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STRATEGIC PLAN OF THE
PAN AMERICAN HEALTH ORGANIZATION
2014-2019

Amended, September 2017

STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2014-2019

Amended
September 2017

"Championing Health: Sustainable Development and Equity"

Pan American Sanitary Bureau
Regional Office of the World Health Organization
for the Americas

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PAHO STRATEGIC PLAN 2014-2019

I. Foreword by the Director

1. As the Pan American Health Organization (PAHO) renews its commitment to improving the health of the peoples of the Region of the Americas, it builds upon important past achievements, the strengths of its Member States, and the competence of the Pan American Sanitary Bureau (PASB). With many complex challenges at hand and much work to be done, it is my great pleasure to present the Organization's Strategic Plan for the period 2014-2019, entitled ***"Championing Health: Sustainable Development and Equity."*** This ambitious Plan is the product of intensive consultation and collaboration with Member States and staff across the Organization. While ensuring a country focus, it provides a clear direction for the coming years, allowing the Organization to remain in the forefront of efforts to improve the health and quality of life of the Region's peoples.

2. In developing this Plan, the Organization continues to be responsive to Member States and to the Region's public health priorities while ensuring programmatic alignment with the World Health Organization's global health objectives. Furthermore, the Plan defines the accelerated actions required for the final push to achieve the Millennium Development Goals by 2015 and the new strategic interventions required for improving health in the post-2015 development agenda.

3. The Region of the Americas has made sustained progress in addressing the determinants of health and improving the health of its population. Human development indicators are improving, employment income is rising, there is notable progress on reducing poverty and inequality, and significant advances have been made toward achieving universal primary education. All of these factors have a positive impact on health. Together with these social advances, the Region has seen positive trends in health indicators, including declines in infant and maternal mortality, a reduction in HIV morbidity and mortality, falling rates of tuberculosis, and a reduced burden of malaria in countries where that disease is endemic. The elimination from the Region of several neglected infectious diseases is within reach, an achievement that will benefit future generations.

4. While we celebrate these important milestones, we all recognize that much remains to be accomplished. This Plan details how the Organization, together with its Member States, will build upon our collective successes and address the remaining gaps in an equitable and sustainable manner. For example, an important challenge facing the Region over the next six years is to halt and reverse the epidemic of chronic noncommunicable diseases. Our Member States have shown considerable leadership on this issue, which has dramatic social and economic impacts on individuals, families, communities, and health services, and demands an integrated, multisectoral response. The rights-based approach is fundamental to ensure fairness and equity in these efforts. Attaining universal health coverage is therefore a key commitment embedded in the Strategic Plan.

5. The leadership, involvement, and ownership of the Member States will be critical for the success of this Strategic Plan. Accordingly, the Plan establishes the joint responsibility and commitment of Member States and PASB to support the range of interventions needed to sustain progress and meet new challenges. The Plan also details targets and indicators by which the performance of the Organization (both Secretariat and Member States) will be assessed. In this way, the Plan reflects PAHO's ongoing commitment to a results-based approach, leading to improved efficiency, effectiveness, accountability, and transparency.

6. Through ongoing collaboration and dialogue with the range of stakeholders, we will build upon and implement this Plan together. Our commitment to **sustainable development and health equity** depends upon the Organization's leadership and its ability to build a broad coalition with engaged partners across sectors. The Strategic Plan 2014-2019 recommits PAHO to improve the health of the peoples of the Americas in the years to come.

II. Executive Summary

7. Under the theme "Championing Health: Sustainable Development and Equity," the Pan American Health Organization (PAHO) Strategic Plan ("the Plan") sets out the Organization's strategic direction, based on the collective priorities of its Member States and country focus, and specifies the results to be achieved during the period 2014-2019. The Plan also establishes the commitments made by PAHO Member States and the Pan American Sanitary Bureau (PASB), thus serving as the basis for developing biennial Program and Budgets to implement the Plan.

8. The Plan is a product of extensive collaboration and consultation between Member States and PASB. A Member States Countries Consultative Group, appointed by PAHO's Executive Committee (EC), provided strategic and technical input in the crafting of the Plan and its first Program and Budget (PB 2014-2015). National consultations were also conducted, enabling all countries and territories to provide their input to the documents to be presented to the Directing Council. More than 1,100 health professionals participated from 48 countries and territories across the Region. Member States and PASB will work jointly over the next six years to deliver the results set forth in the Plan.

9. The Plan responds to both regional and global mandates. As a result, its strategic agenda represents a balance between PAHO's response to the regional priorities established in the Health Agenda for the Americas 2008-2017, other regional mandates set by PAHO Member States, the collective national priorities identified in PAHO's Country Cooperation Strategies (CCS), and the programmatic alignment with the General Programme of Work (GPW) of the World Health Organization (WHO). The Plan is also consistent with the parameters of the main intergovernmental agreements for development operations of the United Nations system. The development and implementation of the Plan are guided by PAHO's vision, mission, values, and core functions.

10. This Plan will enable PAHO to build on the public health gains achieved in the Region and on lessons learned from previous planning periods to guide interventions that address new and existing challenges. The Plan will support the continuing effort to increase the accountability, transparency, and effectiveness of PAHO's work in line with its Results-based Management (RBM) framework and the new PAHO Budget Policy.

11. The Plan adapts the WHO results chain, clearly identifying the relationship between planning instruments at different levels as well as the accountability and respective responsibilities of the PAHO Member States and PASB. Because the Plan is a joint commitment of PAHO Member States and PASB, results will be derived from the implementation of individual countries' plans and strategies (at national or subnational level), PASB operational plans, and the collective efforts of the Organization in collaboration with other partners.

12. An analysis of the leading health gains, gaps, and trends in the Region was the basis for defining the strategic agenda and corresponding interventions outlined in the Plan. The analysis draws on recent information in Health in the Americas 2012, the Mid-term Evaluation of the Health Agenda for the Americas 2008-2017, a review of the Country Cooperation Strategies, and a review of reports on PAHO's strategies and plans of action, among other sources.

13. With a vision focused on healthy living and well-being, the Plan seeks to catalyze changes in the health system response in the Region that transcend the traditional disease-oriented approach. Toward this end, the Plan addresses emerging health issues linked to current changes in the Region, advances a new development model based on equity and environmental sustainability, and reaffirms health as a key element in sustainable development.

14. The Plan focuses on reducing health inequities, both within and between countries and territories. Specific actions to tackle these inequities include those recommended by the Commission on Social Determinants of Health. A multisectoral approach is at the center of the effort to address the social determinants of health and is applied as a cross-cutting strategic approach in the Plan. Health in All Policies is also a key strategy that emphasizes coordinated planning and interventions across all sectors and between levels of government with a view to influencing the social determinants that are beyond the direct responsibility of the health sector. The Plan also outlines key public health strategies, such as health promotion, primary health care, and social protection in health.

15. In line with PAHO's commitment to advancing universal health, and in light of achievements by Member States toward this goal, the Plan embraces the progressive realization of universal access to health and universal health coverage as a central approach. This will enable the Region to consolidate advances in maternal and child health and control of communicable diseases, reduce the burden of chronic diseases with innovative models of care that include prevention and health promotion, and reduce gaps in access to and utilization of health services.

16. The Plan highlights four cross-cutting themes (CCTs): gender, equity, human rights, and ethnicity. These programmatic approaches will be applied across all categories and program areas to improve health outcomes and reduce inequities in health. The Plan also makes full use of the new PAHO Budget Policy and the "key countries" concept. In line with the principles of equity and Pan American solidarity, the Plan identifies eight key countries—Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname—where the Organization will place greater emphasis on its technical cooperation to ensure that gaps are closed. Taking into account that countries and territories in the Region have different health situations and needs, the Plan identifies target countries and territories by outcome indicators to focus the Organization's technical cooperation on specific public health issues.

17. Aligned with the impact goals at the global level (as expressed in the WHO 12th GPW 2014-2019), and addressing the specific goals for the Region, the Plan outlines nine impact goals for the period 2014-2019:

I. Improve health and well-being with equity

II. Ensure a healthy start for newborns and infants

III. Ensure safe motherhood

IV. Reduce mortality due to poor quality of health care

V. Improve the health of the adult population with an emphasis on NCDs and risk factors

VI. Reduce mortality due to communicable diseases

VII. Curb premature mortality due to violence, suicides, and accidents among adolescents and young adults (15-24 years of age)

VIII. Eliminate priority communicable diseases in the Region

IX. Prevent death, illness, and disability arising from emergencies

18. The Plan's programmatic structure is organized in six categories and 34 program areas. The 34 program areas represent the *priorities* for the Organization. Most of the program areas were identified by Member States as part of the development of the WHO 12th GPW 2014-2019, with further consultation to reflect regional specificity. The second amended version of the Plan presents revisions that have been made in line with programmatic changes introduced by the WHO emergency management reform presented at the 69th World Health Assembly (May 2016), along with necessary updates to reflect new and emerging priorities. The six categories are as follows:

I. *Communicable diseases:* Reducing the burden of communicable diseases, including HIV/AIDS, sexually transmitted infections, and viral hepatitis; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; vaccine-preventable diseases; and, foodborne diseases, as well as the impact of antimicrobial resistance.

II. *Noncommunicable diseases and risk factors:* Reducing the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of noncommunicable diseases and their risk factors.

