. In order to ensure compliance with ethical standards in research, various other elements of research ethics systems, which are not captured by the indicator, must be strengthened throughout the Region.				

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	Partially Achieved

RER Assessment Summary (3 out of 4 RER indicator targets achieved; 1 not achieved)

120. This RER was partially achieved; one indicator target was not met. Visibility of the PAHO website increased more than 150% in search engines during the biennium 2012-2013, and the access to evidence-based health information and advocacy material was granted to the all the Member States. Also, more than 150 collaboration sites were established. The methodology of Community of Practices (CoP) and new tools for CoP will be reviewed in the biennium 2014-2015. The PAHO regional platform was installed and will be adjusted in order to complete phase II for corporate coordination.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.5.1	Number of hits on the PAHO web page	20 million	40 million	Yes
Comments: The visibility of PAHO Website increased on Google (+192%), Yahoo (+191%), and Bing (+187%).				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	33	33	Yes
Comments: 35 countries achieved this indicator: 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, and VEN. All 35 countries have had access to health information and advocacy material produced by PAHO in the 2012-2013 biennium. The goal to reach 35 countries was achieved.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.5.3	PAHO Regional Information Platform created, integrating all the PASB technical health databases and information from health and development partners	Core data and MAPIS	Platform created and fully operative	No

Comments: The necessary technology platform was installed. Organization for a systematic and articulated flow of information was pending review and adjustment for phase II of corporate coordination.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
11.5.4	Number of Communities of Practice established and in use in the PASB entities	2	20	Yes
Comments: There are 161 collaboration sites. See: http://sites.paho.org/Pages/HealthTopics.aspx				

SO12: To ensure improved access, quality, and use of medical products and technologies			Partially Achieved[25] (89% of indicator targets achieved)
RER Status[26]	12.1	12.2	12.3

SO12 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
59.9	20.2	38.1	58.3	90%	97%

SO12 Programmatic Assessment

121. Member States consider access to medicines and other health technologies a priority area of work in health systems development, core to the principles of the right to the highest attainable standard in health. Countries are prioritizing this area of work through mechanisms of intercountry cooperation, in particular in the regulation and use of health technologies, as well as through subregional mechanisms of integration. The Region has retained leadership in the development of reference frameworks for pharmaceutical and other health technology policy and the development of regulatory systems and processes for the evaluation, incorporation, and use of health technologies in health systems. Nonetheless, important inequities in access persist, and expenditures in health technologies (in particular out-of-pocket expenditures) are increasing rapidly and are a cause for concern. Future work programs in this area will address the issue of equity in access and financing for health technologies.

SO12 Main Achievements

a) The PAHO 50th Directing Council approved Resolution CD50.R9 (2010), Strengthening National Regulatory Authorities for Medicines and Biologicals, in 2010. This decision was based on an evaluation of 17 NRAs, seven of which were designated as PAHO/WHO reference NRAs. In addition, cooperation agreements were signed with three NRAs (the Brazilian National Health Surveillance Agency (ANVISA), the Argentine National Drug, Food, and Medical Technology Administration (ANMAT), and the United States Food and Drug Administration (FDA), as well as an agreement to support the development of regulatory systems in the Caribbean. Under PAHO leadership, the Pan American Network for Drug Regulatory Harmonization (PANDHR) adopted a strategic plan for development of the network after the identification of priority areas of work in the regulation and quality of medicines and health technologies

[25] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[26] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

and the adoption of a strategic plan for regulatory convergence in the Region. In addition, five WHO official medicine quality control laboratories were prequalified during the period.

b) An evaluation of the Regional Initiative and Plan of Action for Transfusion Safety 2006-2010 was conducted by an external evaluation group. The evaluation highlighted that countries have advanced in the voluntary donation of blood, that capacity has been developed in ensuring quality, and that the blood services are being rationalized in service networks within countries. The results were presented to the PAHO 51st Directing Council as a basis for development of the future Regional Plan, to be presented for the consideration by the PAHO 53rd Directing Council in 2014.

c) The Regional Platform on Access and Innovation in Health Technologies was launched in May 2012 as a regional instrument to support implementation of the Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property. There are more than 25 active communities of practice with 1,000 participants collaborating in areas of policy and innovation, regulation, and use of health technologies.

d) The Regional Network for Health Technology Assessment was established and launched in 2012, with cooperation agreements signed with the Brazilian National Health Surveillance Agency (ANVISA), the Canadian Agency for Drugs and Technologies in Health (CADTH), and USAID. The network was established pursuant to Resolution CSP28.R9 of the 28th Pan American Sanitary Conference (2012) on Health Technology Assessment and Incorporation into Health Systems, an innovative policy document that proposes linkages between evidence-based decision-making for assessment of health technologies with decision-making processes in health systems to manage and use health technologies.

e) The number of countries participating in the PAHO Strategic Fund increased to 24, with support being provided to more participating countries on the strengthening of procurement and supply systems. Procurement volumes continued to grow, with renewed interest from Member States in access to medicines for NCDs.

f) The Member States adopted Resolution CSP28.R15, Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards, during the 28th Pan American Sanitary Conference (2012) and countries have prioritized the organization of radiology services to ensure access, quality, and safety.

SO12 Main Challenges

a) 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 (e.g., maternal mortality reduction) will require significant additional support in the aforementioned areas of work, using a health systems-based approach.

b) The need for integration on medicines and health technologies across the PAHO technical areas is of the utmost importance. This need also extends to the Ministries of Health, linking their work in health technology management with the disease program areas and health services, as well as within the national regulatory authorities.

c) Renewed efforts are required to promote access to medicines, universal health coverage, and the rational and appropriate use of medicines in the community, while also addressing out-of-pocket expenditures, in particular for over-the-counter medicines. These issues will be addressed in the implementation of the PAHO Strategic Plan 2014-2019, in particular in implementation of the program of work in Category 4.

SO12 Lessons Learned

a) Progressively expanding access to medicines and other health technologies is key to moving towards universal health coverage (UHC). Effective policies in health technologies, aligned with health, research and innovation, and industrial policy, facilitate the progressive expansion of access to medicines and health technologies within health systems and services.

b) Medicines and health technologies are consuming an ever-increasing proportion of national health budgets. However, the provision of effective and quality medicines can be ensured within health systems through the establishment of processes that assess efficacy, cost-effectiveness, and economic impact of the health technologies in health systems. Nevertheless, additional criteria need to be considered by Member States in health technology incorporation.

c) Strategic alliances have been very effective in strengthening regulatory capacity for medicines and other health technologies Region-wide. Collaborative agreements between regulatory authorities and countries, as well as intercountry cooperation, have resulted in significant improvements in regulatory capacity throughout the Region.

d) Regional initiatives like the PAHO Revolving Fund for Strategic Public Health Supplies and the Regional Platform for Access and Innovation for Health have provided effective platforms for Member States to collaborate collectively on issues of health technology and innovation, access, and procurement of essential public health supplies. Other WHO regions are examining these initiatives with a view to developing similar approaches to improve access to medicines and health technologies.

Progress towards Impact Results

SO12 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

Nineteen countries in the Region have incorporated the principle of the right to the highest attainable standard in health either as part of their constitution or within national health legislation. In addition, more than 30 countries have signed international treaties adopting these same principles. A core component of the expression of this right is access to medicines and other health technologies. Following extensive work over a period of four years, PAHO completed a consultation on pharmaceutical policies that included the principle of the right to health as a means of ensuring access to quality, safe, and efficacious medicines in a manner that would not result in financial hardship for the individual. The policy reference document was reviewed favorably by Member States at a meeting on pharmaceutical policies in Quito in April 2013 and it is currently being published. Countries are adopting pharmaceutical policies using guidance provided within this framework.

SO12 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

Thirteen Member States have strengthened national mechanisms to ensure the quality, safety, and efficacy of health technologies during the period. In 2010, the Member States adopted Directing Council Resolution CD50.R9, Strengthening National Regulatory Authorities for Medicines and Biologicals, and in 2012, Pan American Sanitary Conference Resolution CSP28.R15, Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards. Sixteen countries have initiated processes to assess core regulatory functions for medicines and other health technologies with PAHO cooperation and leadership, and as a consequence, institutional development plans are under way. National Regulatory Authorities are working collaboratively to strengthen regulatory processes and to move towards more convergent regulatory systems.

SO12 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

Twenty-four countries in the Region strengthened their national processes for the procurement and supply management of health technologies. Access to such health technologies constitutes a critical area of work

for countries as they move towards universal health coverage. Essential to the process is planning, programming, procurement, and distribution of quality medical products and health technologies.

SO12 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) pharmaco-surveillance; (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

According to Resolution CD50.R9 adopted by the PAHO Directing Council in 2010, seven national regulatory authorities were considered to be WHO/PAHO Reference National Regulatory Authorities with a high level of functionality. In addition, nine countries were considered to have intermediate functionality, while the remainder had a basic level but were working to link with more established regulatory authorities in national decision-making processes and/or to establish collaborative agreements.

Assessment of the Region-wide Expected Results

RER 12.1 Member States supported through technical cooperation to promote and ensure equitable access to medical products and health technologies and the corresponding technological innovation	Partially Achieved

RER Assessment Summary (4 out of 5 RERs indicator targets achieved; 1 not achieved)

122. Member States have made important advances in improving access to medical products and health technologies as measured by the indicators, in particular in the areas of pharmaceutical policy development and implementation, strengthening of national procurement and supply systems for health technologies, and processes relating to prioritization and incorporation of health technologies in health systems. Despite not achieving the indicator target, countries made important progress in voluntary blood donation as a means to ensure access to safe, quality blood.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.1.1	Number of countries that have implemented policies promoting access to or technological innovation for medical products	17/36	27/36	Yes
Comments: 27 countries achieved this indicator: ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUT, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SUR, TRT, URU, and VEN. In addition, the document on concept, strategies and instruments for pharmaceutical policies in the Americas was disseminated and validated by the LAC countries in 2013, providing a tool for the improvement and/or development of comprehensive health technology policies.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.1.2	Number of countries that have established or strengthened their national systems of procurement, production, or distribution of medical products	15/36	24/36	Yes
Comments: 24 countries achieved this indicator: BAH, BAR, BLZ, BOL, BRA, COL, COR, CUB, DOR, ELS, ECU, GUT, GUY, HAI, HON, JAM, MEX, PAN, PAR, PER, NIC, SAL, SUR, and TRT.				

Countries have strengthened key functions in their procurement and supply system for medical products. A monitoring and evaluation system to ensure availability of antimalarial and antiretroviral drugs has also been established to ensure treatment continuity in the countries.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.1.3	Number of countries with 100% voluntary nonremunerated blood donations	8	17	No

Comments:
10 countries/territories achieved this indicator: ABM, BLZ, CAN, CUB, FDA, NEA, NCA, NIC, SUR, and USA.

Countries have made significant improvement in this indicator vis-à-vis 2008. Even though this indicator constituted an overly ambitious target for the six-year period, voluntary nonremunerated blood donation will constitute an important pillar of the new five-year Blood Safety Strategy to be considered for adoption by the PAHO Directing Council in 2014.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.1.4	Number of countries that have tools to evaluate access to health technologies	5	20	Yes

Comments:
20 countries achieved this indicator: ARG, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, HAI, MEX, NIC, PAN, PER, TRT, URU, and VEN.
Countries are prioritizing the issue of access to health technologies within the universal health coverage agenda. GUT developed a tool to evaluate access to health technologies which was sent to a few institutions for validation. ECU made great progress on the regulation of medical devices and participates actively in the Medical Devices Working Group and in the Health Technology Assessment (HTA) Network of the Americas (RedETSA). DOR was included in the Medical Devices Working Group and developed an important tool for health technology management. ELS approved the Unified List of Medicines and has been included in RedETSA. PAN is an active member of the Medical Devices Working Group and participated in the mapping exercise designed to build knowledge about the situation of medical device regulation, evaluation, and management in the Region The other 15 countries had achieved the target by the end of 2011.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.1.5	Number of countries using the PAHO Strategic Fund of Essential Public Health Supplies	10	18	Yes

Comments:
23 achieved this indicator: ARG, BAH, BAR, BLZ, BOL, BRA CHI, COL, COR, DOR, ELS, GUT, HAI, HON, JAM, NIC, PAN, PAR, PER, TRT, TCA, URU, and VEN.

The above-mentioned countries participate in the PAHO Strategic Fund through signed participation agreements, availing themselves of technical cooperation on the procurement and management of supplies or using the Fund mechanism to procure essential medicines and supplies. In 2013, countries used the Fund to purchase supplies valued at $43.6 million.

RER 12.2 Member States supported through technical cooperation to promote and assure the quality, safety, and efficacy of medical products and health technologies	Fully Achieved

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

123. Member States made notable advances in the strengthening of national regulatory systems and the adoption and implementation of international norms to ensure the quality, safety, and efficacy of health technologies. Pursuant to PAHO resolutions, Member States carried out the assessment of regulatory functions and defined national pathways for strengthening regulatory capacity, including the development and implementation of international collaborative agreements between Member States. In addition, Member States participated actively in the PANDRH, adopting WHO/PAHO norms and standards in key regulatory thematic areas. Member States also participated in International Atomic Energy Agency/PAHO Regional workshops on the adoption of International Basic Safety Standards for Protection against Ionizing Radiation and for the Safety of Radiation Sources.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.2.1	Number of countries evaluated on their regulatory functions for medical products	0	13	Yes

Comments:
14 countries achieved this indicator: BOL, BRA, CHI, COL, CUB, DOR, ECU, ELS, HAI, HON, MEX, PAN, PER, and SUR.

Also, DOR, ECU, ELS, GUT, HAI, HON, PER and SUR have been working on strengthening their local capacities. To date, there are five National Regulatory Authorities (NRAs) that are recognized as regional reference agencies (ARG, BRA, COL, CUB, and MEX). The NRAs in CAN and USA have applied for the assessment procedure to be recognized also as a regional reference agency. Many other countries in the Region are committed to strengthening their national regulatory capacity. In addition, the following countries had their regulatory functions for medical devices evaluated: ARG, CAN, COR, PAR, and URU, and the following countries have received support on establishing national regulatory bodies for radiation safety: BAH, BAR, DOM, GUY, HAI, JAM, SCN, SAL, SAV, and TRT.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.2.2	Number of countries that have implemented international rules, norms, standards, or guidelines on quality, safety, and efficacy of health technologies	4	14	Yes

Comments:
19 countries/territories achieved this indicator: ARG, BAH, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, GUT, GUY, MEX, PAN, PER, SUR, TCA, TRT, and URU.

In addition, subregional initiatives were developed to implement internationally agreed principles for the improvement of national regulations in the Andean Region, Central America, the Caribbean, and the Southern Cone.

Considerable progress was made in this area: national regulations on biological products, pharmaceutical products, and other health technologies, including ionizing radiation, have been developed and in some cases approved and implemented. Also, through Health Canada and other NRAs, several collaborative agreements have helped to promote implementation of international recommendations on medicines and health technologies by Member States. All the countries of the Region participated in the VII PANDRH Conference (Ottawa, 5-7 September 2013) and countries also participated in two regional workshop/meetings on radiation safety (in Costa Rica in 2012 and in Uruguay in 2013) to present international radiation safety standards and initiate the process of developing/reviewing/updating national regulations.

RER 12.3 Member States supported through technical cooperation to promote and ensure the rational and efficacious use of cost-effective medical products and health technologies based on the best evidence available	Fully Achieved

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

124. Member States prioritized processes to evaluate essential medicines and other health technologies, and they committed to regularly updating, disseminating, implementing, and publishing lists of national essential medicines. In addition, Member States actively strengthened national processes for the evaluation and incorporation of health technologies in benefits plans and health services, pursuant to PAHO resolutions. Member States improved the use of medicines and other health technologies, developed national strategies to promote improved use, and assessed their use and trained human resources with PAHO's technical cooperation. At the same time, Member States participated in RedETSA, exchanging information and experiences within the network on the evaluation of health technologies and national mechanisms for decision-making with regard to their use in health systems. Countries in other WHO regions are reviewing this work program as a model for future development.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
12.3.1	Number of countries that have norms to define the incorporation of health technologies	11/36	20/36	Yes
Comments: 20 countries achieved this indicator: ARG, BAH, BOL, BRA, COL, CHI, COR, CUB, DOM, ECU, ELS, GUY, JAM, MEX, NIC, PAN, PER, SUR, TRT, and URU. ELS was included in RedETSA in 2013, demonstrating its commitment to advance towards the establishment of decision-making processes based on HTA; PER is an active member of RedETSA and undertook a national mapping of HTA capacity, which was presented the RedETSA meeting in September 2013; DOM participated in its first activity in the integrated approach on HTA through the workshop "Implementing Essentials Tools for the Decision-making Process towards Universal Health Coverage."				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	19	28	Yes
Comments: 28 countries achieved this indicator: ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SAL, SAV, SUR, TRT, and URU. Many countries have made progress towards regularly updating, disseminating, implementing, and publishing their lists of essential medicines.				

SO13: To ensure an available, competent, responsive, and productive health workforce to improve health outcomes					Partially Achieved[27] (92% of indicator targets achieved)
RER Status[28]	13.1	13.2	13.3	13.4	13.5

SO13 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
63.4	26.0	14.4	40.4	92%	64%

SO13 Programmatic Assessment Summary

125. Member States achieved and sustained significant progress during the period in the development of Human Resources for Health (HRH) plans, policies, and strategies aimed at increasing access to a qualified health workforce, in line with primary health care-based health systems. At the end of 2013, 29 countries and territories had policies for strengthening HRH. The assessment and monitoring of the 20 regional goals for HRH at the country level showed progress with regard to five critical challenges: (1) long-term HRH plans and policies; (2) equitable access to health personnel; (3) management of migration of health workers; (4) improvement of working conditions; and (5) coordination between the health and education sectors. Progress has been unequal between countries. The distribution/retention of health workers vis-à-vis the need and coordination between health and education institutions are the two challenges more resistant to change.

126. The national health authorities in many countries of the Region developed a capacity for strategic management of the health workforce, adopting policies supportive of changes in the health system and the model of care, reaching out to other relevant government sectors, and involving social actors and critical stakeholders. Various initiatives (International Specialty Course on Management of HRH Policies, training offered by New York University's Center for International Research in the Humanities and Social Sciences (CIRHUS), the PAHO virtual course on leadership in HRH policies, others) have contributed to the professionalization of the management of HRH in the Region. The international migration of health workers, previously a concern limited to Caribbean countries, is now fully acknowledged and documented throughout the Region and the subject of specific policies at national and subregional levels. In 2010, the PAHO Directing Council approved Resolution CD50.R7, Strategy for Health Personnel Competency Development in Primary Health Care-based Health Systems, and in 2013 the 52nd Directing Council approved Resolution CD52.R13, Human Resources for Health: Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems. Two regional networks, associated with the HRH Observatory and the Virtual Campus of Public Health, have played an important role by providing dynamic platforms for policy debate and technical cooperation between countries.

SO13 Main Achievements

a) 29 countries and territories of the Region have developed a national HRH plan.

[27] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[28] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

b) 24 countries produced a baseline assessment of the 20 Regional Goals for HRH and 16 monitored progress with a second assessment; some countries are implementing the assessment at the subnational level.

c) Evaluation of HRH priority programs were conducted in 17 countries using a participatory implementation research methodology.

d) An HRH Road Map for the Caribbean, 2012-2017, was developed.

e) Main issues and challenges for the development of HRH for indigenous peoples of the Americas were identified.

f) Professional and institutional capacity for the strategic management of HRH was upgraded in most countries of the Region. More than 200 high-level HRH leaders and managers participated in a virtual course on HRH leadership and the CIRHUS program.

g) HRH plans and commitments to achieve universal health coverage were adopted by 16 countries during the Third Global Forum on Human Resources for Health (Recife, 10-13 November 2013).

h) Nine countries of the Region modernized their legislation on the career path in the public health sector.

i) The Region's five major associations of schools and faculties of health sciences (medicine, nursing, pharmacy, dentistry, and public health) agreed to strengthen their social mission and transform their education of health professionals and gear it towards supporting PHC-based health systems.

j) The Virtual Campus of Public Health was enlisted as a technical cooperation strategy between countries to further develop the public health competencies of in-service health personnel and also to develop a virtual training clinic to support the clinical competencies of PHC teams. At the end of 2013, a total of 16 country nodes and more than 150 public health institutions were part of the decentralized network of the Virtual Campus.

k) Students in the health sciences from 511 academic centers in Latin America benefited from financially accessible instructional materials and basic medical equipment through the PALTEX program.

SO13 Main Challenges

a) The equitable distribution of health workers relative to need and the reform of the education sector to support the implementation of PHC-based health systems remain major challenges, as documented in the second assessment of the 20 Regional Goals for HRH.

b) Institutional capacity for HRH planning and forecasting to address current and future gaps is poorly developed in the Region.

c) The regulatory frameworks governing professional practice are often archaic and limit the optimal use of existing and new professional profiles to respond to expectations of communities and improve accessibility, quality, and acceptability of care.

d) Major disparities persist in the composition of the health workforce, with a deficit of PHC/family physicians, nurse practitioners, community pharmacists, nutritionists, and other categories of health workers.

e) Support systems for PHC teams, such as access to continuing education and telemedicine networks, especially in rural or remote areas and indigenous communities, are limited.

f) The development and regulation of health labor markets, especially at the first level of care, to ensure effective access to quality services, including the provision of competitive working conditions and incentive systems, is still limited in most countries.

SO13 Lessons Learned

a) The 20 Regional Goals for HRH 2007-2015 marked a shift in the approach to HRH from process-centered to achieving change. The methodology developed for their assessment contributed to a

culture of monitoring and evaluation. Its participatory nature mobilized numerous and varied stakeholders under the leadership of the NHAs and promoted the development of a common vision on desired change and how to achieve it.

b) The combination of cooperation strategies aimed at policy development, program implementation, and capacity-building is effective in improving governance and achieving progress towards desired outcomes.

c) The use of decentralized networks articulated by a common regional model and architecture, supported by dynamic Web 2.0 platforms such as the Observatory of Human Resources and the Virtual Campus of Public Health, plays a critical role in facilitating cooperation between countries and the exchange of knowledge and tools as open resources.

Progress towards Impact Results

SO13 Indicator 1: Number of countries where the density of the health workforce (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

The target of 35 countries with a density of health workers equal to or greater than 25:10,000 was overly ambitious and not achieved at the end of the period. Increasing the density of health workers requires scaling up the production and/or inflow, reducing attrition, or both in a way that exceeds population growth. The related financial investments and planning capacity may be prohibitive, particularly for low-income countries and those negatively impacted by the economic crisis of 2008. Given the complexity of scaling up the availability of HRH, the progress achieved at the end of the period is remarkable in that the number of countries with a density equal or greater than 25:10,000 more than doubled during this period, from 12 to 25 in 2013.

Assessment of the Region-wide Expected Results

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 achievement of the Millennium Development Goals (MDGs)	Fully Achieved

RER Assessment Summary (2 out of 2 RER indicators targets achieved)

127. The Member States were strongly committed to the development of HRH plans, policies, and strategies aimed at improving effective access to qualified health workers, in line with PHC-based health systems. Twenty Regional Goals for HRH were adopted by the 27th Pan American Sanitary Conference in 2007. A baseline assessment was taken at the country level in 2009-2010, and a second assessment, in 2013. Countries have established strategic units on HRH with planning capacity, articulated with units in the health services and also reaching out to other sectors (education) and relevant social stakeholders. HRH program design and implementation capacity was assessed at the country level. Subregional entities—Union of South American Countries (UNASUR), Southern Common Market (MERCOSUR), Ministers of Health of the Andean Region (REMSA), Andean Health Organization (ORAS), and Council of Ministers of Central America and Dominican Republic (COMISCA)—have established specialized HRH technical groups and developed subregional HRH agendas. At the end of the period, bottlenecks were analyzed and a new resolution was adopted by the 52nd Directing Council in 2013. Numerous countries participated actively and presented formal commitments on HRH and UHC at the Third Global Forum on HRH in Recife. Various cohorts of HRH leaders were trained in HRH policies and HRH planning on the Virtual Campus of Public Health.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.1.1	Number of countries with national policies for strengthening the health workforce, with active participation of stakeholders and governments	12	28	Yes

Comments:
29 countries/territories achieved this indicator: ABM, ANI, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUT, GUY, HAI, JAM, MEX, NEA, NIC, PAR, PER, PUR, SAL, SUR, TRT, URU, and VEN.

Progress has been sustained throughout the Region, with policies aimed at the health workforce in general, a specific professional group (e.g., nursing), or a specific program (e.g., family health). A Road Map for HRH was developed with countries in the Caribbean. New challenges will emerge in the context of NCDs and UHC.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.1.2	Number of countries with horizontal cooperation processes for the fulfillment of regional goals in human resources in health	2	6	Yes

Comments:
10 countries achieved this indicator: ARG, BRA, CAN, CUB, ECU, GUT, MEX, NIC, PER, and USA.

Countries have developed technical and financial cooperation strategies, bilateral and multilateral agreements, and initiatives to sustain progress in achieving HRH goals and objectives.

RER 13.2 Member States supported through technical cooperation to establish a set of basic indicators and information systems on human resources for health	Partially Achieved

RER Assessment Summary (1 out of 2 RER indicators targets achieved)

128. In parallel with the development of HRH plans, policies, and strategies in the countries of the Region, there was sustained progress in the establishment of HRH information systems and core data. The assessment of the 20 regional goals for HRH provided an impetus to collect and organize HRH information. The Regional Network of National and Subregional Observatories of HRH has been instrumental in promoting information-based HRH policy with the involvement of stakeholders. The Observatory's strategic model was reviewed and renewed with a Web architecture that facilitates the exchange of information, evidence, and experiences between national, subregional, and regional nodes. The target was not achieved with regard to the number of national observatories because of the challenges encountered in the development of a Caribbean Observatory Network.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	10	29	Yes

Comments:
29 countries/territories achieved this indicator: ABM, ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAR, PER, SAL, TRT, URU, and USA.

There has been substantial progress in the Region, as indicated by the increase in the number of countries monitoring situations and trends of the health workforce. USA established a Health Workforce

Center in its Health Resources and Services Administration during the period, collecting and analyzing information on HRH in the context of the Affordable Care Act. Chile has a well-developed HRH information system.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.2.2	Number of countries participating in the Human Resources for Health Observatory network for the production of information and evidence for decision-making	18	36	No

Comments:
29 countries/territories achieved this indicator: ARG, BAR, BLZ, BOL, BRA, CAN, CHI, COL, CUB, DOR, COR, ECU, ELS, FEP, GRA, GUT, HON, JAM, MEX, NIC, NCA, PAR, PER, PUR, SAL, TRT, URU, USA, and VEN.

This target could not be achieved without the participation of most of the Caribbean Countries and Territories, which in turn was dependent on the creation of a Caribbean Observatory of HRH. The institutional and financial requirements for the operation of a Caribbean Observatory were not met, partly because of the impact of the economic crisis in the subregion.

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	Fully Achieved

RER Assessment Summary (2 out of 2 RER indicators targets achieved)

129. "Precarious" work, referring to health workers without any formal contractual arrangement and therefore without any type of social protection, has decreased significantly in the countries of the Region, not only because it was a moral imperative but also to improve the motivation and performance of health workers. Increasing attention was given to ensuring healthy and safe working conditions for health workers. Regional and subregional initiatives were developed to share country experiences and modernize their career paths; studies were carried out on the health and safety aspects of working conditions in hospitals; leaders were trained through the VCPH in the development of decent work policies.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.3.1	Number of countries that have established a career path policy for health workers	4	14	Yes

Comments:
14 countries achieved this indicator: ARG, BOL, BRA, CAN, CHI, COR, DOR, ECU, ELS, GUT, NIC, PAR, PER, and USA.