III. *Determinants of health and promoting health throughout the life course:* Promoting good health at key stages of life, taking into account the need to address the social determinants of health (societal conditions in which people

are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

IV. *Health systems:* Strengthening health systems based on primary care; focusing health governance and financing toward progressive realization of universal access to health and universal health coverage; organizing people-centered, integrated service delivery; promoting access to and rational use of health technologies; strengthening health information and research systems and the integration of evidence into health policies and health care; facilitating transfer of knowledge and technologies; and developing human resources for health.

V. *Health emergencies:* Reducing mortality, morbidity, and societal disruption resulting from emergencies and disasters through the detection, management, and mitigation of high-threat pathogens, together with all-hazards risk reduction, preparedness, response, and early recovery activities that build resilience and use a multisectoral approach to contribute to health security.

VI. *Leadership, governance, and enabling functions:* Fostering organizational leadership and governance and implementing the enabling functions that are required to maintain the integrity and efficient functioning of the Organization to deliver effectively on its mandates.

19. For each category, the document sets forth the scope, the context by program area, key stakeholders' analysis, strategies for technical cooperation, cross-cutting themes, strategic approaches in health, and assumptions and risks. This is followed by tables presenting outcomes and outcome indicators for each program area within the corresponding category.

20. Recognizing that the Plan will be implemented in a context of limited resources, and responding to the recommendations of Member States to focus the work of the Organization on priorities where PAHO clearly adds value, the Plan establishes a prioritization framework to complement the PAHO Budget Policy.

21. PASB has set out nine overarching leadership priorities to guide its convening and brokering role in relation to the Strategic Plan 2014-2019:

(a) Strengthen the health sector's capacity to address the social determinants of health, utilizing the Health in All Policies strategy and promoting increased community participation and empowerment.

(b) Catalyze the progressive realization of universal access to health and universal health coverage, with emphasis on the eight key countries, including promotion and preventive interventions.

(c) Increase intersectoral and multisectoral action for prevention and care of noncommunicable diseases.

(d) Enhance the core capacities of countries to implement the International Health Regulations of 2005.

(e) Accelerate actions for the elimination of priority communicable diseases in the Region.

(f) Conclude work on the health-related Millennium Development Goals, influence the integration of health in the 2030 Agenda for Sustainable Development, and support countries in the implementation of the health-related Sustainable Development Goals (SDGs).

(g) Strengthen the health sector's capacity to generate information and evidence to measure and demonstrate progress on healthy living and well-being.

(h) Leverage the knowledge and expertise in countries of the Region for the provision of technical cooperation, sharing successful experiences and lessons learned.

(i) Increase accountability, transparency, efficiency, and effectiveness of the Bureau's operations.

22. The Plan outlines the different factors that will be required to ensure its efficient and effective implementation, including strategies for technical cooperation, roles and responsibilities of PASB and Member States, funding of the Plan (using a programmatic approach to mobilize flexible resources), and risk management.

23. The Plan also includes the Organization's monitoring, assessment, and reporting framework for 2014-2019. PAHO's performance will be assessed by measuring progress toward the attainment of the impact goals and outcomes set out in the Strategic Plan 2014-2019, using 26 impact indicators and 90 outcome indicators and corresponding targets. Performance will also be assessed under each Program and Budget through the assessment of output indicators.

III. Introduction

24. The Pan American Health Organization (PAHO) Strategic Plan ("the Plan") is the Organization's highest-level planning instrument, as approved by its Governing Bodies. The Plan sets out the Organization's strategic direction, based on the collective priorities of its Member States, and specifies the results to be achieved during the planning period. The Plan also establishes the commitments made by the PAHO Member States and the Pan American Sanitary Bureau (PASB), thus serving as the basis for developing the biennial Program and Budgets to implement the Plan. The Plan is country- focused and a product of collaboration and consultation with Member States and incorporates contributions of staff at all levels of PASB.

25. The PAHO Strategic Plan 2014-2019 responds to both regional and global mandates. As a result, its strategic agenda represents a balance between PAHO's responses to the regional priorities established in the Health Agenda for the Americas (HAA) 2008-2017, other regional mandates set by PAHO Member States, the collective national priorities identified in analyses of PAHO's Country Cooperation Strategies (CCS), and programmatic alignment with the General Programme of Work (GPW) of the World Health Organization (WHO). The Plan is also consistent with the parameters of the main intergovernmental agreements for development operations of the United Nations (UN) system. The development and implementation of the Plan are guided by PAHO's vision, mission, values, and core functions. The Plan lays down the framework for championing health, sustainable development, and equity, and for advancing toward the goal of universal health coverage. It incorporates the determinants of health as an all-encompassing theme that cuts across all its components.

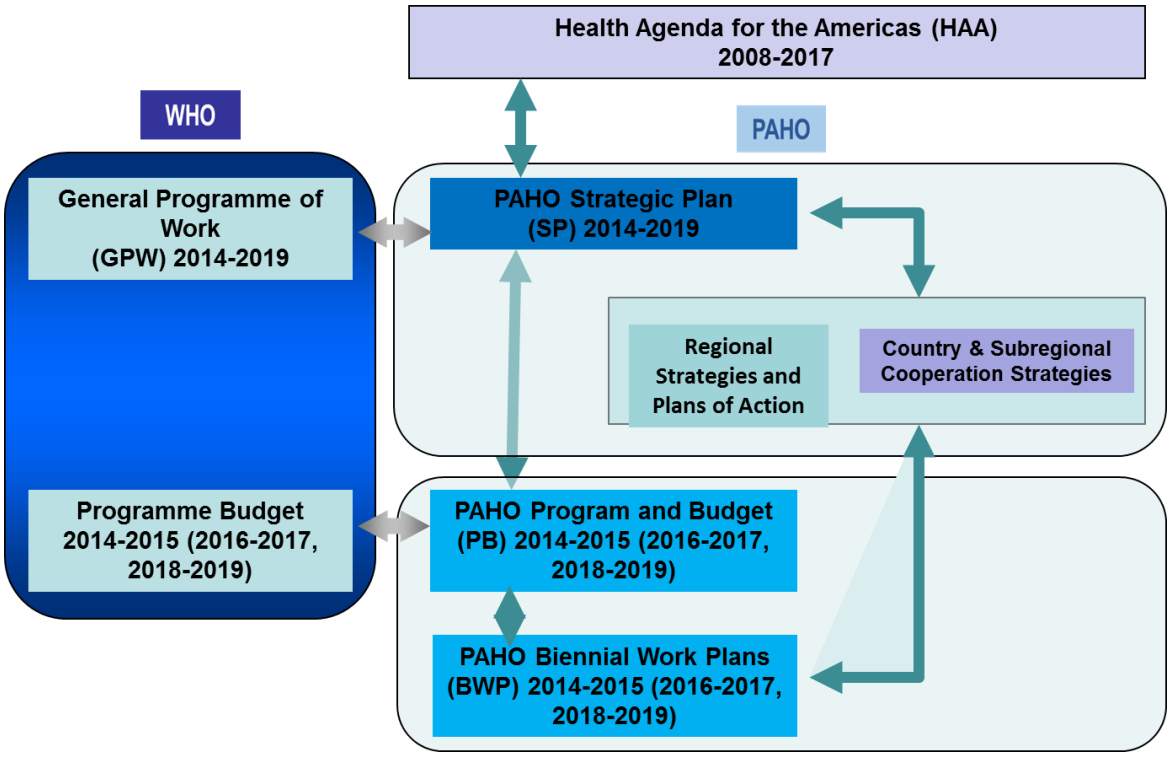
26. The Strategic Plan 2014-2019 will enable PAHO to continue building on the public health gains achieved thus far in the Region of the Americas ("the Region"). It will also enable PAHO to guide interventions that address both new and existing challenges affecting the Region. The Plan will continue to build on PAHO's rich experiences and on lessons learned during previous planning periods. It will support the continuing effort to increase the accountability, transparency, and effectiveness of PAHO's work, in line with its Results-based Management (RBM) framework and the new PAHO Budget Policy.

27. The Strategic Plan 2014-2019 represents an important milestone in enhancing the alignment and synchronization with WHO planning, programming, and budgeting processes, given that—for the very first time—WHO's GPW has been developed prior to PAHO's Strategic Plan. The Plan also benefitted from input provided by the Mid-term Evaluation of the Health Agenda for the Americas that was conducted in 2012. Furthermore, the Strategic Plan 2014-2019 is shaped by the vision of the new PASB Director, "Championing Health in the Americas: Sustainable Development and Equity"; by the push toward achieving the Millennium Development Goals (MDGs); and by the role of health in the new 2030 Agenda for Sustainable Development. Other key inputs include a review of regional public health strategies and plans of action. The Plan will also contribute to strengthening the United Nations development system in line with the

Quadrennial Comprehensive Policy Review of operational activities for development of the United Nations system (A/67/226).

28. Figure 1 shows the key elements of PAHO planning frameworks and their alignment with the Health Agenda for the Americas 2008-2017 as well as with WHO's planning frameworks. The Strategic Plan 2014-2019 will be implemented over the course of three consecutive programs and budgets (2014-2015, 2016-2017, and 2018-2019). Increased alignment and harmonization between the Strategic Plan and the CCSs is an important aspect of the formulation and implementation of the Plan. The Biennial Work Plans (BWPs) are operational plans developed by PASB entities to implement the Program and Budget, and by extension the PAHO Strategic Plan.

Figure 1. PAHO and WHO Planning Frameworks

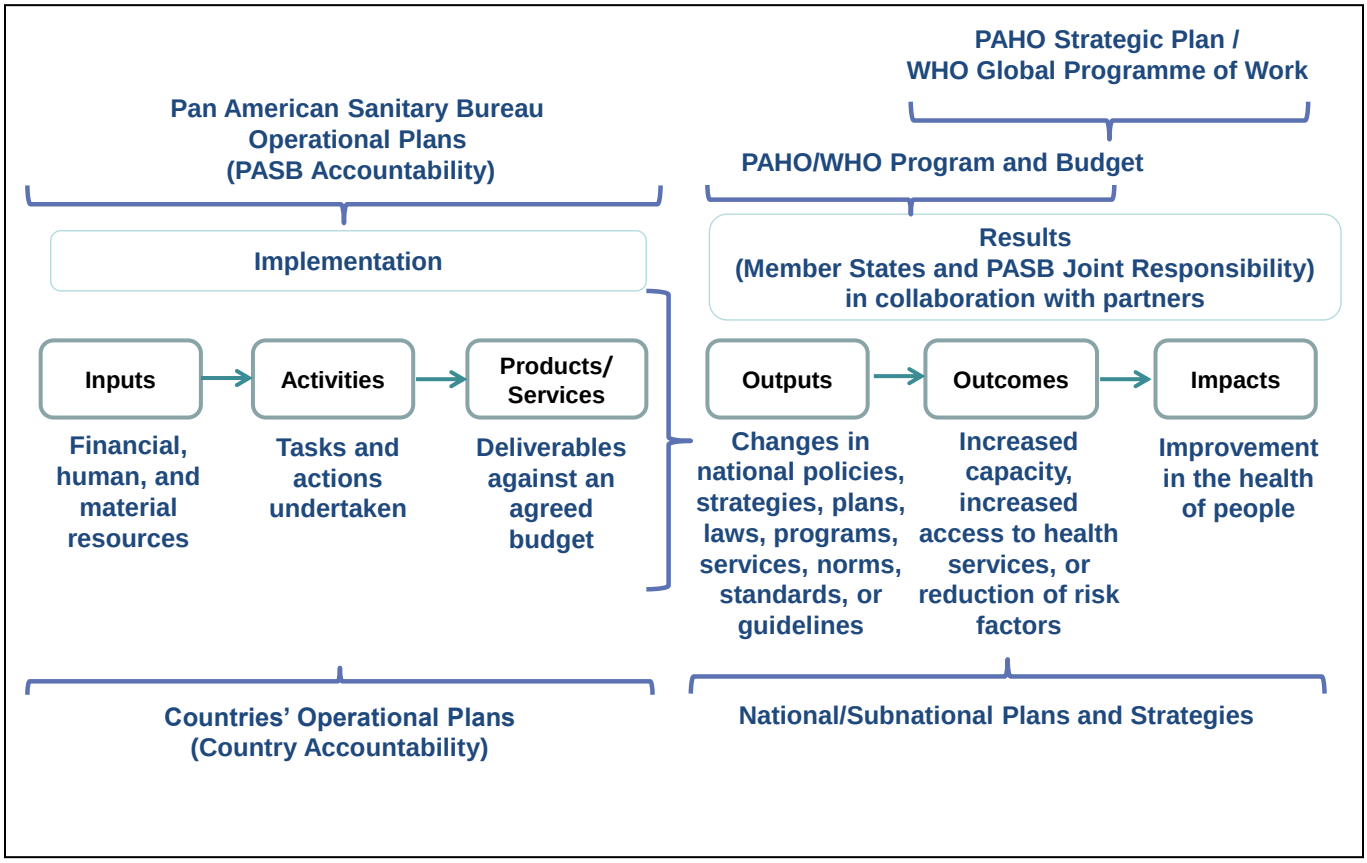


29. **Results chain:** The Strategic Plan 2014-2019 adapts the WHO results chain, clearly identifying the relationship between planning instruments at different levels as well as the accountability and respective responsibilities of PAHO Member States and PASB. Because the Plan is a joint commitment of PAHO Member States and PASB, results will be derived from the implementation of individual countries' plans and strategies (at national or subnational level), PASB operational plans, and the collective efforts of the Organization, as shown in Figure 2. Section VIII includes details on monitoring, reporting, accountability, and transparency for the Plan.

30. The Strategic Plan and the Program and Budget together cover the complete chain of results. The Strategic Plan contains impact and outcome results with their respective

indicators, while the PB outlines the outputs that Member States and PASB agree jointly to achieve in a particular biennium, as well as the biennial outcome indicator targets.

Figure 2. PAHO/WHO Results Chain



31. **Impacts** are sustainable changes in the health of populations, to which PAHO Member States, PASB, and other partners contribute. Such changes will be assessed through impact indicators that reflect a reduction in morbidity or mortality or improvements in well-being of the population (e.g., increases in people's healthy life expectancy). Consequently, implementing the PAHO Strategic Plan will also contribute to both regional and global health and development.

32. **Outcomes** are collective or individual changes in the factors that affect the health of populations, to which the work of the Member States and PASB will contribute. These include, but are not limited to, increased capacity, increased service coverage or access to services, and/or reduction of health-related risks. Member States are responsible for achieving outcomes, in collaboration with PASB and other PAHO partners. The outcomes contribute to the Plan's impact goals. Progress made toward achieving outcomes will be assessed with corresponding indicators that measure changes at national or regional level.

33. **Outputs** are changes in national systems, services, and tools derived from the collaboration between PASB and PAHO Member States, for which they are jointly responsible. These outputs include, but are not limited to, changes in national policies, strategies, plans, laws, programs, services, norms, standards, and/or guidelines. The outputs will be defined in the respective PB and will be assessed with a defined set of output indicators that will measure PASB's ability to influence such changes.

34. For Category 6 (Leadership, Governance, and Enabling Functions), the outputs and outcomes will reflect institutional changes that support the efficient and effective delivery of technical cooperation by the Organization in the other five programmatic categories.

35. PASB **operational plans** include the following components:

(a) Products and services: deliverables against an agreed budget for which PASB is directly accountable during the biennium. Products and services are tangible and observable.

(b) Activities: actions that turn inputs into products or services.

(c) Inputs: resources (human, financial, material and other) that PASB will allocate to activities and that produce products or services.

36. The operational planning components are necessary in order to achieve the outputs and contribute to the outcomes and impacts. PASB operational planning components are not included in the Organization's PB; they are included in the operational plans of the different PASB entities (offices, departments, or units) Member States participate directly in PASB operational planning process through the PAHO/WHO Representative Offices.

37. **Risks and assumptions:** The full results chain is predicated upon a number of risks and assumptions. For example, they include the premise that resources and country collaboration are in place to ensure that interventions contribute to and achieve the outputs and outcomes as outlined in the Plan. This will contribute to the realization of the impact results and by extension the strategic vision of the Plan.

38. **Lessons learned:** The PAHO Strategic Plan 2014-2019 builds on experiences and lessons learned from previous plans, programs, budgets, and other high-level planning instruments and processes, including those of WHO. Particular emphasis has been placed on the lessons learned from the PAHO Strategic Plan 2008-2013, given that this was the first plan to have been implemented using the Results-based Management approach and the first to be aligned with WHO's planning and budgeting processes. The application of these lessons will be essential for the successful implementation of the Plan and for continuing improvement in the efficient and effective management of the Organization. Key lessons learned are outlined below, and Annex I includes additional details.

(a) Increased ownership and involvement of Member States in the development and implementation of the Plan, particularly in setting priorities and targets, is critical for successful implementation of the Plan.

(b) Implementation of all aspects of the RBM framework is necessary and should be accompanied by simplification of processes, improvements in the quality of indicators, delegation of authority, and mechanisms for accountability.

(c) Enhanced programmatic alignment with WHO will facilitate better program management, optimization of resources, and improved monitoring and reporting processes.

(d) Greater coherence is needed between the Strategic Plan and the different planning frameworks, including the CCSs and regional plans and strategies.

(e) Allocation of resources should be improved, according to programmatic priorities and using objective prioritization criteria and methodology.

(f) A basic level of funding for country presence, as addressed in the new Budget Policy, should be ensured by the Organization in order to effectively deliver technical cooperation programs to Member States.

(g) National Voluntary Contributions should be included in the Program and Budget to provide a full appreciation of the contribution of the Member States to the work of the Organization.

(h) Efforts to increase efficiencies should be continued, including through cost containment measures, use of technology and innovation, and new modalities of technical cooperation.

IV. The Context

39. Over the past decade the Region of the Americas has made sustained progress in improving the health of its population, but it still faces important gaps and emerging issues that countries are attempting to solve both individually and collectively. This analysis highlights the leading health gains, gaps, and trends in the Region as the basis for defining the strategic agenda and corresponding interventions outlined in the Strategic Plan 2014-2019. The analysis draws on recent information in Health in the Americas 2012, the Mid-term Evaluation of the Health Agenda for the Americas 2008-2017, a review of the Country Cooperation Strategies (CCS), and a review of reports on PAHO's strategies and plans of action, among other sources.

Political, Economic, Social, and Environmental Context

40. The Region continues to move toward greater **democracy**, with notable progress in a number of areas. Countries are undertaking reviews of their constitutional frameworks and initiating more transparent electoral and participatory processes. There is a gradual trend from electoral democracy toward participatory democracy, with growing decentralization, greater community empowerment, redistribution of power, and new concepts of citizenship.

41. Countries of the Region are participating in various alliances, initiatives, and blocs based on geographic proximity and/or on shared commercial, cultural, or political interests. Countries are playing a more prominent role in global strategic blocs such as the Organisation for Economic Co-operation and Development (OECD), the Group of 20 (G20), the forum for Asia-Pacific Economic Cooperation (APEC), and the BRICS group (Brazil, Russia, India, China, and South Africa). Furthermore, new partnerships and forums have recently emerged within the Region, including the Bolivarian Alliance for the Peoples of Our America (known by its Spanish acronym, ALBA), the Union of South American Nations (UNASUR), and the Community of Latin American and Caribbean States, which coexist with older regional and subregional entities.