Countries have dedicated significant resources to the review and modernization of their HRH career path in alignment with changes in the organization of health services, expectations of their population, and the need to improve motivation and retention of their workforce. In some countries, intense negotiations took place with associations of health personnel and parliamentary commissions developed new legal frameworks.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.3.2	Number of countries with human resources management policies and systems to improve the quality of employment in the health sector	4	17	Yes

Comments:
18 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, DOR, ECU, ELS, GUY, NIC, PAN, PAR, PER, URU, and USA.

9 countries reached the regional goal of reducing by half the proportion of health workers without formal contracts and social protection, while others are making significant progress in this direction. 7 countries are implementing health and safety policies for health workers.

RER 13.4 Member States supported through technical cooperation to strengthen education systems and strategies at the national level, with a view to developing and maintaining health workers' competencies centered on primary health care	Fully Achieved

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

130. There has been a growing interest among Member States in promoting better alignment between the production of the health workforce, health system policies, and greater recognition of the need for strategic partnerships with training institutions in the development of HRH plans and strategies. In some countries, this interest took the form of a dialogue between health and education institutions; others have created formal coordination mechanisms; and still others have been relocating or decentralizing medical education to rural or remote areas or within vulnerable communities and are reforming their graduate medical education to ensure the availability of PHC or broad-based specialties. Increasingly, curriculums have been revised with greater orientation towards PHC and the social determinants of health. Higher education remains elitist in a number of countries, and more change is needed. E-learning networks are expanding rapidly in the Region, as exemplified by the development of the Virtual Campus of Public Health and the design of a virtual training clinic. Resolution CD50.R7 of the 50th Directing Council, Strategy for Health Personnel Competency Development in Primary Health Care-based Health Systems, was adopted by the Member States in 2010. A regional framework for essential public health competencies was produced with broad professional and institutional participation in LAC. The Leaders in International Health Program (LIHP) contributed to the development of country capacities in global diplomacy and cooperation between countries. The PALTEX program was transferred to PAHO in 2012, serving a network of more than 500 educational institutions of 19 countries of LA.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.4.1	Number of countries with joint planning mechanisms with training institutions and health services organizations	4	23	Yes

Comments:
23 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, FEP, ELS, GUT, GUY, HON, JAM, MEX, NIC, PER, PAN, SUR, and URU.

Countries have implemented a variety of mechanisms for coordination between health and education. Examples are memorandums of understanding, working agreements, interministerial roundtables, joint forums, and others. The practice is more prevalent with graduate medical education (or medical residencies).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.4.2	Number of countries with policies that reorient health sciences education towards primary health care	4	13	Yes

Comments:
21 countries achieved this indicator: ARG, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, GUT, HAI, MEX, NIC, PAR, PER, SUR, URU, USA, and VEN.

Schools of Health Sciences in these countries, mainly public institutions, are actively engaged in transforming their curricula towards PHC through early exposure to and increased learning within households and communities, greater appreciation of the social determinants of health, and /or greater focus on rural health.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.4.3	Number of countries that have established learning networks to improve the public health competencies of their staff	5	15	Yes

Comments:
16 countries and territories have established an e-learning network in public health: ARG, BOL, BRA, CHI, COL, CAN, COR, CUB, ECU, ELS, MEX, PAR, PAN, PER, PUR, and URU.

The Virtual Campus of Public Health experienced a sustained expansion during the period as a regional collaborative open source platform for the development of public health competencies in the health workforce. It has reached 16 country nodes, or more than 150 public health institutions. A total of 83 tutored courses have been developed and offered at the regional level in PAHO priority policy areas. Some 160 tutored courses have been developed by country nodes, and 36 self-administered courses are now available online. The VCPH virtual library of open educational resources at BIREME has more than 7,000 resources. Approximately 3,500 professionals in the Region have completed one of its courses. Special applications have been designed for tablets and mobile phones. 4 countries are participating in the design of a virtual training clinic, aimed at developing clinical competencies of professionals on PHC teams.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.4.4	Number of countries participating in the PAHO Leaders in International Health Program	0	25	Yes

Comments:
35 countries/territories achieved this indicator: ANI, ARG, BAH, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HAI, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TRT, URU, USA, and VEN.

The LIHP is the most ambitious and the only fully bilingual training program offered by PAHO through VCPH. The interest in the Program has been sustained, with the participation of high-level professionals from public health authorities, offices of international relations, Social Security Institutes, academic institutions, NGOs, coordinators of the Cuban Brigades in priority countries. It supports the countries' capacities in global diplomacy and promotes cooperation between countries on issues of common interest. The remaining challenge is to establish an institutional node of the VCPH in the English-speaking Caribbean.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.4.5	Number of countries with accreditation systems for health sciences education programs	13	20	Yes

Comments: 24 countries/territories achieved this indicator: ABM, ANI, ARG, BAR, BLZ, BRA, CAN, CHI, COL, COR, DOM, ECU, FEP, GRA, JAM, MEX, PAN, PAR, PER, SAL, SAV, SCN, TRT, and USA. These countries established accreditation programs for medical and nursing education, usually implemented under an independent specialized accreditation agency.

RER 13.5 Member States supported with technical cooperation regarding the international migration of health workers	Fully Achieved

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

131. This RER represents a remarkable achievement in the Region, as the issue of migration of health workers was initially confined to the nursing profession in Caribbean countries. PAHO took the lead in 2007, with the adoption of three HRH Regional Goals on the management of HRH migration. Countries in Latin America became interested not only in documenting the flows of health workers across their borders but also in searching for new strategies to retain or even bring back health workers who had migrated to other countries. Intense follow-up was given to adoption of the WHO Global Code of Practice on the International Recruitment of Health Workers, the promotion of "self-sufficiency" policies for receiving countries, and the development of systems for the evaluation of foreign-trained health workers. The Cuban Cooperation has made specific arrangements with many countries in the Region. The health workforce is very mobile between countries, and the competition for PHC professionals is likely to intensify in the future in the context of UHC.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.5.1	Number of countries that analyze and monitor the dynamics of health worker migration	5	20	Yes
Comments: 20 countries achieved this indicator: BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GUY, JAM, NIC, PAR, PER, TRT, URU, USA, and VEN. At the beginning of the period, migration of health workers was a concern for a limited number of countries, both receiving countries (CAN and USA) and source countries (Caribbean-countries). Much progress was achieved in the Region in positioning the issue and documenting migration, thanks to studies carried on at the national level, specifically on nursing or including other health professions, with the support and involvement of subregional entities.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
13.5.2	Number of countries that participate in bilateral or multilateral agreements that address health worker migration	4	16	Yes
Comments: 17 countries achieved this indicator: ARG, BLZ, BRA, BOL, CAN, CHI, COL, CUB, ECU, ELS, JAM, PAR, PER, TRT, URU, USA, and VEN. Much progress has been achieved in the Region in regard to this indicator. The WHO Global Code of Practice on the International Recruitment of Health Workers was adopted at the WHA in 2010; the Ibero-American Network on Migration of Health Professionals was established; and a growing number of countries have bi- or multilateral agreements (with the Cuban Cooperation, Mais Médicos, etc.) to address the migration of health workers.				

SO14: To extend social protection through fair, adequate, and sustainable financing					Fully Achieved[29] (100% of indicator targets achieved)
RER Status[30]	14.1	14.2	14.3	14.4	14.5

SO14 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
35.1	12.9	6.0	18.9	95%	54%

SO14 Programmatic Assessment

132. Member States have achieved significant progress in extending social protection through fair, adequate, and sustainable financing. Social protection schemes like the Social Health Protection System (*Seguro Popular*) in Mexico and the Unified Health System (*Sistema Único da Saúde*, SUS) in Brazil have helped to incorporate hundreds of millions of individuals. Throughout the Region, programs of conditional cash transfers have facilitated access to health services, extending social protection to otherwise excluded populations. Despite this progress, and the reduction in the proportion of total health financing represented by out-of-pocket expenditures from 60% to less than 40%, much remain to be done with respect to fairness and equity. Indeed, the large majority of countries remain with figures above 30%, which is considered too high, exposing individuals and their families to catastrophic expenditures and financial hardship. With regard to adequate sustainable financing, it may be noted that public health expenditures have increased since the 2006 baseline, benefiting from an expanding economic cycle in most countries (except for 2008-2009). However, despite the increase in public health expenditure in real terms, its share of GDP has declined from 4.1% in 2010 to an average of 3.8% in 2011, reflecting a decrease in the social priority accorded to health. Moreover, expenditures on primary health care are not being measured, so it is not possible to say whether public funding for health has been promoting people-centered models of care within Integrated Health Service Delivery Networks, which are the main avenue for making health systems sustainable over time and more responsive to the needs of the population.

SO14 Main Achievements

a) 16 targeted countries have plans available to improve their financial mechanisms.

b) Eight countries produced systematic studies on catastrophic expenses in health, poverty, and inequalities.

c) Eight countries have explicit policies and/or financial mechanisms intended to reduce or eliminate financial risk associated with disease and accidents.

d) MERCOSUR and the Andean countries have conducted in-depth analyses of financial protection in health and catastrophic expenditures.

e) All countries in the Region are reporting financial information either to the PAHO Core Indicators database or to the WHO National Health Accounts database.

f) 17 countries have institutionalized processes to produce information on health expenditures.

[29] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[30] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

g) 12 countries have implemented insurance schemes and national health plans that addresses universal health coverage through explicit health care warranties.

h) 16 countries have improved the level and quality of information related to health exclusion and health coverage.

SO14 Main Challenges

a) Despite plans to improve financial mechanisms, a lot remains to be done, on the one hand, to implement these plans and, on the other, to develop similar plans in the remaining countries.

b) More systematic information is needed in all the countries to better understand the relationship between health, poverty, and inequalities. The most affected countries in this regard do not participate in Equity in Health in Latin America and the Caribbean (EquiLAC) analyses because of lack of data availability.

c) Indicators of health financial protection are not systematically collected. A major remaining challenge is the need to use a common methodology to measure the impact of out-of-pocket expenditures in cases of poverty and catastrophic expenses on health

d) Producing information on financial protection in a systematic manner and with a standard methodology remains a challenge for countries in the Region.

e) Adopting common methodologies to produce health accounts, now that most countries are shifting towards the SHA 2011 health accounts system, is a major challenge.

f) Still about half the countries in the region have yet to implement schemes to address UHC with explicit health care warranties.

g) Countries receiving a significant portion of their health resources from international aid are not able to properly align these contributions with their health priorities

SO14 Lessons Learned

a) Improvements in financial mechanisms are not sufficient to resolve the problems related public expenditures on health, efficiency, and financial protection. Political will to change the model of care is also necessary.

b) Reforms centered on financial aspects are not sufficient to ensure effective progress towards access to health services when needed. A major transformation of the health system is required.

c) Common methodologies are needed to measure progress in financial protection and produce financing information based on health accounts, to inform decision-making and monitor and evaluate interventions.

d) The information produced by the EquiLAC studies on the effect of catastrophic expenses on health, poverty, and inequalities has helped to consolidate a network of 8 countries.

e) Some impact indicators were difficult to measure (Indicator 1, for instance). In future exercises, they need to be more carefully defined in order to ensure appropriate measurement.

Progress towards Impact Results

SO14 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 indicator was fully achieved as an average for the Region. However, it is important to note that: (1) the assessment is based mainly on estimates of SUS coverage in Brazil, the Social Health Protection System in Mexico, and a variety of conditional cash transfer programs that have become common throughout the Region, all of which include some form of health services coverage; and (2) these numbers mask sizable differences between and within countries in terms of coverage and quality of care.

SO14 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 indicator was not achieved.
- Public health expenditures in the Region as a percentage of GDP increased from 3.1% in 2006 to 4.1% in 2010, but had had a slight decrease to 3.8% in 2011.
- These results are still far from the 5% target. Only CAN, CUB, NEA (Aruba and Curaçao), NIC, URU and the USA showed figures above 5% of GDP.
- Information on primary health care expenditure is almost nonexistent for countries in the Region. ELS is an exception: expenditures on primary health care increased from 21.5% to 27.3% of public health expenditure from 2010 to 2012.

SO14 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 indicator has been reached by the eight countries where it has been measured. However, the target of 40% is still very high for other countries, and measurement is still missing in most of the countries. As a consequence, the impact indicator could not be assessed for the Region.

Assessment of the Region-wide Expected results

RER 14.1 Member States supported through technical cooperation to develop institutional capacities to improve the financing of their health systems	Fully Achieved

RER Assessment Summary (1 out of 1 RER indicator target achieved)

133. The RER was fully achieved with the target countries, showing plans to improve financial mechanisms. However, as the situation evolves, along with new possibilities and constraints from the particular economic environments of each country, the plans need to be constantly assessed and revisited, as well as extended to include more people, more services of better quality, and/or a combination of both.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.1.1	Number of countries with institutional development plans to improve the performance of financing mechanisms	7	15	Yes
Comments: 16 countries and territories achieved this indicator: BAR, BAH, BLZ, BRA, CHI, COL, COR, CUR, DOR, ECU, ELS, JAM, MEX, NEA, PAR, and PER.				

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	Fully Achieved

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

134. Achievement of this RER is particularly important because it provides direct information on the background against which UHC will have to be developed in the countries. The work done on 14.2.2 with regard to the effect of catastrophic expenses on health, poverty, and inequalities places PAHO in a leadership position with other partners in this area. Continuous support should be provided in order to maintain the achievements made under 14.2.1 and 14.2.3.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.2.1	Number of completed country studies applying the PAHO evaluation framework to assess household capacity to meet health expenditures	0	7	Yes
Comments: 7 countries achieved this indicator: ARG, BRA, CHI, COL, MEX, ELS, and PER. These countries produced information on household capacity to meet health expenditures.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.2.2	Number of countries with studies on catastrophic expenses on health, poverty, and inequalities	1	6	Yes
Comments: 7 countries achieved this indicator: BRA, CAN, CHI, COL, JAM, MEX, and PER. These countries, with the participation of 32 professionals, completed 8 studies, the results of which were published in the special edition of the *Pan American Journal of Public Health*.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	8	Yes
Comments: 8 countries achieved this indicator: BOL, CHI, DOR, JAM, ELS, MEX, PER, and URU. These countries have explicit policies and/or financial mechanisms intended to reduce or eliminate financial risk associated with disease and accidents.				