42. There is a shift in the communications environment in the Region, driven by the rapid expansion of Internet access, growing use of mobile communications, and increased access to online information and services. New and emerging methods of communication emphasize interactive platforms, two-way communication, and the sharing of content, news, and feedback. Increasing time is spent on social networking sites, especially among women, and social media are redefining the way we think about communication in the area of health and health risks. While these trends offer new opportunities to communicate, learn, and exchange information, they are also influencing changes in culture, lifestyles, behavior, and consumption patterns, with direct impact on people's health.

43. Since the 1990s, Latin American and Caribbean countries have made structural changes that include adjustments to social security, trade, tax, and finance programs. In

some cases these have included massive privatizations. These changes have not always been coupled with public investments in health, education, infrastructure, and environmental protection. This highlights the need for structural changes that increase support to and harmonization of these vital sectors. Although still controversial, evidence suggests that public investments in the health and human capital of poor people have contributed substantially to reducing poverty in many Latin American countries.

44. Countries of the Region are becoming increasingly integrated into the global economy, a process that is considered to hold potential benefits for Latin America. Although Latin American countries did not escape the effects of the global economic and financial recession, they weathered the crisis more successfully than other regions of the world, showing faster signs of recovery. Between 2008 and 2010, most of the Region's countries implemented anticyclical economic policies to counteract and mitigate the cycle. Such measures protected, and in some cases even expanded, public social spending. Of particular note are conditional cash transfer programs, which by 2010 amounted to 3% of total gross domestic product (GDP) in Latin American countries.

45. Due to the unfavorable international context, economic growth in Latin America and the Caribbean slowed during 2012, although the positive trend continues. Regional GDP grew by an estimated 3.1% in 2012, about 1 percentage point lower than in the preceding year. The slowdown affected most of the South American countries, whose GDP growth was estimated at 2.7% in 2012 (1.8 percentage points less than the 4.5% registered in 2011). By contrast, the countries of Central America registered a growth rate similar to the preceding year, while the Caribbean showed slightly higher growth. This lower performance of the largest economies in South America decisively influenced the regional trend. Despite the slowdown of GDP growth in the Region, most of the countries maintained a positive growth rate, which is mainly explained by the dynamics of domestic demand and, to some extent, by the relatively favorable performance of investments and exports in some countries.

Social Determinants of Health

46. Income, employment situation, education, and housing are among the most relevant social determinants of health, with influence on other intermediate and proximal determinants of health.

47. Human development indicators are improving in the Region. Between 2000 and 2012, the Human Development Index (HDI) value increased from 0.683 to 0.741 in Latin America, 0.632 to 0.687 in the Caribbean, and 0.906 to 0.935 in North America. Latin America has reached what the United Nations Development Programme (UNDP) considers to be a high level of human development (0.711). However, differences still exist within and between countries, as shown by the lower HDI figures for the Caribbean countries.

48. Despite these encouraging indicators, **poverty and inequities** continue to be challenges for the Region. Some recent evidence qualifies Latin America and the Caribbean (LAC) as the most inequitable region in the world, with 29% of the population below the poverty line and the poorest 40% of the population receiving less than 15% of total income. On the other hand, evidence points toward an overall reduction in income inequality. During the first decade of this century, income inequality declined in most Latin American countries.

49. Despite the level of macroeconomic stabilization, there is recognition of the need to intensify reforms in certain critical areas—fiscal, labor, and social protection, among others.

50. The increase in **employment income** and the effect of redistributive income policies implemented through programs that provide progressive and sustained conditional cash transfers to the most vulnerable groups have had a positive impact on poverty and inequality levels in the Region.

51. The overall unemployment rate decreased for women and men in most countries of LAC in 2012. However, gender gaps persist in employment, as unemployment among women continues to be 1.4 times the male unemployment rate. By the third quarter of 2012, the regional unemployment rate was 7.7% for women and 5.6% for men. A decline was also observed in the unemployment rate for young people, which moved from 15.2% to 14.3%. Despite this progress, there are still concerns about the exclusion of young people from the labor market, as youth unemployment is triple that of the adult population.

52. **Payroll employment** continued to grow more vigorously than self-employment in some of the countries, which is an indication of labor market modernization and the growth of the formal sector in these countries. Nonetheless, informal employment remains important in many countries. Consideration has to be given to the quality of employment and workplace conditions in both the formal and informal sectors.

53. **Education** and health are interrelated cornerstones of development. A boost in educational levels is associated with improvements in population health and increases in productivity, social mobility, poverty reduction, and citizenship building. In LAC, significant advances have been made toward achieving universal primary education. By 2010 such coverage reached 95%, with some countries having up to 99%. The school lag—measured by the number of girls and boys who drop out of primary school or do not finish their last year in the period assigned—is very important for the health sector. Adolescent pregnancy is most concentrated among girls who have dropped out of school, and the highest child mortality and morbidity rates are seen in children born to adolescent mothers. Various studies find that completing secondary education constitutes the bare minimum of schooling that a person needs to improve his or her living conditions.

54. **Gender equity and ethnic equity** are increasingly a part of the political agendas of many of the Region's countries. There has been greater empowerment and recognition of the rights and contributions of women, of indigenous and Afro-descendant populations, and of groups of diverse sexual orientation, including lesbians, gays, and transgender persons. In particular, more women have assumed leadership positions: in 2011, five of the Region's countries were governed by women. However, the number of women who hold elected positions at all levels is still insufficient, as only about 20% of such posts in LAC were filled by women in 2010.

55. In LAC, women account for the majority of caregivers (90%) to the elderly. They shoulder a physical and economic burden that is not remunerated or acknowledged. Available evidence indicates that with the aging of the population, the epidemic increase in chronic diseases and disability, and the limited institutional response, women's unremunerated workload in providing elder care will continue to rise.

56. Poverty reduction programs have promoted women's greater control over their resources, including access to health care and education. In the Region of the Americas, women as a group have surpassed men in terms of schooling. However, these gains are not fully reflected in economic well-being, especially in terms of wages, where women continue to lag behind men.

57. Some 1,100 indigenous groups live in the Region. Indigenous people represent 10% of the total population in LAC, 4% in Canada, and 1.6% in the United States. Regardless of their country of residence, indigenous and other ethnic groups, along with Afro-descendants, suffer varying degrees of social exclusion and vulnerability. According to the World Bank, some of these populations receive only 46% to 60% of what nonindigenous populations earn. Given the current levels of poverty and social exclusion among discriminated ethnic groups, it can be expected that negative impacts on health will persist across generations.

Demographic Trends

58. Between 2005 and 2012, the Region's **total population** rose from 886 million to 954 million inhabitants. However, a relative deceleration in demographic expansion is underway. From 1.3% in 1995-2000, average annual population growth at the regional level dropped to 1% in 2005-2012.

59. Between 2005 and 2012, the Region's **total mortality rate** declined, from 6.9 to 5.9 per 1,000 population. The total fertility rate for the same period dropped from 2.3 to 2.1 children per woman. Demographic changes show different evolutionary gradients from country to country.

60. Between 2005 and 2012, **life expectancy** in the Americas for both sexes is estimated to have risen from 72.2 to 76.4 years—a four-year increase in one decade—

with an additional increase of 6.5 years projected for 2050. However, significant differences between countries persist.

61. In 2012, more than 100 million people **over 60 years of age** lived in the Region. By 2020 this figure is expected to double, and more than half of these people will live in Latin America and the Caribbean. Consequently, total dependency ratios are increasing. In 2010, the estimated total dependency ratio in LAC was 53.3, while in North America it was 49.0. By 2050, these figures are expected to rise to 57.0 and 67.1, respectively. In 2010, the highest proportion of dependency in the Region occurred among lower-income populations—which, in a pessimistic scenario, could help perpetuate the cycle of poverty.

62. Latin American countries without exception have an advantageous demographic situation for economic development, the so-called **demographic bonus.** The first phase of this process is characterized by a ratio of more than two dependents for every three economically active persons. In the second phase, regarded as the most favorable, the dependency ratio reaches a low level of fewer than two dependents per three active persons and remains steady. In the third phase the ratio is still favorable, with fewer than two dependents per three active persons, but it is changing because of the increasing number of old people. Overall, Latin America is in the second phase. This phase started by the beginning of the 21st century and is expected to last until the end of the 2011-2020 decade, when the third phase is expected to start and extend to the early 2040s.

Health and Environment

63. In tandem with population growth, **urbanization** is having a direct influence on the environment and its sustainability. Almost 80 percent of the LAC population lives in urban areas, but there are considerable variations within the Region, across subregions and countries. Countries and territories with highly urbanized populations (over 77%) include Anguilla, Argentina, Bermuda, Brazil, Canada, Cayman Islands, Chile, Guadeloupe, Mexico, Peru, Puerto Rico, United States, Uruguay, U.S. Virgin Islands, and Venezuela. Those with low urbanization (below 50%) include Antigua and Barbuda, Aruba, Barbados, British Virgin Islands, Grenada, Guatemala, Guyana, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago.

64. The Region of the Americas has already reached the Millennium Development Goal for access to improved **drinking water** sources and **basic sanitation** and is on track to reach the sanitation target for 2015. However, marked inequalities persist within and between countries. While addressing inequalities in access to drinking water and basic sanitation, the Region also needs to tackle other environmental issues with a direct impact on health:

(a) **Solid waste** management remains a concern. Hazardous waste without prior treatment is frequently disposed of alongside common waste in many LAC countries.