RER 14.3 Technical cooperation provided to Member States in the development and use of national health expenditure and health system financing information	Fully Achieved

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

135. Achievement of this RER has not been easy, and a lot of work remains to be done to consolidate the progress made, especially in terms of capacity to provide information on financing and health expenditure to the Regional PAHO Core Data Initiative and the Statistical Annex of WHR/WHO (14.3.1).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.3.1	Number of countries reporting up-to-date information on financing and health expenditure to the Regional PAHO Core Data Initiative and the Statistical Annex of WHR/WHO	24/35	35/35	Yes
Comments: 35 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, DOM, ECU, GUT, GUY, ELS, HON, JAM, MEX, NEA, NIC, NCA, PAN, PAR, PER, SAL, SCN, SAV, SUR, TRT, URU, and VEN. It is important to note that not all countries produce the information yearly because of their own cycles and processes.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.3.2	Number of countries that have institutionalized the periodic production of Health Accounts/National Health Accounts harmonized with the UN statistical system	3	24	Yes
Comments: 24 countries/territories achieved this indicator: ABM, ANI, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, DOM, ELS, ECU, GRA, GUT, HON, MEX, NIC, PAR, SAL, SAV, SCN, TRT, and USA. Institutionalization of the production of health accounts was achieved in these countries as of 2011. BAR COL, ELS, HAI, and HON are aligning now with System of Health Accounts SHA 2011 approach, which is also part of health accounts recognized by the United Nations (and supported by the OECD).				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.3.3	Number of countries with studies on expenditure and financing of public health systems or social health insurance	0	15	Yes
Comments: 15 countries achieved this indicator: ARG, BLZ, CAN, CHI, DOM, DOR, ECU, ELS, GRA, HON, PAR, SAL, SAV, SCN, and VEN.				

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	Fully Achieved

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

136. All the countries targeted for indicator 14.4.1 have achieved it and have insurance schemes aimed at improving health coverage, quality of service, and/or financial protection. The countries targeted for indicator 14.4.2 have improved the level and quality of their information on health exclusion and coverage and they are using it to formulate health policies.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.4.1	Number of countries with insurance schemes and other mechanisms to expand social protection in health	8	12	Yes
Comments: 12 countries/territories achieved this indicator: ARG, BAR, BLZ, BRA, CHI, COL, COR, ECU, HAI, MEX, NEA, and PER. Countries have implemented insurance schemes and national health plans that address universal health coverage through explicit warranties of health care services.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
14.4.2	Number of countries with updated information to formulate policies for the expansion of social protection in health	11	16	Yes
Comments: 16 countries achieved this indicator: BLZ, BOL, BRA, CHI, COL, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PAR, PER, and VEN. Countries have improved the level and quality of information related to health exclusion and health coverage.				

RER 14.5 Member States supported through technical cooperation to align and harmonize international health cooperation	Fully Achieved

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

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	3	8	Yes
Comments: 8 countries achieved this indicator: HON, NIC, BLZ, BOL, GUT, PAN, GUY, and VEN. In GUY, Health Vision 2020 has been finalized. In VEN, technical cooperation tools have been developed in accordance to international agreements and national context.				

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 the WHO Eleventh General Program of Work and the Health Agenda for the Americas			Fully Achieved[31] (100% of indicator targets achieved)
RER Status[32]	15.1	15.2	15.3

[31] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[32] RER Status: Green (Fully Achieved); Yellow (Partially Achieved)

SO15 Budget Overview

Approved Budget (PB 08-13)	Funds Available (in US$ millions)			Expenditure (%)	Funded (%)
	RB	OS	Total		
209	180.6	37.2	217.8	96%	104%

SO15 Programmatic Assessment Summary

This SO was fully achieved. All 3 RERs were fully achieved, and 3 out of the 15 RER indicators were exceeded. The 3 SO impact indicators were also achieved.

137. PAHO has a long-standing history of leadership in public health in the Region of the Americas, fostering and nurturing strong partnerships and relations with Member States and stakeholders. The Organization has been successful in strengthening governance and forging alliances with partners at the regional, subregional, and country levels by positioning and promoting the advancement of the global health agenda as mandated through the WHO 11th General Programme of Work (GPW), the Health Agenda for the Americas (HAA) 2008-2017, and the regional priorities approved by PAHO Governing Bodies.

138. Member States have implemented, or are currently implementing, resolutions passed by the Governing Bodies, and they are increasingly engaged in the PAHO governance process, including the development of documents and resolutions. Thirty-six country offices led the development of the Country Cooperation Strategies (CCSs) in close collaboration with government counterparts, other levels of the Organization, and partners. The CCSs, which integrate national frameworks for health with international agreements and PAHO mandates, are the basis for defining the PAHO/WHO technical cooperation program and country presence. There was successful implementation of Technical Cooperation among Countries (TCC) and South-South and Triangular Cooperation initiatives, with mainstreaming of the Cross-Cutting Priorities (CCPs). PAHO has been actively participating in the United Nations Regional Directors Team, and at the country level the Organization participated in the United Nations Country Teams (UNCTs), with active presence and leadership in Inter-Agency Working Groups (IAWGs).

139. Numerous agreements were signed with bilateral and multilateral organizations and other partners, including United Nations agencies and agencies of the Inter-American system, to further the Health Agenda of the Americas. The PASB also successfully advocated for the inclusion of health in summit declarations such as the Cartagena Declaration emanating from the 6th Summit of the Americas in 2012. In 2013, the PASB was accepted as an Associate Member of the Ibero-American Process, a position that will contribute to further increasing the visibility of health at the highest levels.

140. In 2012, the Member States, with technical support from the PASB, conducted a mid-term evaluation of the HAA 2008-2017. The evaluation documented the progress made by the countries in the eight areas of action of the HAA and the issues that required increased attention in the remaining period of the Agenda. The consultative process and the results of this evaluation provided key inputs for development of the new PAHO Strategic Plan 2014-2019. A copy of the HAA mid-term evaluation report can be obtained from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=20125

SO15 Main Achievements

a) A mid-term evaluation of the Health Agenda of the Americas was conducted by a 10-Member State Working Group, with the PASB as Technical Secretariat. All the Member States participated in the evaluation and endorsed the final report, which was presented to the 28th Pan American Sanitary Conference in September 2012 and the 7th Subcommittee on Program, Budget, and Administration in March 2013.

b) The PAHO Strategic Plan 2014-2019 and PB 2014-2015 were developed with full participation of the Member States, as directed and approved by the Governing Bodies.

c) A new PAHO Budget Policy was developed in 2012, building on lessons learned from the previous policy in order to better define PAHO country core presence and guide the allocation of regular budget resources across the three levels of the Organization (country, subregional, and regional), with an increased focus on countries.

d) The Organization's leadership in the United Nations Health Cluster and its contribution to addressing emergencies were strengthened through participation in responses in other WHO regions, as in the emergencies and disasters in the Philippines and Syria. Rapid resource mobilization for health and partnerships were essential for an immediate and effective response to countries in the Region affected by natural phenomena, epidemics and the 2009 H1N1 influenza pandemic.

e) PAHO governance, transparency, and positioning were strengthened by reinforcing Member States' participation and involvement in the process of preparing and making decisions about key Governing Body documents.

f) The international nature of PAHO technical cooperation and efficient country presence in response to the CCSs were maintained through use of a mix of national and international personnel, with backstopping from subregional, regional, and global offices as required. The PAHO/WHO country offices found innovative ways to implement the technical cooperation programs, including mobilization of resources from nontraditional donors, such as South Korea (Bolivia and Peru) and the European Union (Belize); through South-South Cooperation (Jamaica-Brazil and Brazil-Cuba); through increased national voluntary contributions (Argentina, Brazil, and Colombia); and through collaboration with faith-based organizations (Guatemala).

g) Approximately US$ 70 million in technical and financial resources were mobilized over a three-year period (2011–2013) from traditional and nontraditional partners, including three key bilateral strategic partners (AECID, CIDA, and USAID). In addition, there was a growing trend in the mobilization of national voluntary contributions in countries such as Argentina, Brazil, and Colombia.

h) A policy on Cooperation for Health Development in the Americas was developed, presented, and adopted by the 52nd PAHO Directing Council Meeting in September 2013 (Resolution CD52.R15).

i) Latin America and the Caribbean were fully involved at the United Nations High-Level Meeting on Noncommunicable Diseases, reflecting the priority of NCDs in the health development agendas at the country, subregional, and regional levels. Establishment of the Pan American Forum for Action on NCDs reflects the whole-of-government and the whole-of-society approaches needed to address these priorities.

j) There was significant and more sustainable mainstreaming of Cross-cutting Priorities (CCPs) in the PASB and Member States to comply with global, regional, and country mandates towards Health for All and contribute to the reduction of health inequities.

SO15 Main Challenges

a) PAHO's alignment with the rest of the United Nations system in the context of the United Nations Reform and Delivering as One approach and with WHO Reform, given the different governance structure of the Organization and its systems, notwithstanding the Organization's commitment to effective partnerships.

b) Definition of interaction with nontraditional partners, such as the private sector, especially in the case of companies with products that may be deemed harmful to public health.

c) Strengthening of PAHO position as the lead health agency in the Americas and wide recognition of its added value in health development.

d) Tracking of the implementation of Governing Body resolutions and determination of their continued relevance.

e) Adequate financing to ensure core country presence with appropriate human resources to undertake technical cooperation programs within the framework of the CCSs despite the provisions in the 2012 Regional Budget Policy.

f) Pending finalization of the corporate Resource Mobilization Strategy applicable to both the international community and national resources.

g) Provision of consistent guidance to countries from all organizational entities on important administrative and managerial issues—e.g., attribution of direct and indirect costs to Voluntary Contribution (VC) projects, accompanied by appropriate tools.

h) Review and possible updating of the policy on Program Support Costs (PSC) to determine how best VC resources may be used to support management and administration costs incurred by country offices.

i) Achievement of consistent CCP mainstreaming across PASB entities and Member States, with adequate capacity within and outside of the Organization to address the issues.

SO15 Lessons Learned

a) Strengthening the CCS cycle and process will result in an improved strategic agenda for implementation by all organizational entities, a more strategic contribution to the UNDAF, a framework for resource mobilization for countries, and enhanced bottom-up planning of Program Budgets and Strategic Plans.
b) Sustaining strategic alliances and partnerships, both internally and externally. involves the identification of common interests, evidence-based priorities, and agreements on outcomes and impact, especially at the country level.
c) The approach to the assessment and evaluation processes, such as those related to the Country Cooperation Strategy and the Biennial Work Plan, with the involvement of counterparts and other development partners, will benefit from standardization, using a semi-structured process with basic criteria for the evaluations.
d) Supportive corporate policy, culture, and managerial support, as well as monitoring and evaluation, are critical factors for mainstreaming CCPs in the PASB and Member States.

Progress towards Impact Results

PAHO/WHO technical expertise and the Organization's capacity to access additional expertise where necessary through its network of country, regional, and global offices, as well as its specialized and collaborating centers, led to continued recognition and appreciation of the its leadership role in public health. The promotion of TCC facilitated exchanges of technical expertise among Member States, and new and enhanced partnerships led to the mobilization of financial resources, all in support of national, subregional, regional, and global health goals. These actions were enhanced by the integration of the cross-cutting priorities of human rights, gender, ethnicity, primary health care, social protection in health, and health promotion into plans, policies, and programs.

The PAHO Strategic Plan 2008-2013 was aligned with the WHO 11th General Programme of Work (GPW), the Health Agenda for the Americas 2008-2017, and the resolutions, plans, and strategies approved by the PAHO/WHO Governing Bodies. The PASB entities' BWPs, developed within the framework of the Strategic Plan, the health priorities of the major subregional integration processes, and the PAHO/WHO Country/Subregional Cooperation Strategies (CCSs/SCSs), emphasized results-based planning and management. They addressed national health policies, strategies, and plans, as well as the Member States' collective agreements as expressed through their integration processes.

Member States participated actively in the mid-term evaluation of the HAA and the PAHO Strategic Plan 2008-2013 and in development of the 2012 Budget Policy, the Strategic Plan 2014-2019, and the Program and Budget 2014-2015; a wider cross-section of Member States contributed to the deliberations and decisions in the Governing Body meetings; and Member States advanced the global health agenda through

their advocacy for the United Nations High-Level Political Declaration on Noncommunicable Diseases in 2011, as well as for the inclusion of health in the United Nations Post-2015 Development Agenda.

SO15 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 periods
Baseline: 0 countries in 2007
Target: 19 countries by 2013

The target was exceeded. All the countries of the Region implemented resolutions adopted by the PAHO Governing Bodies, and 60% of the resolutions were related to health policy.

SO15 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. Thirty-six (36) countries and territories developed CCSs. The CCSs proved to be excellent frameworks for BWP development, discussion with the government and other partners, and input into the United Nations Development Assistance Framework (UNDAF). However, they need to be better promoted, disseminated, and used by all entities in the Organization, including for purposes of resource mobilization. The CCS continued to be a sound departure point for strengthening country focus and implementing WHO reform at the country level.

SO15 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

Eighteen (18) Latin American and the Caribbean countries endorsed the 2005 Paris Declaration on Aid Effectiveness. In 2005, WHO endorsed the Declaration and was the first United Nations agency to adopt a resolution based on this declaration, which articulated a clear approach to harmonization and alignment at the country level. The CCS is a critical tool in making this approach operational, as it aligns with national health policies, strategies, or plans, and it harmonizes with the UNDAF. A total of 36 countries in LAC have CCSs. There are also other mechanisms in the countries that contribute to harmonization and alignment, such as the International Health Partnership Plus (IHP+) (Haiti and El Salvador) and multisectoral Country Coordinating Mechanisms for Global Fund projects (21 Member States).

Assessment of the Region-wide Expected Results

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 work to fulfill its mandate in advancing the global, regional, subregional, and national health agendas	Fully Achieved

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

141. The performance of the Organization in achieving this RER was very good, with all indicator targets met. The work with the Governing Bodies was greatly enhanced in terms of the quality of the documents and the engagement of Member States, as they continued to be more intimately involved in the processes and the content of the technical material, including the selection of topics for discussion and the development of documents.
Greater emphasis was placed on identifying and managing risks associated with the Organization's functions. The PAHO Enterprise Risk Management Policy was approved and incorporated into the PAHO e-Manual in May 2013, and all entities received appropriate training in developing risk management plans.

142. PAHO continued to strengthen its leadership role, effectively negotiating technical cooperation initiatives and implementing Biennial Work Plans. The BWPs were aligned with the Strategic Plan 2008-2013, which responded to the Health Agenda for the Americas 2008-2017 and the CCSs and SCSs, as well as the corresponding national and subregional health agendas. The BWPs ensured that all initiatives included the cross-cutting priorities of gender, ethnicity, human rights, health promotion, primary health care, and social protection in health, as appropriate. The Strategic Plan was also closely aligned with the WHO 11th General Programme of Work 2006-2015 and the WHO Mid-Term Strategic Plan 2008-2013.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.1.1	Percentage of PAHO Governing Bodies resolutions adopted that focus on health policy and strategies	40%	55%	Yes
Comments: An average of 55% of the resolutions approved by the Governing Bodies during the period under evaluation were focused on public health policies and strategies. The Organization improved the quality of the documents and resolutions by offering training to the writers of the documents and by a thorough revision of documents and resolutions.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.1.2	Percentage of all oversight projects completed which evaluate and improve processes for risk management, control, and governance	0%	90%	Yes
Comments: 96% of all oversight projects that evaluated and improved processes for risk management, control, and governance were completed. During 2008-2013, 59 internal audit assignments were scheduled and completed, and only 2 final reports were pending at the end of 2013. The assignment reports contained specific recommendations on improving internal controls. The rate of cumulative implementation of the recommendations by management was 89% at the end of 2013, which compares favorably with the range of 75%-90% for most international organizations that publish analyses of the kind. Mechanisms were put in place for swifter implementation of the recommendations in the 2012-2013 biennium. The high implementation rate was indicative of management's continuing commitment to improve internal controls.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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, and Biennial Work plans, and reports) on time and within budget	43/69	69/69	Yes
Comments: PASB entities continued to strengthen their management and leadership skills, effectively negotiating initiatives, projects, TCCs and other technical cooperation mechanisms in line with their BWPs. The BWPs were aligned with the PAHO Strategic Plan 2008-2013, which responded to the Health Agenda for the Americas 2008-2017 and Country and Subregional Cooperation Strategies, which in turn responded, respectively, to national and subregional health agendas. The BWPs ensured that all initiatives included the cross-cutting priorities of gender, ethnicity, human rights, health promotion, primary health care, and social protection in health, as appropriate.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.1.4	Percentage of Governing Bodies and Member States legal inquiries addressed within 10 working days	70%	100%	Yes
Comments: The PASB responded to all legal inquiries from the Governing Bodies and Member States within the set time frame. In addition, support for Governing Bodies' meetings was strengthened, with legal personnel responsible for editing all resolutions and supporting the Credentials Committee. The PASB contributed to a successful electoral process for the new Director of PAHO and the incorporation of three new Associate Member States in 2012-2013.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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 Work Plans	N/A	54/54	Yes
Comments: There was significant progress in mainstreaming CCPs: gender, ethnicity, human rights, health promotion, primary health care, and social protection in health—into the operational planning process. All relevant entities (technical, subregional, and country entities) were required to integrate the CCPs into their work plans, and guidelines and training were provided across the different levels of the Organization. The CCPs were also incorporated into the corporate BWP review and Performance Monitoring Assessment processes. A monitoring report of the PASB integration of gender was also produced and presented to the Directing Council as part of the implementation of Gender Equality Policy.				

RER 15.2 Effective PAHO/WHO country presence established to implement the PAHO/WHO Country Cooperation Strategies (CCSs), which are: (1) aligned with Member States' national health and development agendas, and (2) harmonized with the United Nations country team and other development partners	Fully Achieved

RER Assessment Summary (5 out of 6 RER indicator targets achieved; 1 not achieved)

143. Overall, the Organization's country presence was significantly strengthened in both its technical work and its administrative structure. In particular, the 2004 Regional Program Budget Policy continued to ensure the allocation of at least 40% of the regular budget to countries and maintained the subregional level of budget to accommodate technical cooperation with subregional integration processes in addressing the respective health agendas. The Office of Eastern Caribbean Countries expanded the number and role of the Country Program Specialists based in countries/territories under its jurisdiction. The CCSs proved to be excellent frameworks for consolidating PAHO/WHO country presence and ensuring synergies and value-added to the Member States' development agendas, and their national health policies, strategies, and plans. Furthermore, there was increased alignment between the CCSs and the national development arena; the CCS cycle was an outstanding tool for fostering participation and harmonizing the work done by PAHO/WHO with the wider national and international development agendas, and specifically with the United Nations Country Team (UNCT).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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 Work Plan	26	35	Yes
Comments: 36 countries/ territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN,				

CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, PUR, SAL, SAV, SCN, SUR, TRT, URU, and VEN.

Two Associated Member States developed a CCS for the first time: NEA (Aruba) and PUR. In addition to the new CCSs that were developed, 9 countries updated their CCSs. CAN does not have a CCS, but a Framework Cooperation Agreement with PAHO guided PAHO technical cooperation with that country. The UK Overseas Territories and Haiti will have their first CCSs completed in the next biennium.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	26	35	Yes

Comments:
35 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HON, JAM, MEX, NEA, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, and VEN.

There was increasing alignment between CCSs and UNDAFs, as the CCSs were used as input for developing the health aspects of the UNDAFs. CAN had no UNCT or UNDAF, but there was cooperation between the USA and CAN on indigenous health in accordance with the Framework Cooperation Agreement between CAN and PAHO. Aruba also had no UNCT or UNDAF, but there was a national commission that worked as a liaison with UNESCO, and cooperation with this development partner was initiated through preparation of the CCS for Aruba.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.2.3	Number of countries where the Biennial Work Plan (BWP) is evaluated jointly with government and other relevant partners	17	35	Yes

Comments:
37 countries/territories achieved this indicator: ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOM, DOR, ECU, ELS, FEP, GRA, GUT, GUY, HON, JAM, MEX, NCA, NEA, NIC, PAN, PAR, PER, SCN, SAL, SAV, SUR, TCA, TRT, URU, and VEN.

The National Authorities were consulted at the political and/or technical level on programming the BWP, which involved a review of the previous cycle. An evaluation of the BWPs was also done as part of the CCS process. Greater involvement of other relevant partners is needed.

In addition, there were four subregional BWPs: Andean (AND), Central America (CAM), Caribbean (CRB), and South America (SAM) evaluated with relevant subregional partners.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.2.4	Number of PASB subregions that have a Subregional Cooperation Strategy (SCS)	0/5	4/5	Yes

Comments:
Four subregions achieved this indicator: AND, CAM, CRB, and SAM.

Despite differences in the nature of the SCSs across the subregions, they all respond to subregional health priorities and agendas. The Caribbean developed a formal SCS 2010-2015 within the framework of Caribbean Cooperation in Health, Phase III, the health agenda of the Caribbean Community (CARICOM), while the Central American, Andean, and Southern Cone had more informal SCSs defined on the basis of the health agendas of the respective subregional integration processes.

Going forward, there will be four subregions: CAM (Central America), CRB (Caribbean), NAM (North America), and SAM (South America). SAM will include the Andean Region and Southern Cone; it will be high priority to develop a SCS for SAM, and a formal SCS for CAM.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.2.5	Number of PASB country and subregional entities with improved administrative support, physical infrastructure, transport, office equipment, furnishings and information technology equipment as programmed in their Biennial Work Plans	20/29	29/29	Yes

Comments:
29 entities achieved this target:

- 27 country offices (ARG, BAH, BAR/ECC, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN)
- 2 subregional offices: The Office of Caribbean Program Coordination (OCPC) and the Field Office in El Paso (FEP)

Assessments of building conditions will take place in the next biennium.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	20/29	29/29	Yes

Comments:
29 entities achieved the target:

- 27 country offices (ARG, BAH, BAR/ECC, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN)
- 2 subregional offices: the Office of Caribbean Program Coordination (OCPC) and the Field Office in El Paso (FEP).

The target was fully achieved, and the United Nations Department of Safety and Security (UNDSS) ratings of the facilities of PASB entities showed proper compliance with Minimum Operating Security Standards (MOSS).

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	Fully Achieved

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

144. Cooperation with United Nations agency partners through the United Nations Development Group for Latin America and the Caribbean (UNDG LAC) and UNCTs was effective, with PAHO playing an important role in these mechanisms and ensuring that health priorities were included in the various lines of work, such as the preparation of UNDAFs. There was successful partnering with other bilateral and international organizations, including nontraditional partners, through mechanisms such as the Pan American Forum for NCDs (PAFNCDs), and multiple technical cooperation agreements were signed with traditional and nontraditional partners in support of the PAHO Strategic Plan and the Health Agenda for the Americas (HAA). As a result, health was prominently positioned in the different Summits, such as the Summit of the Americas and Ibero-American Summit. A mid-term evaluation of the HAA conducted in 2012 indicated that the majority of Member States, but only a few international organizations working in

health in the Region, were using this framework as a reference in developing their health plans and strategies. However, as the evaluation also showed, there is scope for greater promotion and utilization of the HAA.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	Yes

Comments:
27 countries with country offices achieved this indicator: ARG, BAH, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, TRT, URU, and VEN.

PAHO continued to be an active member of the UNDG LAC, and country offices maintained membership in their respective UNCTs. PAHO also participated in multiple IAWGs, including groups on human rights, indigenous peoples, youth, HIV/AIDS, emergency preparedness and response, gender equality and women's empowerment, reduction of maternal mortality, and the Pan American Alliance on Nutrition and Development. PAHO was also involved in the UNDAF processes, ensuring that health was properly reflected. In addition, PAHO engaged in partnerships with bilateral donors; multilateral funds such as the Global Alliance for Vaccination and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and civil society organizations, including the private sector, at both the national and regional level. In countries without a physical country office but where a PAHO/WHO Representative had responsibility for the Organization's technical cooperation, significant leadership and partnerships were maintained. These countries include the UK Overseas Territories, the French Departments in the Americas, and the Netherlands Overseas Territories.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.3.2	Number of agreements with bilateral and multilateral organizations and other partners, including United Nations agencies, supporting the Health Agenda for the Americas	0	25	Yes

Comments:
The target of 25 agreements was far surpassed, with over 200 agreements signed at the regional and country levels in the 2012-2013 biennium alone. This number included new agreements, renewals, and amendments.

The PAHO Strategic Plan was designed to support implementation of the HAA, and all agreements signed with partners, including the Ministries of Health, were in line with the PAHO Strategic Plan.

A mid-term evaluation of the HAA was done in 2012 and showed that 20 Member States and three international organizations used it as a frame of reference. There was a commitment to its greater use as a framework for actions in health by all stakeholders, and PAHO was requested to actively promote it.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.3.3	Percentage of Summit Declarations reflecting commitment in advancing the Health Agenda for the Americas 2008-2017	N/A	75%	Yes

Comments: Declarations emanating from the Cartagena, Ibero-American, and United Nations Summits, among other high-level conferences increasingly included firm commitments in the area of health that supported the Health Agenda for the Americas 2008-2017. In 2013, PAHO was accepted as an Associate Member of the Ibero-American Summit Process. This achievement will contribute to further increasing the visibility of health at the highest levels and ensuring that health figures prominently in discussions and commitments, including the Post-2015 Development Agenda.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
15.3.4	Percentage of country requests for PAHO support to mobilize technical and financial resources from external partners that PAHO has fulfilled	75%	95%	Yes
Comments: Guidelines for the management of voluntary contributions were widely disseminated and all the Country Offices that requested assistance to mobilize technical and financial resources were supported. Numerous voluntary contribution proposals and initiatives were reviewed.				

SO16: To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively					Fully Achieved[33] (100% of indicator targets achieved)	
RER Status[34]	16.1	16.2	16.3	16.4	16.5	16.6

SO16 Budget Overview

Approved Budget (PB 08-13)	**Funds Available (in US$ millions)**			**Expenditure (%)**	**Funded (%)**
	RB	**OS**	**Total**		
265.2	201.2	93.3	294.4	97%	111%

SO16 Programmatic Assessment Summary

145. The PASB has been successful overall at improving its efficiency and effectiveness in carrying out its mandate as a flexible learning organization during the period, as reflected throughout this report. The success and progress being made in major Organization-wide projects—including the PASB Management Information System (PMIS), the collaborative and consultative process with Member States in preparing the PAHO Strategic Plan 2014-2019, results-based management (RBM), International Public Sector Accounting Standards (IPSAS), and the Enterprise Risk Management Policy—has and will continue to increase the effectiveness and efficiency of the entire Organization.