(b) Regarding ambient and indoor **air pollution**, it is estimated that more than 100 million people in the Region are exposed to concentrations of environmental contaminants exceeding the recommended limits in WHO air quality guidelines. Indoor air pollution from the burning of solid fuels is the environmental risk with the greatest disease burden in LAC.

(c) **Pesticide contamination** is a prevalent problem in the Region. It has been most extensively documented in Central America, where 33 million kilos of active ingredient were imported each year between 1977 and 2006. Seventy-seven percent of these are persistent organic pollutants that should be eliminated, according to the Stockholm Convention.

(d) Control and management of **chemical risks** is particularly related to the growth of mining activity. In Latin America, mining increased from 4.3% of regional GDP in 2001 to 6.1% in 2011. Although the expansion of mining is positive from an economic point of view, it has direct and indirect impacts on health and the environment that can result in higher costs to public health. This means that impact assessments are essential.

65. Vulnerability to **natural disasters** and the effects of **climate change** is a global problem. Of the 63 cities in LAC with one million or more inhabitants, 38 are in areas at greatest risk for at least one type of natural disaster. Many populations in situations of socioeconomic vulnerability are settled on lands that are potentially affected by climate change. Higher rainfall caused by extreme weather phenomena connected to climate change leads to increased deposits of chemical contaminants such as nutrients and fertilizers in coastal zones, supporting the proliferation of toxic algal blooms. These changes have implications for food and nutrition security and safety and for safe drinking water, as well as for the prevalence of vector-borne diseases.

Regional Health

66. Given the 2015 target date for the **MDGs**, 84% of the time for achieving these goals has already passed. The Region has made progress but challenges remain, mostly related to inequities in health within and between countries.

(a) **Infant mortality** continues to decline in the Region. In Latin America and the Caribbean, the Infant Mortality Rate (IMR) fell from 42 per 1,000 live births in 1990 to 16 per 1,000 in 2011, a 62% reduction. Even lower IMRs are observed in Barbados, Canada, Chile, Costa Rica, Cuba, the United States, and Uruguay (5 to 12 per 1,000 live births), while the highest rates are in Bolivia and Haiti (40 to 45 per 1,000 live births).

(b) **Maternal mortality** has declined in the Region but remains too high. Many countries will fail to meet the MDG target by 2015. The regional Maternal Mortality Ratio (MMR) declined from 140 per 100,000 live births in 1990 to 80 in 2010, a 41% reduction. However, the trends differ between countries. The leading causes of maternal mortality remain associated with quality of care.

(c) Estimates of new **HIV infections** in the countries of the Region reflect a reduction in morbidity and mortality. In 2011, the Region accounted for nearly 6% of all new HIV infections worldwide. Certain populations face higher deleterious impact, including men who have sex with men (MSM), sex workers, and mobile populations.

(d) Between 2000 and 2011, the Region reported a 58% reduction in morbidity and a 70% reduction in mortality from **malaria**. The majority of countries with endemic malaria have successfully reduced the disease burden, but challenges remain.

(e) Member States have made progress in **tuberculosis** (TB) control. In 2011 the detection rate was 81% of the cases estimated by WHO for the Region of the Americas. Despite this progress, multidrug-resistant tuberculosis and HIV-associated tuberculosis pose serious challenges that must be addressed. TB control is hindered by the persistence of social inequities and vulnerabilities, notably poverty, migration, and limited access to health services, especially among vulnerable populations such as drug users, homeless, mentally ill, and ethnic minorities.

(f) Regarding sustainable access to **safe water and basic sanitation**, access to improved water sources was 96% in the Region in 2010 (99% in urban areas and 86% in rural areas). Coverage of improved basic sanitation was at 88% (91% in urban areas and 74% in rural areas). However, concerns about water quality continue; as of 2010, 36 million people in the Region did not have access to drinking water fit for human consumption. Approximately 120 million lacked improved wastewater and sewage disposal services, and nearly 25 million people in LAC defecate outdoors. Low safe water and sanitation coverage tends to be observed among people in lower income quintiles. Water, sanitation, and hygiene, particularly for the most vulnerable populations, needs ongoing support.

67. The Region faces an important burden of **noncommunicable diseases** (NCDs), with an estimated 250 million people suffering from at least one of them. In 2010, more than 75% of health care costs were due to chronic conditions.

(a) **Cardiovascular diseases** (CVDs) are the leading cause of death from NCDs. Premature deaths from CVDs are more frequent among men than women and occur at the age of greatest productivity, causing severe economic and social damage.

(b) **Malignant neoplasms** are the second leading cause of death in the countries of the Americas. Cancers of the lung, stomach, colon, and breast are the leading contributors to cancer mortality. Incidence of cancers, particularly cervical and prostate cancers, is highest in low- and middle-income countries. The incidence of malignant neoplasms depends on complex interrelationships among biological, genetic, and lifestyle factors.

(c) **Diabetes mellitus** causes around 242,000 deaths annually in the Region. Studies estimate that 22,000 of these deaths (8%) could be avoided through early

detection and treatment, especially in people younger than 50 years of age. Forecasts indicate that the number of people with diabetes in the Americas will increase from 62.8 million in 2011 to over 91 million in 2030.

(d) **Chronic kidney disease** (CKD), caused mainly by complications of diabetes and hypertension, has increased in the Region. From 1990 to 2010, disability-adjusted life years (DALYs) due to CKD increased 20% in the United States and 58% in LAC. Many Central American countries have recognized the need to better understand and control a severe type of CKD that is unrelated to diabetes and hypertension. This severe disease primarily affects young men working in the agricultural sector, a situation that is having a dramatic social and economic impact on families, communities, and health services.

68. Shared **risk factors** for NCDs are tobacco consumption, harmful use of alcohol, unhealthy diet, and physical inactivity. Of particular concern are the rapid and deleterious changes taking place in food consumption and eating habits across the Region. These shifts affect broad sectors of the population, especially low-income and less-educated people. Serious efforts to address the risk factors must undergird the effort to halt NCDs.

69. **Violence**, including gender-based violence, is a growing problem and a major public health challenge in the Region. Between 1999 and 2009, it is estimated that over 5.5 million people died from external causes (those distinct from natural causes and recognized as avoidable, including homicides, accidents, and suicides). Three and a half million of these deaths (64%), an average of 319,000 per year, occurred among youth and adults 10-49 years of age. Of total deaths from external causes, 84% were among males, five times more than among women. The most frequent external causes were homicides (33%) and land transport accidents (26%).

The Health System Response

70. The Region's health systems are characterized by their segmentation, manifested by a variety of financing and affiliation mechanisms. The supply of health services is also fragmented, with many different institutions, facilities, or units that are not integrated into the health care network. Both of these characteristics increase the inequity in access and reduce efficiency in health care delivery and service management.

71. The underlying reasons for this segmentation and fragmentation are complex. They frequently reflect systemic factors of a social, political, and economic nature that have been accumulating over time. In this context, the health services themselves become an important health determinant. Health services have the potential to help improve equity insofar as they advance universal coverage financed through progressive public resources that reduce out-of-pocket expenditures to a minimum and eliminate discriminatory practices and differential quality of care.

72. In recent years, the Region's countries have progressed toward the **universalization of health systems** through policy reforms and changes that emphasize

the right to health and the reaffirmation of **primary health care** (PHC). The importance of effectively implementing the values and principles of the PHC strategy, particularly through comprehensive and multisectoral approaches to address the determinants of health, is widely recognized. Nonetheless, several challenges persist, particularly with respect to how to advance toward comprehensive service coverage, reduce copayments and other out-of-pocket expenses, and guarantee similar benefits to all. Other important challenges include improvements to the quality of care and tailoring the response capacity of the services to health care demand.

73. The Region has reaffirmed the primary health care strategy and the goal of Health for All, and several countries of the Region are making substantive efforts to incorporate PHC into their renewed health care models. In some countries, however, PHC practice has been limited to offering first-level care, frequently to low-income groups, with only a few health promotion and preventive activities. Such an approach compromises the response capacity during health crises.

74. The most recent period has been characterized by a sustained dynamism in developing **human resources** policies, strategies, and plans in tune with global, regional, and national priorities. There is broad consensus in the Region on the steering role of the health authority for strengthening human resources. This implies seeking strategic coherence in the organization of health systems and services while building a close relationship with training institutions. This approach has brought about an effective expansion of coverage through multidisciplinary family and community health teams, which are responsible for a given population and territory in rural, urban, outlying, and remote areas. Although the countries of the Region have made progress in the area of human resources for health (HRH), they have not yet achieved a satisfactory composition or distribution of their health workforce.

75. Throughout the history of LAC, expanding health service coverage has been the main objective for several countries. Evidence indicates, however, that **quality of care** is also pivotal for maintaining and improving individual and population health.

76. From 2005 to 2010, **total health expenditure** in LAC as a percentage of GDP rose from 6.8% to 7.3%. During the same period, average public health expenditure in LAC increased from 3.3% to 4.1% of GDP. Expenditure was significantly higher in Canada (8.4% of GDP) and the United States (8.0% of GDP) in 2010.

77. In 2010, **total per capita health expenditure** ranged from US$ 90[1] in Bolivia to $2,711 in the Bahamas, $5,499 in Canada, and $8,463 in the United States. Although per capita expenditure is relevant, no linear relationship exists between the amount spent and health outcomes. Other variables also carry great weight, among them social protection policies (or lack thereof), health system management and organization, the scope of

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

public health programs and health promotion activities, and regulation of the health market.

78. **Out-of-pocket** health expenditures in LAC dropped from 3.5% to 3.2% of GDP from 2005 to 2010. Direct out-of-pocket expenditures have an impoverishing effect on families. Experience indicates that providing universal coverage and pooling funds constitute the best options for protecting families' finances when they face catastrophic medical expenses.

79. Although LAC countries have moved forward in formulating and implementing **pharmaceutical policies** over the past five years, only a few have updated them. In 2008, estimates show that in LAC, average annual per capita out-of-pocket expenditures for medicines amounted to $97, ranging from $7.50 in Bolivia to over $160 in Argentina and Brazil. The use of generic drugs in the Region has not advanced as much as desirable, partly due to limited incentives and inadequate regulatory frameworks.

80. The countries of the Americas differ widely in terms of the coverage and quality of their **health information systems**. A 2008 study revealed that 7 of 26 countries have improved their vital statistics registries, exceeding 85% coverage at the national level. Seven other countries only record up to 50% of these events, or one of every two births or deaths. The low number of births in health facilities in some countries and the limitations of statistical offices make it difficult for countries to improve the recording of vital statistics. In terms of data quality, a recent regional assessment showed that only 19 countries studied provided good data. Regarding vital statistics, a recent analysis in the Region shows that there is a growing awareness of the importance of registering all vital events and that coverage of births tends to rise when *(a)* the country accepts the right to identity as a human right, and *(b)* other sectors of society such as education and health require registration of these vital events. Regarding death registry, the monitoring of the commitments made by the countries to achieve the MDGs, especially in relation to infant and maternal mortality, has motivated countries to increase coverage.

Status of the PAHO Strategic Plan 2008-2013

81. As previously noted, the Strategic Plan 2014-2019 builds upon progress toward the achievement of the objectives and results set forth in the Strategic Plan 2008-2013. The final assessment of the Strategic Plan 2008-2013 revealed that the Organization maintained a consistent implementation rate throughout the three biennia covered by the Plan. By 2013, seven of the 16 Strategic Objectives (SOs) were fully achieved (with 100% of targets met or exceeded) and nine partially achieved. Of the nine partially achieved, eight reached over 75% of their indicator targets; and only one (SO1– communicable diseases) attained less than 75% of its targets. Out of 90 Region-wide Expected Results (RERs), 75 (83%) were fully achieved and 15 were partially achieved. Of the 256 RER indicator targets for 2013, a total of 233 (91%) were reached. Not only were they reached, but 127 of them (54%) were exceeded.

82. The 15 RERs partially achieved were as follows:

1.1 Equitable access to vaccines: challenges with achieving 95% coverage at subnational level.

1.3 Prevention, control, and elimination of neglected diseases and communicable diseases: targets related to leprosy, elimination of human rabies transmitted by dogs, surveillance of preparedness for emerging zoonotic diseases, and domiciliary infestation index not achieved.

1.6 International Health Regulations (IHR) and epidemic alert and response: 6 countries met the requirements and 29 requested extensions.

2.1 Prevention, treatment, and care of HIV/AIDS and TB: ART (antiretroviral therapies) coverage for HIV not achieved; challenges with TB treatment success and low antenatal care and surveillance systems for congenital syphilis.

3.4 Interventions for chronic noncommunicable conditions: target for cost analysis studies on violence not achieved.

6.2 Surveillance of major risk factors: 27 out of 30 countries developed national surveillance systems using the Global School Health Survey to produce routine reports on health risk factors that affect youth.

6.3 Prevention and reduction of tobacco use: 19 out of 23 target countries implemented regulations on the packaging of tobacco products and updated at least one component of their tobacco surveillance system; 5 more countries (out of 35) need to achieve the target.

6.5 Prevention and reduction of unhealthy diets and physical inactivity: there were challenges in advancing national policies to promote healthy diets and physical activity (only 9 out of 20 countries achieved the indicator).

9.4 Nutrition plans and programs: 21 out of 25 target countries reported nutritional interventions in their programs for responding to HIV/AIDS and other epidemics.

10.1 Intercultural health policies: only 5 countries reported progress with integrating intercultural considerations into policies and PHC-based health systems.

11.2 Health information systems: 20 out of 27 target countries implemented the PAHO Core Health Data Initiative.

11.3 Access, dissemination, and utilization of health information, knowledge, and scientific evidence for decision making: target number of countries monitoring the health-related MDGs was not achieved.

11.5 PAHO as the broker for public health information and knowledge: The regional information platform is installed but pending review and adjustment for Phase II implementation/corporate coordination and roll out.

12.1 Access to medical products and health technologies: unrealistic target (17) set for number of countries to achieve 100% voluntary nonremunerated blood donations; 12 out of 17 achieved.

13.2 Basic indicators and information system for HRH: the expected number of countries participating in the HRH Observatories Network was not achieved (29 out of 36 achieved).

**Figure 3. Rating of Strategic Objectives (SOs)
and Region-wide Expected Results (RERs), 2008-2013**



SO 01 Communicable diseases
SO 02 HIV/AIDS, tuberculosis, and malaria
SO 03 Chronic noncommunicable diseases
SO 04 Maternal, child, adolescent, and elderly health
SO 05 Emergencies and disasters
SO 06 Health promotion and risk factors
SO 07 Social and economic determinants of health
SO 08 Healthier environment

SO 09 Nutrition, food safety, and food security
SO 10 Health services
SO 11 Health systems leadership and governance
SO 12 Medical products and technologies
SO 13 Human resources for health
SO 14 Social protection and financing
SO 15 PAHO/WHO leadership and governance
SO 16 Flexible and learning organization

V. Strategic Agenda

Strategic Overview

83. This section constitutes the core of the PAHO Strategic Plan 2014-2019. It sets out the Plan's strategic direction for the Organization over the next six years, guided by PASB's vision, mission, and values and by the Organization's core functions, outlined below.

PASB's Vision, Mission, and Values

Vision

The Pan American Sanitary Bureau will be the major catalyst for ensuring that all the peoples of the Americas enjoy optimal health and contribute to the well-being of their families and communities.

Mission

To lead strategic collaborative efforts among Member States and other partners to promote equity in health, to combat disease, and to improve the quality of, and lengthen, the lives of the peoples of the Americas.

Values

Equity - Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.
Excellence - Achieving the highest quality in what we do.
Solidarity - Promoting shared interests and responsibilities and enabling collective efforts to achieve common goals.
Respect - Embracing the dignity and diversity of individuals, groups, and countries.
Integrity - Assuring transparent, ethical, and accountable performance.

PAHO's Core Functions

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, dissemination, and application of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Establishing technical cooperation, catalyzing change, and building sustainable institutional capacity.
6. Monitoring the health situation and assessing health trends.

84. The Strategic Plan responds to the priorities set out in the Health Agenda for the Americas 2008-2017 and is also aligned with the WHO 12th GPW 2014-2019. It responds to key regional mandates and to countries' collective priorities as identified in the Country Cooperation Strategies and other national strategic documents.

85. Under the theme "Championing Health: Sustainable Development and Equity," the Plan focuses on reducing inequities in health in the Region within and between countries and territories in order to improve health outcomes. In line with this, and with attention to a country focus, the Plan's main strategies: *(a)* promote health and well-being; *(b)* advocate a multisectoral approach aimed at addressing the social determinants of health; and *(c)* foster collaboration with all the countries and territories toward the progressive realization of universal access to health and universal health coverage. Specific strategies are outlined under each category according to PAHO's core functions.

86. PAHO's commitment to equity in health is long-standing and explicit in the Organization's vision, mission, values, and mandates; it is also in line with the Health Agenda for the Americas 2008-2017. The term "inequity" has a moral and ethical dimension, referring to unfair and unjust inequalities that are unnecessary and avoidable. In order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society. Reducing health inequities is a matter of fairness and social justice. The Strategic Plan 2014-2019 clearly articulates the commitment of Member States and PASB to *(a)* reduce health

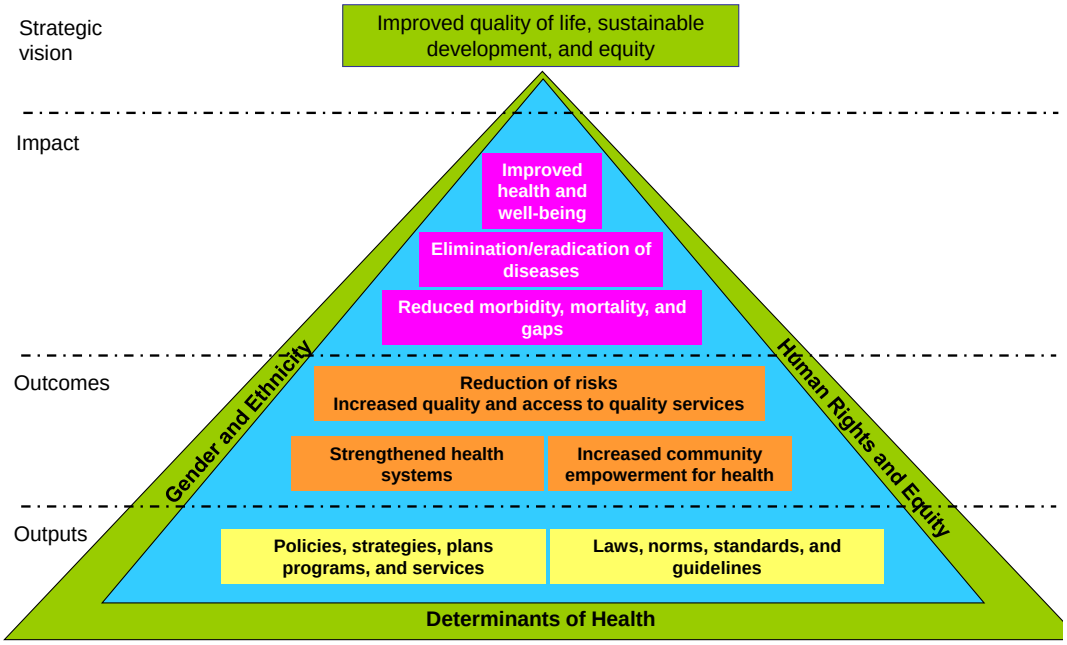
inequities; *(b)* reduce the health differentials within and between countries to the lowest level possible; and *(c)* in doing so, create the opportunity for all to attain their full potential in health.