SO16 Main Achievements

a) The business case analysis for the PAHO Enterprise Resource Planning (ERP) system—in other words, the PASB Management Information System—was completed in 2012, which identified and confirmed potential savings in the implementation of the PMIS. The pre-implementation phase of the PMIS

[33] SO Status: Green (Fully Achieved); Yellow (Partially Achieved)
[34] RER Status: Green (Fully Achieved+); Yellow (Partially Achieved)

was completed in 2013 with signing of the contracts for the new ERP software and a core contract for systems integration, change management, training, and an external project manager.

b) The PAHO RBM Framework approved by the Member States in 2010 and training courses in RBM were conducted across the PASB.

c) In an environment of limited financial resources, the PASB Program and Budgets for 2008-2009, 2010-2011, and 2012-2013 were approved by the Member States with an increase in assessed contributions.

d) Integrated operational planning and the Performance Monitoring and Assessment (PMA) process were established across the PASB in line with the PAHO RBM Framework.

e) A new PAHO budget policy was approved by the Member States in 2012 The policy was developed in close collaboration with a countries working group.

f) The new PAHO Strategic Plan 2014-2019 and Program and Budget 2014-2015 were approved by the Member States in 2013. The new Plan and PB were developed with unprecedented participation and consultation with Member States and staff at all levels of the PASB.

g) Transition from the United Nations System Accounting Standards (UNSAS) to IPSAS was completed in 2010 and annual financial statements from 2011-2013 were prepared in accordance with IPSAS. This change has improved: (i) PAHO alignment with best accounting practices through the application of credible, independent, and internationally recognized accounting standards, and (ii) Internal controls as a result of having a better understanding of the assets/liabilities and resources available to the Organization. A more accurate assessment of the financial stability of the Organization was provided through more comprehensive financial information and increased transparency, which allowed for more informed decisions and management of the assets that support the RBM framework.

h) An unqualified audit opinion was received on the 2008-2009 biennium financial statements as well as on the annual IPSAS-compliant financial statements for 2010, 2011, 2012 and 2013.

i) In efforts to improve efficiencies in operational planning, the PASB expanded its Biennial Work Plan (BWP) development process to include human resources planning and the integration of cross-cutting themes (CCTs) in all entities' BWP.

j) Negotiation of the terms for the Mais Médicos Program to ensure compliance with PAHO policies and procedures.

k) The Information Technology Governance Policy was issued and is functioning for the entire Organization.

l) Extensive procurement training was conducted in countries and at Headquarters.

m) An update of the Procurement Practitioner's Handbook was completed.

n) At the close of the strategic planning period, all the country offices and centers were applying Minimum Operating Security Standards (MOSS) were compliant with UNDSS standards.

o) The Enterprise Risk Management Policy was approved and is being implemented.

SO16 Main Challenges

a) Important gaps in RBM implementation remain, especially in the evaluation and learning components. The PASB is working on improving these RBM components.

b) There is need to address better availability of near-real time management information in the Country Offices and Centers. This situation should be significantly improved with implementation of the PMIS.

c) The requirement to maintain the legacy systems while implementing the new PMIS (ERP) has been and will continue to be extremely demanding for the Organization.

d) The completion of Business Continuity Plan (BCP) for HQ and ensuring that all BCPs in HQ and countries are maintained up to date is required in accordance with good management practices.

e) The incorporation of National Voluntary Contributions into the PAHO Program and Budget is required in order to adequately reflect their contribution to the regional programmatic priorities as set out in the Strategic Plan.

f) Quality control for translated documents remains a challenge because of staff shortages, which result in a high volume of translations being outsourced.

SO16 Lessons Learned

a) The strong leadership and commitment of PAHO Executive Management has been critical for the successful implementation of the PAHO RBM framework and it will continue to be an asset to fully consolidate its application.

b) Close collaboration between Member States and the PASB, supported by a broad range of technical staff, contributed to and facilitated the joint development of the new PAHO Strategic Plan 2014-2019 and Program and Budget 2014-2015, and it will be equally critical for their successful monitoring and evaluation.

c) The new Regional Program Budget Policy builds on the lessons learned from the previous one.

d) Lessons learned after creation and implementation of the Master Capital Investment Fund (MCIF) during 2008-2013 have greatly improved the procedures and processes for its implementation in the future.

e) Incorporating emergency procedures into the PAHO/WHO e-Manual greatly facilitated the countries' understanding of their responsibilities and authority in emergency situations.

Progress towards Impact Results

SO16 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

81% of Region-wide-Expected Results (RERs) under Strategic Objectives 1-15 were achieved by at the end of 2013.

SO16 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

A gradual reduction from 2008-2009 in the percentage of the total PAHO budget represented by SO 16 has taken place during implementation of the Strategic Plan, almost reaching the target set from 2013.
2008-2009: 20.2%
2010-2011: 17.5%
2012-2013: 15.6%

Assessment of the Region-wide Expected Results

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

RER Assessment Summary (5 out of 5 RER indicator target achieved)

146. As noted in the assessment of RER indicators below, the Organization made significant progress in the implementation of RBM and used the experiences and lessons learned to improve its planning, budgeting, and Performance Monitoring and Assessment processes. These achievements were made possible through collaboration with Member States, the commitment of PASB Executive Management (EXM) and the involvement of staff across all PASB levels. The lessons learned and good practices identified during 2008-2013 have been applied to development of the new PAHO Budget Policy 2014-2019, the new PAHO Strategic Plan 2014-2019 and Program and Budget 2014-2015, and the operational planning process for 2014-2015 with a view to increasing the efficiency and effectiveness of PAHO technical cooperation.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.1.1	PAHO Results-based Management (RBM) framework implemented	In progress	RBM frame-work imple-mented	Yes
Comments: The PAHO Strategic Plan 2008-2013 was the first such plan to be implemented following the Organization's RBM framework approved by the Member States. Since 2008, the Organization made significant strides in the implementation of RBM, particularly in the areas of planning, PMA, and accountability. The progress made in the implementation of RBM in PAHO is the result of the demand from Member States, the leadership of PASB EXM, the involvement of managers and staff across all levels of the PASB, and the development of processes and tools to facilitate its implementation. As documented in the various reports related to the implementation of RBM in PAHO (i.e., the United Nations Joint Inspections Unit, the PASB Internal Oversight and Evaluation Services Office, and an evaluation by an external consultant), important gaps remain in the independent evaluation and learning components. These components will require further attention in the upcoming biennia for the Organization to consolidate the application of RBM.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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	In progress	SP 14-19 approved by Governing Bodies	Yes
Comments: The PAHO Strategic Plan 2014-2019 and the PBs for all the biennia during the period assessed were approved by the Directing Council. The new Plan and PB were developed with unprecedented participation by Member States and staff at all levels of the PASB. The process was country-led under the strategic and technical input of a Countries Consultative Group (CCG), composed of 10 Member States established by the PAHO Executive Committee. All the Member States participated in the extensive consultation undertaken during development of the Plan and the PB. Lessons learned and experiences from previous plans and budgets were applied to further improve the implementation of RBM through these documents in order to better demonstrate the strategic, technical, and enabling work of the Organization. The opportunity was also taken to improve on key aspects, such as a revised results chain with clearer responsibility and accountability for Member States and the PASB; development and application of a new programmatic prioritization framework using a robust methodology and scientific method; clearer definition of the Organization's commitment to key countries; incorporation of strategic approaches (universal health coverage, determinants of health, and health promotion); and cross-cutting themes (gender, equity, human rights, and ethnicity). During the consultation process, Member States identified and committed to their achievement of specific targets relevant to their respective countries and territories.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.1.3	Percentage of progress towards the resource reallocation goals among the three PASB levels per PAHO Regional Program Budget Policy (RPBP)	33%	100%	Yes
Comments: 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) to the fullest extent possible. In 2012, a new PAHO Budget Policy was developed and approved by the Member States. The new policy was developed in collaboration with a Countries Consultative Group and builds on the lessons and experiences gained from implementation of the previous RPBP.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.1.4	Percentage of PASB entities that achieve over 75% of their OSERs	N/A	90%	Yes
Comments: 91% of the entities (63/69) achieved over 75% of their results, despite funding challenges in the last biennium. This achievement is well demonstrated in the various PMA reports of the PASB.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.1.5	Percentage of performance monitoring and assessment reports on expected results contained in the Strategic Plan and Program and Budget documents submitted in a timely fashion to the PASB Executive Management after peer review	50%	100%	Yes
Comments: 100% of PMA reports were submitted on a timely basis to the PASB Executive Management. The PASB has conducted the PMA exercises and submitted all corresponding reports to Executive Management and the PAHO Governing Bodies in accordance with the monitoring and reporting framework approved by the Member States in the Strategic Plan 2008-2013. The reports presented to the Governing Bodies have been consistently improved by drawing on previous experiences, input from teams across the PASB, guidance from PASB EXM, and recommendations from Member States.				

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	Fully Achieved

RER Assessment Summary (6 of 6 RER indicator target achieved)

147. Through the development of new mechanisms and processes, including the Biennial Work Plan processes of monitoring and assessment, IPSAS policy development and implementation, and resource mobilization coordination mechanisms, significant progress was made in the 2008-2013 period, resulting in the achievement of RER.16.2. During the period, PAHO maintained VC agreements with three key bilateral partners (AECID, CIDA, and USAID) utilizing a programmatic approach: about 40% of funds were flexible, at least at the SO level. In addition, PAHO returned to partners less than 0.5% of the total VC funds available for this period. Furthermore, PAHO transitioned successfully from the United Nations System Accounting Standards (UNSAS) to IPSAS effective 1 January 2010. PAHO received an unqualified audit opinion on the 2008-2009 biennial Financial Statements, as well as on the annual IPSAS-compliant Financial Statements for the 2010, 2011, and 2012 financial reporting periods. The audit opinion on the 2013 Financial Statements will be issued by 15 April 2014. Finally, PASB entities have consistently achieved over 90% budget implementation at the end of each biennium.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.1	International Public Sector Accounting Standards (IPSAS) implemented in PAHO	IPSAS not imple-mented	IPSAS imple-mented	Yes
Comments: PAHO transitioned from the United Nations System of Accounting Standards (UNSAS) to the IPSAS as of 1 January 2010. The Financial Statements for the 2010, 2011, 2012 and 2013 financial reporting periods were prepared in accordance with the IPSAS.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.2	Percentage of strategic objectives meeting at least 75% of their unfunded gap at the end of the biennium	N/A	70%	Yes
Comments: 81% of the SOs (13/16) had at least 75% funding of their approved budgets. The SOs with funding lower than 75% were SO 2 (49%, HIV/AIDS, Malaria, and TB), SO13 (64%, Human Resources for Health) and SO14 (54%, Health Financing and Social Protection).				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.3	Percentage of Voluntary Contributions that are un-earmarked (funds that are flexible with restrictions no further than the SO level)	5%	15%	Yes
Comments: PAHO maintained VC agreements with three key bilateral partners (AECID, CIDA, and USAID), utilizing a programmatic approach with about 40% funds flexible, at least at the SO level.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.4	Percentage of PAHO Voluntary Contributions (earmarked and un-earmarked) funds returned to partners	1%	0.50%	Yes
Comments: The amount of VC funds returned to partners was reduced to less than 0.5% of the total VC funds available for the period.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.5	Sound financial practices, as evidenced by an unqualified audit opinion	Unquali-fied audit opinion	Unqua-lified audit opinion	Yes
Comments: PAHO has received an unqualified audit opinion on the 2008-2009 biennial Financial Statements. PAHO has also received an unqualified audit opinion on the annual IPSAS-compliant Financial Statements for the 2010, 2011, 2012 and 2013 financial reporting periods.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.2.6	Percentage of PASB entities that have implemented at least 90% of their programmed amount in their Biennial Work Plans	70%	90%	Yes
Comments: PASB entities have consistently achieved over 90% budget implementation at the end of each biennium. (Pending validation based on EOB12-13 closure data from PBU and FRM).				

RER 16.3 Human resource policies and practices promote (a) attracting and retaining qualified people with the competencies required by the Organization, (b) effective and equitable performance and human resource management, (c) staff development, and (d) ethical behavior	Fully Achieved

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

148. Significant progress was made towards the Regional Expected Results of improved quality of staff, more efficient human resources management, professional development of staff, and ethical behavior. HRM was successful through the period in establishing HRM in the role of strategic partner for the entity managers, as indicated by the following accomplishments: 100% of the Human Resources Plans for all the entities were approved by the Executive Management and post descriptions were revised and brought up to date in all cases of personnel movements, following the Competency Framework implemented in the Organization. Furthermore, the selection processes were led entirely by the framework approved by the Executive Management.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.3.1	Percentage of PASB entities with human resources plans approved by Executive Management	15%	100%	Yes
Comments: 100% of HR Plans of the entities were approved by the Executive Management.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.3.2	Percentage of staff assuming a new position (with competency- based post -description) or moving to a new location during a biennium in accordance with HR strategy	15%	75%	Yes
Comments: 100% of the staff assuming a new position or moving to a new location during the biennium had an updated post description based on the PAHO Competency Framework.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.3.3	Percentage of Selection Committees working with new framework approved by the Executive Management, which includes psychometric evaluation for key positions	N/A	100%	Yes
Comments: During the biennium, 100% of the Selection Committees worked with the new framework approved by the Executive Management, which includes a psychometric evaluation for key positions.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.3.4	Percentage of PASB workforce that have filed a formal grievance or been the subject of a formal disciplinary action	<1%	<1%	Yes
Comments: During the 2012-2013 biennium, the Organization received only 4 new formal grievances and only 2 formal disciplinary actions were deemed necessary to be taken. The percentage of grievances and disciplinary actions has been less than the 1% of the PASB workforce (833 x 1%= 8.33) during the period.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.3.5	Number of queries received per year raising ethical issues which reflect a higher level of awareness regarding ethical behavior	40	150	Yes
Comments: 170 consultations were received during the 2012-2013 biennium. The number of consultations received from 2008 to 2010 averaged about 65 per year. In 2011, that number increased by about 50%, to 95. In both 2012 and 2013, ETH received 85 consultations. As a result, the target for the biennium was achieved.				

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	Fully Achieved

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

149. The PASB improved its Information Management Systems strategies, policies, and practices over the last six years. Examples include: an Information Security Policy that resulted in fewer security incidents within the PASB, an updated IT Strategy, the introduction of an IT Governance process, and significant infrastructure improvements both in the Country Offices and at Headquarters.

150. The Organization led efforts to select the PAHO PMIS contractors (Workday and Tidemark), finalized the scope of work for the systems integrators, and selected the change management company and the external project manager following the established PASB procurement process.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.4.1	Percentage of significant IT-related proposals, projects, and applications managed on a regular basis through portfolio management processes	0%	80%	Yes
Comments: This target was achieved using the IT Governance process in place through all of 2013.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.4.2	Level of compliance with service-level targets agreed for managed IT-related services	0%	75%	Yes
Comments: This target was achieved through infrastructure upgrades both at Headquarters and in Country/Center Offices, as well as through monitored service desk reporting. • 94% of all incoming service requests were triaged and assigned within 4 hours of request creation				

and 71% within 1 hour;
- 100% of high priority service requests were resolved or escalated within 6 working hours; and
- 93% of all other service requests received were resolved or escalated within 16 working hours.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.4.3	Number of PAHO/WHO country and subregional entities and Pan American Centers using consistent, near-real-time management information	35/35	35/35	Yes
Comments: All offices continue to have consistent near-real-time management information.				