87. Health inequity is at the core of the social determinants of health. The Commission on Social Determinants of Health (CSDH) was established by WHO to address the question of what, if anything, can be done to tackle health inequalities. This Plan follows the proposed set of overarching recommendations and focuses on the **role of the health sector in addressing social determinants of health**. In that regard, the Americas Region proposed the concept of Health in All Policies as a key State strategy that emphasizes coordinated planning across all sectors and between levels of government with a view to influencing those social determinants that are beyond the direct responsibility of the health sector (e.g., education, employment, housing). The Health in All Policies strategy centers on equity, facilitates progressive realization of the right to health, and generates synergies to advance the sustainable well-being of the population. The Strategic Plan 2014-2019 identifies specific actions to tackle health inequities, such as those recommended by the CSDH, across all program areas. A **multisectoral approach to health is at the center of the health system effort to address the social determinants of health**, and is a cross-cutting strategic approach underlying this Plan.

88. **PAHO is committed to advancing universal health coverage, and this is a key pillar of the Strategic Plan 2014-2019.** This approach offers the Region the opportunity to consolidate and maintain achievements by Member States in recent years, and at the same time reaffirms health as a key element in sustainable development. This approach will address existing challenges in the Region: it will consolidate advances in maternal and child health and control of communicable diseases, reduce the burden of chronic diseases with innovative models of care that include prevention and health promotion, and reduce the gaps in access to and utilization of health services.

89. Building on the progress made in the Region, **this Plan aims to move toward a vision focused on healthy living and well-being.** Accordingly, it seeks to catalyze changes in the health response in the Region to transcend the traditional disease-oriented approach. The Plan is influenced by and responds to global processes addressing the development agenda, as health is central to sustainable development. In this regard, the Plan seeks to address emerging issues in line with concurrent changes in the Region and advances a new development model based on equity and environmental sustainability (Figure 4).

Figure 4. Strategic Vision and Hierarchy of Results



90. In line with the above, and building upon the experiences and lessons learned, four **cross-cutting themes** are central to addressing the determinants of health: **gender, equity, human rights, and ethnicity**. In addition, the Plan will apply key public health strategies, such as health promotion, primary health care, and social protection in health. The CCTs are programmatic approaches to improving health outcomes and reducing inequalities in health, and are applicable to Categories 1 through 6. The public health strategies are overarching approaches to attaining better health for all and by all, with special emphasis on proven public health policies and community-wide interventions.

91. This Plan makes full use of the strategic advantage conferred by some of the most recent elements of planning, programming, and budgeting set out by PAHO, namely the PAHO Budget Policy and the identification of "key countries." These inherently recognize a social gradient of health and seek progressivity in the distribution of resources and in technical cooperation actions, giving more attention to those countries in greater need, yet applying the principle of proportionate universalism. In this regard, and in line with the principles of equity and Pan American solidarity, the Plan identifies **eight key countries**—Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname—where the Organization commits to place greater emphasis on its technical cooperation to ensure that gaps are closed. This includes making available the necessary human and financial resources to address the various public health challenges faced by these countries.

92. Taking into account that countries and territories in the Region have different health situations and needs, the Plan identifies **target countries and territories** by program area in order to focus the Organization's technical cooperation on specific public health issues. The target countries and territories are identified at the outcome indicator level based on a comprehensive analysis and in consultation with the Member States. For the purpose of setting baselines and targets, the Plan assumes a universe of 52 countries and territories: these include the 35 Member States, 4 Associate Member States, and 13 Overseas Territories (the latter consisting of 6 United Kingdom Territories, 4 French Departments in the Americas, and 3 Netherlands Antilles Territories). The complete list of countries and territories is included in Annex III.

Impact Goals and Strategic Focus

93. The success of the Plan will be measured by the Organization's contribution to the attainment of the impact goals outlined in Table 1, as measured by their corresponding indicators.

94. If the execution of the Plan is consistent with the Organization's strategic direction, by the end of the planning cycle in 2019 PAHO will be able to show tangible improvements in the health of the population, in particular of those groups at the lower levels of the social gradient. This, by definition, should produce a reduction of health inequities by narrowing the gaps within and between countries. This implies an explicit approach geared toward health equity and a commitment to measure impact on health equity. In keeping with the objective of reducing inequities in health, the Plan identifies specific health equity indicators and targets.

95. Aligned with the impact goals at the global level (as expressed in the WHO 12th GPW 2014-2019), and addressing the specific goals for the Region, Table 1 outlines the impact goals and indicators of the Plan. The rate of change during the planning cycle will be the basis for measuring the success of the Plan, according to the established impact indicators.

96. The proposed goals and indicators are in agreement with the conclusions of the recent consensus document entitled "Health in the Post-2015 Agenda: Report of the Global Thematic Consultation on Health" (April 2013). The proposed indicators can be adapted to national and regional contexts and existing conditions to reflect national health needs and priorities.

97. In line with the vision of the Plan, the nine impact goals were chosen to reflect several strategic dimensions of PAHO's work. These include *(a)* PAHO's mandate to improve the health of the people of the Americas and to reduce health inequities between countries; *(b)* PAHO's support to countries in realizing the Health Agenda for the Americas 2008-2017; *(c)* PAHO's commitment to achieve the health targets of the MDGs in the countries of the Region; *(d)* PAHO's commitment to universality, solidarity, and Pan Americanism; *(e)* the need to address the Region's triple burden of communicable

diseases, noncommunicable diseases, and injuries; and *(f)* the alignment with the WHO 12th GPW.

Table 1: Impact Goals *

1. Improve health and well-being with equity

1.1 At least a 1.0% increase in Healthy Life Expectancy (HALE) for the Americas achieved by 2019 (65.3 years), as compared to the baseline rate in 2014 (64.6 years). *(This information will be updated once the most recent data from the Institute for Health Metrics and Evaluation is received*.)

2. Ensure a healthy start for newborns and infants

2.1 At least a 15% reduction in the regional Infant Mortality Rate (IMR) achieved by 2019 (10.5 per 1,000 live births) compared to 2014 (12.3 per 1,000 live births).

2.2 A relative gap reduction of at least 10% in the IMR between the top and bottom country groups of the Health Needs Index (HNI) by 2019 compared to 2014.

2.3 An absolute reduction of at least 3 excess infant deaths per 1,000 live births between 2014 and 2019 across the HNI country gradient.

3. Ensure safe motherhood

3.1 At least an 11% reduction in the regional Maternal Mortality Ratio (MMR) achieved by 2019 (43.6 per 100,000 live births) compared to 2014 (48.7 per 100,000 live births).

3.2 A relative gap reduction of at least 25% in the MMR between the top and bottom country groups of the HNI by 2019 compared to 2014.

3.3 An absolute reduction of at least 18 excess maternal deaths per 100,000 live births between 2014 and 2019 across the HNI country gradient.

4. Reduce mortality due to poor quality of health care

4.1 At least a 9% reduction in the regional rate of Mortality Amenable to Health Care (MAHR)[**] achieved by 2019 (77.2 per 100,000 population) compared to 2014 (84.7 per 100,000 population).

4.2 A relative gap of no more than 6% increase in the MAHR between the top and bottom country groups of the HNI by 2019 compared to 2014.

4.3 An absolute reduction of at least 8 excess preventable deaths per 100,000 population between 2014 and 2019 across the HNI country gradient.

5. Improve the health of the adult population with an emphasis on NCDs and risk factors

5.1 At least a 9% reduction in the regional Premature NCD Mortality Rate (PNMR) achieved by 2019 (239.6 per 100,000 population) compared to 2014 (260.8 per 100,000 population).

5.2 A relative gap of no more than 6% increase in the PNMR ratio between the top and bottom country groups of the HNI by 2019 compared to 2014.

5.3 An absolute reduction of at least 18 excess premature deaths due to NCDs per 100,000 population between 2014 and 2019 across the HNI country gradient.

6. Reduce mortality due to communicable diseases

6.1 At least a 15% reduction in the mortality rate due to HIV/AIDS by 2019 compared to 2014.

6.2 At least a 30% reduction in the case-fatality rate due to dengue achieved by 2019 (0.05%) compared to 2012 (0.07%).

6.3 At least a 24% reduction in tuberculosis mortality rate achieved by 2019 (0.8 per 100,000 population) compared to 2014 (1.1 per 100,000 population).

6.4 At least a 75% reduction in the number of deaths due to malaria by 2019 (28 deaths) compared to 2011 (112 deaths).

7. Curb mortality due to violence, suicides, and accidents among adolescents and young adults (15-24 years of age)

7.1 At least a 6% reduction in the homicide rate achieved by 2019 (25.7 per 100,000 youth 15-24 years of age) compared to 2014 (27.3 per 100,000 youth 15-24 years of age).