RER 16.5 Managerial and administrative support services, including procurement, strengthened to enable the effective and efficient functioning of the Organization	Fully Achieved

RER Assessment Summary (5 of 5 indicator targets achieved)

151. Effective and efficient daily running of the Organization was ensured and strengthened by improvements achieved in in a number of processes and services. Procedures utilized during regional emergencies were developed and uploaded to the PAHO/WHO e-Manual in 2009 and the Operational Manual for Country Offices and Centers was developed and piloted in 8 countries. Procurement management systems were fully implemented; training was conducted at Headquarters and in Country Offices, and policies were reviewed and included in the PAHO/WHO e-Manual. Surveys were launched to measure level of user satisfaction in selected services, such as the cafeteria, cleaning, travel, and mail room services. The Legal Office also improved client response tools. Translation services were able to exceed internal benchmarks through extensive use of internal and commercial translations tools.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.5.1	Level of user satisfaction with selected managerial and administrative services (including security, travel, transport, mail services, health services, and cleaning and food services) as measured through biennial surveys	Low (satis-faction rated less than 50%)	High (satis-faction rated over 75%)	Yes
Comments: 75% satisfaction achieved according to surveys results. The level of replies to the surveys remains a challenge. Specific surveys that reflect achievement of these services at HQ were: Travel, Cleaning, Mail Room, and Cafeteria Services.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.5.2	Percentage of standard operating procedures utilized by PASB personnel during regional emergencies	0%	100%	Yes
Comments: 100% of standard operating procedures are being utilized by PASB personnel during regional emergencies in accordance with the PAHO/WHO e-Manual.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.5.3	Percentage of internal benchmarks met or exceeded for translation services	60%	80%	Yes
Comments: 100% of internal benchmarks for translation services met (1,216 requests and 4.6 million words).				

This progress was achieved through the extensive use of internal and commercial computer-assisted translation tools. However, because of lack of staff and internal revisers, internal quality control benchmarks were not met; too many translation jobs were outsourced and translations were not being revised internally.

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.5.4	A new procurement management system to measure and monitor compliance with procurement best practices, including targeted training, improved statistical reporting, expanded bidder lists, service level agreements, and procedural improvements, implemented	N/A	Procure-ement Manage-ment System imple-mented	Yes
Comments: The procurement management system was fully implemented: training was conducted at the HQ and country levels, and Key Performance Indicators (KPI) were developed for evaluating performance. Dashboards were implemented to improve statistical reporting and an e-tendering solution was piloted in targeted country offices. All PRO policies were reviewed and included in the PAHO/WHO e-Manual, and the Practitioner Handbook was completed.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.5.5	Percentage of PASB internal requests for legal advice and services acted upon within 10 working days of receipt	70%	100%	Yes
Comments: LEG receives and responds to at least 4,000 formal legal inquiries a year. Despite the volume of work, LEG has consistently strived to improve its response time. During the initial period under review, LEG's staffing situation was a challenge; however, by the close of the period the staffing situation was partially resolved, which facilitated the successful accomplishment of this indicator. In addition, during the 2007-2013 period LEG completed important projects related to software updates and client response tools that helped to improve customer service.				

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	Fully Achieved

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

152. Physical environment was improved to ensure the well-being and safety of staff at Headquarter and in the Country Offices using MCIF funds and local funds. Compliance with Minimum Operating Security Standards (MOSS) in all PAHO offices was also confirmed by periodic UNDSS reports. Country Offices in Bolivia and Colombia moved to new premises during year 2013, and the reconstruction project in Haiti following the earthquake, which required staff to move to PROMESS facilities for an extensive period of time, is expected to be finished in the spring of 2014. The most important infrastructure projects in the last six years were improvements to the Nicaragua and Costa Rica Country Offices in 2008; renovation of the Guyana Office and installation of fences and closed-circuit TV in the Dominican Republic Office during 2009; purchase of land by the Haiti Office for a parking lot; renovation of the Suriname Office in 2010; AC improvements in the Panama Office and facility repairs for the Venezuela Office in 2011; relocation of the Jamaica Office; reconstruction in the Haiti Office in 2012; and completion of new premises for the Bolivia and Colombia Offices in 2013. At Headquarters, the most relevant achievements during the period were installation of the new Emergency Operations Center (EOC) and the Knowledge Center and refurbishing of the main auditorium (Room A).

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.6.1	Corporate performance scorecard implemented	N/A	Score-card imple-mented	Yes
Comments: The corporate performance scorecard has been implemented since 2010. Dashboards were created to facilitate monitoring and assessment of program implementation at entity and corporate levels.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
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%	Yes
Comments: 100% of approved infrastructure projects were completed on timely basis, considering that contracts were amended when unexpected situations arose during the implementation phase. The most visible infrastructure projects in last six years were improvements in the NIC and COR Offices during 2008; renovation of the GUY Office; installation of fences and closed-circuit TV for the DOR offices in 2009; purchase of land by the HAI Office for a parking lot; renovations in SUR in 2010; AC improvements at the PAN Office and repairs to the VEN facilities in 2011; relocation of the JAM Office and the reconstruction project in HAI during 2012; and new premises for the COL and BOL Offices during 2013.			

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.6.3	Percentage of HQ and 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	65%	100%	Yes
Comments: 100% of approved HQ and Pan American Centers physical facilities improvements plans also updated their MOSS and safety plans. Reports from UNDSS showed proper compliance in all PAHO duty stations.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.6.4	Percentage of PASB regional entities and PAHO Pan American Centers that improve and maintain their physical infrastructure, office equipment, furnishings, information technology equipment, and transport as programmed in their Biennial Work plans	75%	100%	Yes
Comments: Using their own entity budget, supplemented with Master Capital Investment Funds (Infrastructure & Vehicle Sub-Funds), all entities were able to improve their working environment. In addition to the countries mentioned under 16.6.2 in connection with infrastructure projects, CHI, ECU, HON, and PER were examples of countries that partially funded the purchase of replacement vehicles from the new MCIF Cars sub-fund.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No

16.6.5	Number of HR policies and practices that address work-life balance and health and safety of the PAHO workforce developed and implemented	2	14	Yes
Comments: HRM HQ and local entities reported on workshops, presentations, and events to provide advice and information on promoting personal and professional life balance and enhancing health, safety, and well-being.				

Ind. #	RER Indicator Text	2007 Baseline	Target 2013	Achieved Yes/No
16.6.6	New HR performance planning and evaluation system which enables effective performance management and integrated with PAHO Strategic Plan implemented	N/A	360 degree evalu-ations imple-mented	N/A
Comments: The 360-degree evaluations indicator target was cancelled, as it is not an attainable goal in light of the current organizational priorities and working environment. This decision was already presented and approved by the Member States as part of the End-of-Biennium Assessment 2010-2011.				

Annex B: RER Indicators Not Achieved

RER Indicator text	Baseline 2007	Target 2013	Achieved by end of 2013	Comments (progress to date and reasons for nonachievement)
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)	38%	32%	No	Small pockets of unvaccinated individuals with limited access to vaccination services remain, thus reducing the percentage of municipalities with vaccination coverage to less than 95%. Persistent problems for measuring and achieving the indicator include: (1) denominator issues, including country decisions to increase the number of children less than 1 year of age in 2012; (2) population movements between and within countries; (3) data quality issues; and 4) timeliness of data reporting.
1.3.1 Number of countries that have eliminated leprosy at national and - subnational levels as a public health concern	16/24	24/24	18	18/24 countries achieved the indicator having successfully eliminated leprosy as a public health concern at both the national and subnational levels. Adequate financial and human resources must be provided for the activities needed in order to maintain progress to date and continue to advance towards achieving the goal of leprosy elimination.
1.3.2 Number of countries that have eliminated human rabies transmitted by dogs	11	18	17	17/18 countries have eliminated human cases of rabies transmitted by dogs, as evidenced by the absence of reported cases in the regional database (SIRVERA). Two countries were unable to achieve the indicator because of a disruption in canine vaccination and lack of awareness among health officials of the need for post-exposure prophylaxis following a dog bite. There is the need for high level political advocacy to sustain programs for the elimination of human rabies transmitted by dogs.
1.3.3 Number of countries that maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases	11	23	11	11/17 countries maintained and/or improved their surveillance efforts and preparedness for emerging or re-emerging zoonotic diseases, primarily in the area of laboratory diagnosis and response capacity in the field. There remains a need to increase country capacity in surveillance, early detection, and rapid response to events of public health importance associated with zoonotic diseases.
1.3.4 Number of countries with Domiciliary Infestation Index for their main triatomine vectors lower than 1%	3/21	18/21	17	17/21 countries achieved the indicator, which underscores the considerable advances made in the fight against Chagas' disease. Countries continue to exert efforts to interrupt vector-borne transmission by reducing household infestation in the area, across the country, and/or in endemic territorial subunits. Continuing challenges include the need for greater political commitment, limitations of the national budgets, and institutional changes in the health sector.

RER Indicator text	Baseline 2007	Target 2013	Achieved by end of 2013	Comments (progress to date and reasons for nonachievement)
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	25	6	6 countries achieved the indicator, confirming that their core capacities were in place and could be maintained, while 29 of the 35 States Parties submitted requests, supplemented with an action plan. The most critical weaknesses identified were the capacity to manage events involving chemical and radiation-related hazards. In all, 31 of the 35 States Parties (89%) indicated their designated ports (64 in total); 34 of the 35 States Parties (97%) indicated their designated airports (77 in total); and 9 States Parties provided a list of their designated ground crossings (22 in total).
2.1.1 Number of countries that provide prophylactic antiretroviral treatment to at least 80% of the estimated HIV- positive pregnant women	9	17	15	15/17 countries achieved this indicator. Lack of data made it impossible to determine whether other countries did so as well. One of the main challenges in measuring progress in this area is that the data depended on accurate information or estimates at the country level. Also, UNAIDS does not release estimates for concentrated epidemics because of the wide margin of uncertainty.
2.1.2 Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need per PAHO/WHO guidelines	6	15	8	8/15 countries achieved this indicator. An additional 7 of them, at >70% coverage, were close to reaching the target. Persisting challenges in scaling up treatment and care programs and removing barriers to the provision of services for key populations have impeded target achievement.
2.1.5 Number of countries with a treatment success rate of 85% for tuberculosis cohort patients	6/27	23/27	15/27	15/17 countries achieved this indicator. Challenges impeding progress in this area include the quality of the DOTS programs, challenges with TB control efforts, delays in the introduction of new treatment tools, and insufficient engagement of other stakeholders/sectors at the country level.
2.1.6 Number of countries that have achieved the regional target for elimination of congenital syphilis	2	26	13	13/26 countries and territories achieved the indicator. Progress was also made in three other countries and territories that are close to achieving the elimination goal. Countries still need to improve their national plans, guidelines, and protocols to include the elimination Initiative; strengthen surveillance, monitoring, and evaluation; expand joint HIV and syphilis testing coverage; improve primary prevention of HIV and syphilis; and build health worker capacity.
3.4.2 Number of countries with cost analysis studies on violence conducted and disseminated	8	15	14	14/15 countries achieved the indicator. Despite advances, country projects remained heterogeneous, and the capacity of the Organization to support the countries was significantly challenged. There is a continued need to establish strong working relationships with institutions of

RER Indicator text	Baseline 2007	Target 2013	Achieved by end of 2013	Comments (progress to date and reasons for nonachievement)
				excellence in the area of cost analysis, including the World Bank and the Inter-American Development Bank.
6.2.2 Number of countries that have developed a functioning national surveillance system using a school-based student health survey (Global School Health Survey) and are producing regular reports on major health risk factors in youth	11	30	27	In addition to the 27 countries and territories that achieved this indicator (ABM, ANI, ARG, BAH, BAR, BLZ, BOL, CHI, COL, COR, DOM, ECU, ELS, GRA, GUT, GUY, HON, JAM, NCA, PER, SCN, SAL, SAV, SUR, TRT, URU, and VEN), 5 others (BRA, CUB, DOR, PAN, and PAR) were at various stages of GSHS implementation. Work is under way and funding has been secured for GSHS implementation in HAI in early 2014.
6.3.3 Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control	8	23	19	19/23 countries met the indicator and are complying with minimum regulatory requirements. The challenge in moving forward with this indicator will be whether or not the countries can take the necessary regulatory actions within the approved time frame (3 years between ratification and compliance with the FCTC mandate).
6.3.4 Number of countries that have updated at least one of the components of the Global Tobacco Surveillance System (GTSS)	9	35	30	30/35 Member States achieved this indicator, having completed the Global Youth Survey (28 countries); the Global Adult Tobacco Survey (5 countries); and the Global Health Professions Student Survey (18 countries). Noteworthy is that 23/30 countries that have achieved the indicator have implemented at least 2 of the 3 GTSS components (GYTS, GATS, GHPSS). The remaining 5 countries did not achieve the indicator because they were not able to update any of the GTSS surveys. However, these countries have been trained and are expected to conduct the GYTS in 2014. Other challenges in meeting the indicator included delays in the review of the GYTS protocol by WHO and CDC; internal difficulties with coordination among stakeholders at the country level; and availability of funds to implement the survey.
6.5.1 Number of countries that have implemented national policies to promote healthy diet and physical activity according to PAHO/WHO guidelines	8	20	No	9/20 countries achieved the indicator. Public policies promoting healthy food extend beyond the health sector. These multisector interests, along with lack of political will and the influence of the industry are the major roadblocks to faster achievement levels for this indicator.
9.4.4 Number of countries that have incorporated nutritional interventions in their comprehensive response programs for HIV/AIDS and other epidemics	11	25	No	21/25 countries achieved this indicator, having incorporated nutrition interventions into the management protocols for HIV/AIDS patients. However, it is necessary to reposition the importance of nutrition in the treatment of patients with HIV.

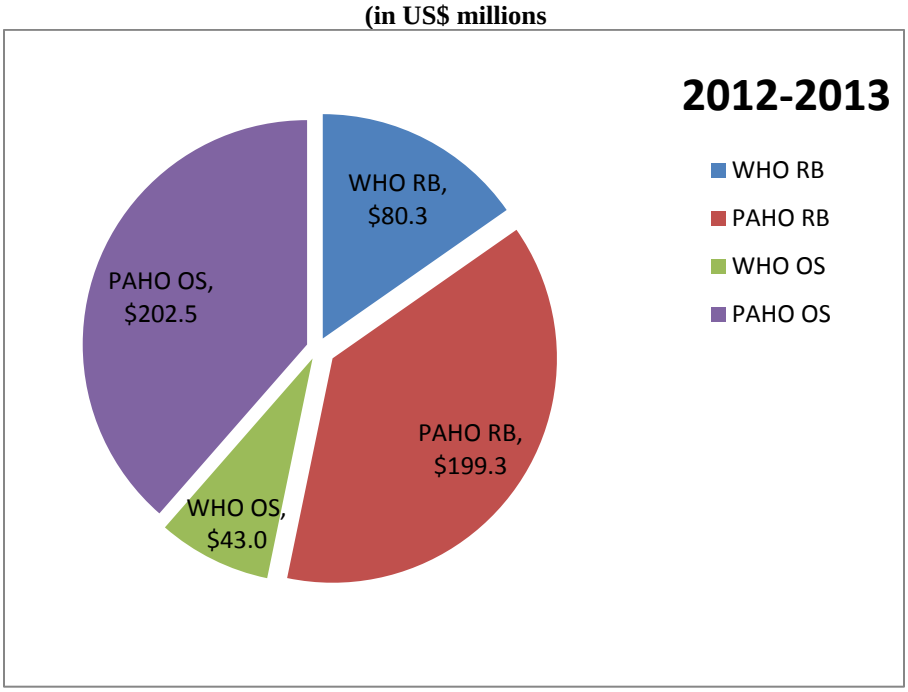
RER Indicator text	Baseline 2007	Target 2013	Achieved by end of 2013	Comments (progress to date and reasons for nonachievement)
10.1.3 Number of countries that integrate an intercultural approach in the development of policies and health systems based on PHC	0	8	No	5/8 countries achieved this indicator. Many changes occurred at the regional level which redirected the priorities in models of care for intercultural ethnic/racial groups, and these changes hampered achievement of the indicator.
11.2.2 Number of countries that have implemented the PAHO Regional Core Health Data	9	27	No	19/27 countries achieved the indicator. There are challenges in advancing in this area in the English-speaking Caribbean, where nationwide implementation of the core health data initiative remains difficult.
11.3.4 Number of countries monitoring the health-related Millennium Development Goals	23	36	33	The countries continued to monitor MDGs achievements using a variety of strategies. Of 33 countries, 12 documented their monitoring of the health-related MDGs and 13/36 countries continued to monitor their MDG achievements by publishing specific reports, supporting improvements in their national health information systems, and/or developing coordination activities with different national political entities and international agencies. One significant challenge is that all the Member States were targeted for this indicator (36) but two countries (CAN and USA) do not monitor the MDGs under the agreements.
11.5.3 PAHO Regional Information Platform created, integrating all the PASB technical health databases and information from health and development partners	Core data and MAPIS	Platform created and fully operative	No	The necessary technology platform was installed. However, the review and adjustments for phase II were pending. Completion of these steps will allow for corporate coordination and rollout.
12.1.3 Number of countries with 100% voluntary nonremunerated blood donations	8	17	No	10 countries achieved the indicator. This indicator was ambitious in its target, but voluntary nonremunerated blood donation will constitute an important pillar of the new five-year Blood Safety Strategy to be considered and adopted by the PAHO Directing Council in 2014.
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	18	36	No	29 countries and territories achieved the indicator. This target remained unachievable without the participation of the Caribbean countries and territories, which in turn was dependent on the creation of a Caribbean Observatory of Human Resources for Health. The institutional and financial requirements for the operation of a Caribbean Observatory were not met, partly because of the impact of the economic crisis in the subregion.

Annex C: Summary of the Program and Budget 2012-2013

1. The approved budget for 2012-2013 biennium was $613 million, of which $285.1 million (47%) corresponded to the Regular Budget (RB) and $328 million came from Other Sources (OS). Funds available for the biennium were $525.1 million, or 86% of the total approved, consisting of $279.6 in RB and $245.5 from OS. As shown in Figure 3, the RB portion was funded with $199.3 million from PAHO and $80.3 million from WHO. With regard to the OS, $202.5 million was mobilized by PAHO, and $43 million came from WHO.

2. The funding gap for 2012-2013 was $88 million ($5.5 million in RB and $82.5 million from OS). The deficit in RB was due primarily to the continued low interest rates, which resulted in a reduction in miscellaneous income. PAHO was able to mobilize $204.6 (83%), against a target of $247 million, from Other Sources for the biennium, while OS received from WHO was $43 million (53%) versus $80.7 budgeted. The amount for WHO OS fund includes base programs and resources allocated for Polio Eradication which is reflected in SO1 in PAHO to support maintenance of the achievement in polio eradication in the Region.

Figure 1. Program and Budget 2012-2013, Funding by Source (Base Programs) (in US$ millions



3. During 2012-2013, RB funds were allocated by functional level in accordance with the Regional Program Budget Policy (RPBP), as shown in Table 1 below. While the RPBP allocation criterion does not apply to OS funds, it is worth noting that the overall allocation of funds exceeded the minimum stipulated for the country level.

Table 1. Budget Breakdown by Functional Level

Functional level	Funds available for the biennium (US$ millions)			Distribution of Funds Available (as a percentage of the total funds available)		
	RB	OS	Total	RB[1]	OS	Total
Country	106.5	97.6	204.1	38%	40%	57%
Subregional	17.3	3.0	20.3	6%	1%	4%
Regional	155.8	144.9	300.7	56%	59%	39%
Total	279.6	245.5	525.1	100%	100%	100%

4. At the close of the biennium, 95% of funds available were expended ($500.7 million of $525.1 million).

5. With respect to non-base programs, Outbreak Crisis and Response (OCR) had 48 % ($10.6 million) of its approved OCR budget of US$ 22 million funded, while National Voluntary Contributions (NVC) exceeded the projected amount ($300 million) by 88% with a total of $565 million. The OCR funding level reflects the lower number and scale of emergencies that occurred in the Region in 2012-2013 compared with the previous biennia. The NVC growth reflects the continued upward trend in the volume of funds and number of Member States using this modality to support national health priorities through PAHO.

6. At the close of biennium, the implementation rate of OCR was 97% ($10.2 of $10.6 million) and 68% ($387.8 of $565 million) for NVC.

Outbreak Crisis and Response (OCR) Segment

7. During the biennium, a total of $10.6 million was available for this segment, against an estimated $22 million presented in the PB 2012-2013. This difference is due to the unpredictable nature of these funds, which become available in the event that a disaster, emergency, or epidemic/pandemics occurs.

8. As expected, almost all OCR funds were implemented (97%). These funds were used mainly to support countries affected by disasters and emergencies, such as floods in Peru, Paraguay, Mexico and the Caribbean; dengue outbreaks in Honduras and Nicaragua; an earthquake in Costa Rica; Hurricane Sandy in Jamaica, Cuba, Bahamas, Dominican Republic, and Haiti; acute respiratory disease in Peru; and a cholera epidemic in Haiti.

[1] The RPBP stipulated the following distribution of RB funds for the 2012–2013 biennium: country level, 40%; subregional level, 7%; and regional level, 53%.

Annex D: List of Subregions, Countries, and Territories

Abbreviation	Country Name
ABM	Anguilla, British Virgin Islands, and Montserrat (United Kingdom Overseas Territories)
AND	Andean
ANI	Antigua and Barbuda
ARG	Argentina
BAH	Bahamas
BAR	Barbados
BLZ	Belize
BOL	Bolivia (Plurinational State of)
BRA	Brazil
CAM	Central America
CAN	Canada
CRB	Caribbean
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 (French Guiana, Guadeloupe, Martinique, Saint Martin)
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 (Aruba, Bonaire, Curacao, Saba, St Eustatius and Sint Maarten)
NIC	Nicaragua
PAN	Panama
PAR	Paraguay
PER	Peru
PUR	Puerto Rico

Abbreviation	Country Name
SAL	Saint Lucia
SAM	South America
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)

Annex E: Abbreviations

Abbreviation	Description
AECID	Spanish Agency for International Cooperation and Development
AFP	acute flaccid paralysis
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
AMRO	WHO Regional Office for the Americas
AQG	(WHO) Air Quality Guidelines
ART	antiretroviral treatment
ARV	antiretroviral
BWP	Biennial Work Plan
CAN	Andean Community of Nations
CARICOM	Caribbean Community
CARMEN	Collaborative Action for Risk Factor Prevention and Effective Management of Noncommunicable Diseases
CCLAC	(FAO/WHO) Coordinating Committee for Latin America and the Caribbean
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (United States)
CELADE	Latin American and Caribbean Demographic Center
CIDA	Canadian International Development Agency
CIRHUS	(New York University) Center for International Research in the Humanities and Social Sciences
CLAP	Center for Perinatology, Woman and Reproductive Health
CNCD	chronic noncommunicable disease
COMISCA	Council of Ministers of Health of Central America and Dominican Republic
DRR	disaster risk reduction
DTP	diphtheria, tetanus, and pertussis
EC	European Commission
ECC	Eastern Caribbean countries
ECLAC	Economic Commission for Latin America and the Caribbean
EOC	Emergency Operations Center
EPHFs	essential public health Functions
EPI	Expanded Program on Immunization
ERP	Enterprise Resource Planning
EVIPNet	(WHO) Evidence-informed Policy Network
EWI	early warning indicator
EXM	PASB Executive Management
FAO	Food and Agriculture Organization of the United Nations
FBD	food-borne disease
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration (United States)
FDN	(WHO) Global Food-borne Disease Network
FIOCRUZ	Oswaldo Cruz Foundation
FMD	foot-and-mouth disease [*fiebre aftosa* (FA)]

Abbreviation	Description
FTP	fixed-term post
GAVI	Global Alliance for Vaccines and Immunization
GBO	Governing Bodies Office (at PAHO)
GFN	Global Food-borne Disease Network
GITI	Inter-Agency Group on Child Labor
GLAAS	Global Analysis and Assessment of Sanitation and Drinking Water
GPW	(WHO) General Programme of Work
GSHS	Global School-based Student Health Survey
GTSS	Global Tobacco Surveillance System
HAA	Health Agenda for the Americas
HFA	Hyogo Framework for Action
HiAP	Health in All Policies
HIV	human immunodeficiency virus
HIV-DR	HIV drug resistance
HP	Health Promotion
HRH	Human Resources for Health
HSI	Hospital Safety Index
IAWG	Inter-Agency Working Group
IDB	Inter-American Development Bank
IHR	International Health Regulations
IHSDNs	integrated health service delivery networks
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
INFAL	Inter-American Network of Food Analysis Laboratories
INFOSAN	International Food Safety Authorities Network
IPSAS	International Public Sector Accounting Standards
IT	information technology
IVT	International Verification Team
LAC	Latin America and the Caribbean
LF	lymphatic filariasis
LIHP	Leaders in International Health
MCIF	Master Capital Investment Fund
MDGs	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results (used in MEASURE-Evaluation)
MERCOSUR	Southern Common Market
MH	mental health
MMR	maternal mortality rate
MoH	Ministry of Health
MOSS	Minimum Operating Security Standards
MSM	men who have sex with men
MTCT	mother-to-child transmission

Abbreviation	Description
NCD	noncommunicable disease
NGO	nongovernmental organization
NID	neglected infectious disease
NIPs	National Immunization Programs
NORAD	Norway Development Agency
NRA	National Regulatory Authority
NTD	neglected tropical disease
NVC	National Voluntary Contributions
OCPC	Office of Caribbean Program Coordination
OAS	Organization of American States
OCR	Outbreak Crisis and Response
OECD	Organisation for Economic Co-operation and Development
ORAS-CONHU	Andean Health Organization–Hipólito Unanue Agreement
OS	other sources
OSERs	Office-specific Expected Results
PAFNCD	Pan American Forum for Action on NCDs
PAHEF	Pan American Health and Education Foundation
PAHO	Pan American Health Organization
PALTEX	Expanded Program on Textbooks and Instructional Materials
PANAFTOSA	Pan American Foot and Mouth Disease Center
PANDHR	Pan American Network for Drug Regulatory Harmonization
PASB	Pan American Sanitary Bureau
PB	Program and Budget
PDNA	post-disaster needs assessment
PEP	post-exposure prophylaxis
PHC	primary health care
PMA	Performance Monitoring and Assessment
PMIS	PAHO Management Information System
PMMHS	Productive Management Methodology for Health Services
PoA	Plan of Action
RB	Regular Budget
RBM	results-based management
RELACSIS	Latin American and Caribbean Network for Health Information Systems
REMSA	Meeting of Ministers of Health of the Andean Region
RER	Region-wide Expected Result
RPBP	Regional Program Budget Policy
RS	road safety
SCH	Schistosomiasis
SCS	Subregional Cooperation Strategy
SDGs	Sustainable Development Goals
SDH	social determinants of health
SICA	Central American Integration System

Abbreviation	Description
SIDA	Swedish International Development Agency
SIP	Perinatal Information System
SO	Strategic Objective
SPBA	Subcommittee on Program, Budget, and Administration
SRH	sexual and reproductive health
STH	soil-transmitted helminthiasis
SUS	(Brazil) Unified Health System
TB	tuberculosis
TCC	Technical Cooperation among Countries
UN	United Nations
UNASUR	Council of Ministers of Health of the Union of South American Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDAF	United Nations Development Assistance Framework
UNDG–LAC	United Nations Development Group for Latin America and the Caribbean
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHLM	United Nations High-Level Meeting
USAID	United States Agency for International Development
VC	Voluntary Contribution
VCPH	Virtual Campus of Public Health
VPD	vaccine-preventable disease
WASH	water, sanitation, and hygiene
WHD	World Health Day
WHO	World Health Organization
WHO-AIMS	WHO Assessment Instrument for Mental Health Systems

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