7.2 No increase in the suicide rate achieved by 2019 compared to 2014 (7.8 per 100,000 youth 15-24 years of age).
7.3 No increase in the mortality rate due to road traffic injuries by 2019 compared to 2014 (20.5 per 100,000 youth 15-24 years of age).

8. Eliminate priority communicable diseases in the Region
8.1 Elimination of mother-to-child transmission of HIV and congenital syphilis in 16 countries and territories.
8.2 Elimination of onchocerciasis in 4 countries.
8.3 Elimination of Chagas transmission in 21 endemic countries.
8.4 Elimination of malaria in at least 3 of 7 endemic countries in the pre-elimination phase.
8.5 Zero human cases of dog-transmitted rabies in 35 Member States.

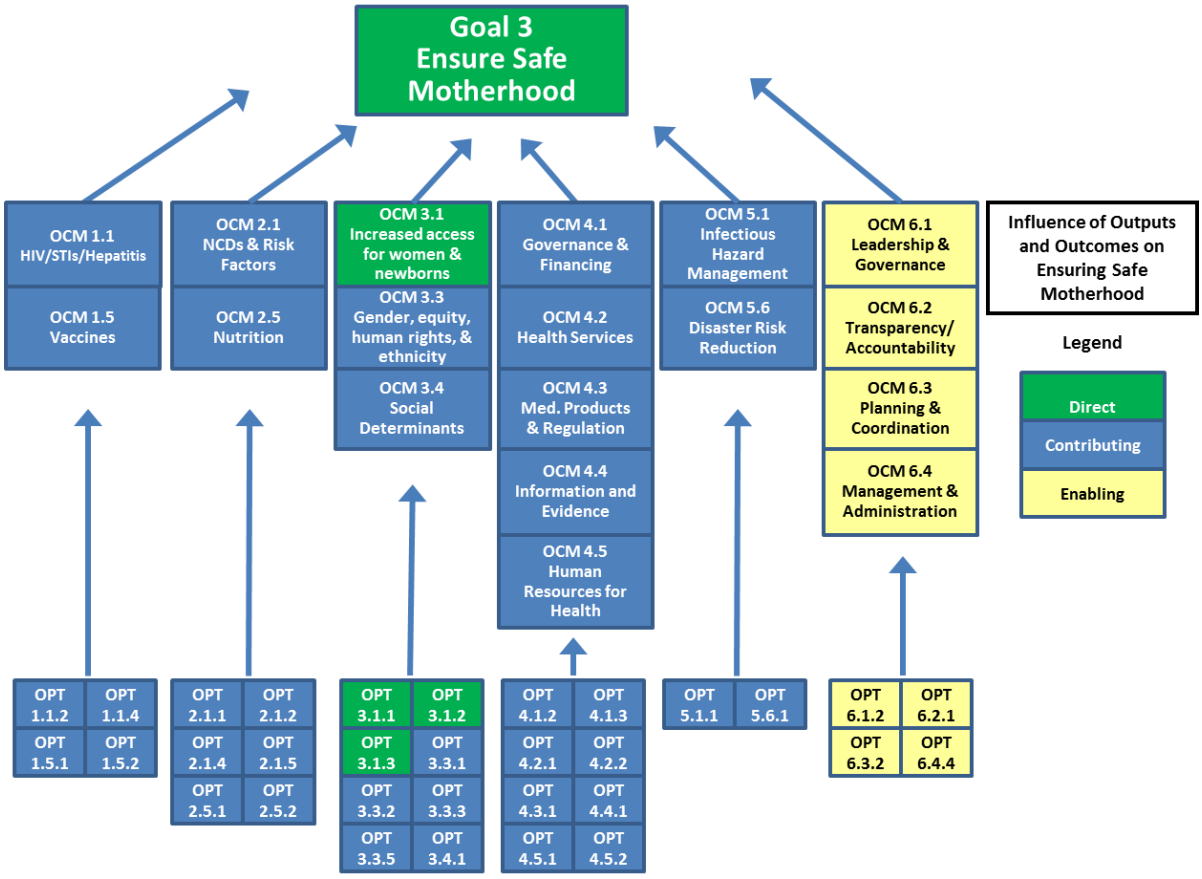
9. Prevent death, illness, and disability arising from emergencies
9.1 At least 70% of emergencies in which the crude mortality rate returns to accepted baseline (pre-disaster levels) within three months.

* These targets represent the collective regional commitment. The definitions, including technical specifications for the impact indicators, are provided in the PAHO Strategic Plan 2014-2019 compendium of indicators, available on the PAHO website.

** Mortality Amenable to Health Care refers to deaths that potentially could have been prevented with appropriate medical care. These are "premature deaths that should not occur in the presence of timely and effective health care," given that they arise from "conditions for which effective clinical interventions exist."

98. In keeping with the results-based approach, and as noted above, Organizational outputs (OPT) and outcomes (OCM) contribute toward the achievement of impacts. These outputs and outcomes may be located in several different categories, as detailed below and shown in Figure 5. Some outcomes, including enabling functions, may contribute toward the achievement of several impacts, as there is not a one-to-one relationship between outcomes and impacts.

Figure 5. Relationships between Outputs, Outcomes, and Impacts: An Illustrative Example



99. In addition to the impact goals, the Plan contains six **strategic areas of focus,** or categories, to guide its implementation:

I. **Reducing the burden of communicable diseases**, including HIV/AIDS, sexually transmitted infections (STIs), and viral hepatitis; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; vaccine-preventable diseases; and foodborne diseases, as well as the impact of antimicrobial resistance.

II. **Reducing the burden of noncommunicable diseases**, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of noncommunicable diseases and their risk factors.

III. **Promoting good health at key stages of life,** taking into account the need to address the social determinants of health (societal conditions in which

people are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

IV. **Strengthening health systems** with a focus on governance for social protection in health; strengthening legislative and regulatory frameworks and increasing financial protection for progressive realization of the right to health; organizing people-centered, integrated service delivery; promoting access to and rational use of quality, safe, and effective health technologies; strengthening information systems and national health research systems; promoting research for integrating scientific knowledge into health care, health policies, and technical cooperation; facilitating transfer of knowledge and technologies; and developing human resources for health.

V. **Reducing mortality, morbidity, and societal disruption resulting from emergencies and disasters** through the detection, management, and mitigation of high-threat pathogens, together with all-hazards risk reduction, preparedness, response, and early recovery activities that build resilience and use a multisectoral approach to contribute to health security.

VI. **Fostering organizational leadership and governance and implementing the enabling functions** that are required to maintain the integrity and efficient functioning of the Organization to deliver effectively on its mandates.

Organization of the Plan

100. The Plan is organized in six categories and 34 program areas, as outlined in Table 2. The details for each category and its respective program areas are provided in the sections that follow. For each category, the document sets forth the scope; the context, broken down by program areas; key stakeholders' analysis; strategies for technical cooperation; and cross-cutting themes and strategic approaches in health, which include opportunities for inter-programmatic collaboration and coordination. This is followed by tables presenting outcomes and outcome indicators for each program area within the corresponding category. For each outcome indicator a list of baseline and target countries is defined. Unless otherwise stated, the baseline is defined as 2013.

Table 2. Categories and Program Areas

Category	Program Areas
1. Communicable Diseases	1.1 HIV/AIDS, STIs, and Viral Hepatitis 1.2 Tuberculosis 1.3 Malaria and Other Vector-borne Diseases (including Dengue and Chagas) 1.4 Neglected, Tropical, and Zoonotic Diseases 1.5 Vaccine-Preventable Diseases (including Maintenance of Polio Eradication) 1.6 Antimicrobial Resistance 1.7 Food Safety
2. Noncommunicable Diseases and Risk Factors	2.1 Noncommunicable Diseases and Risk Factors 2.2 Mental Health and Psychoactive Substance Use Disorders 2.3 Violence and Injuries 2.4 Disabilities and Rehabilitation 2.5 Nutrition
3. Determinants of Health and Promoting Health throughout the Life Course	3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health 3.2 Aging and Health 3.3 Gender, Equity, Human Rights, and Ethnicity 3.4 Social Determinants of Health 3.5 Health and the Environment
4. Health Systems	4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans 4.2 People-Centered, Integrated, Quality Health Services 4.3 Access to Medical Products and Strengthening of Regulatory Capacity 4.4 Health Systems Information and Evidence 4.5 Human Resources for Health
5. Health Emergencies	5.1 Infectious Hazard Management 5.2 Country Health Emergency Preparedness and the International Health Regulations (2005) 5.3 Health Emergency Information and Risk Assessment 5.4 Emergency Operations 5.5 Emergency Core Services 5.6 Disaster Risk Reduction and Special Projects 5.7 Outbreak and Crisis Response
6. Leadership, Governance, and Enabling Functions	6.1 Leadership and Governance 6.2 Transparency, Accountability, and Risk Management 6.3 Strategic Planning, Resource Coordination, and Reporting 6.4 Management and Administration 6.5 Strategic Communications

Priority Setting

101. Priority setting is an important component of strategic planning and decision making. Recognizing that the PAHO Strategic Plan will be implemented in a context of limited resources, and responding to the recommendations of Member States to focus the Organization's work in areas where PAHO clearly adds value, the Plan establishes a prioritization framework to complement the PAHO Budget Policy and Results-based Management framework. General principles, including scientific method and criteria, are set out to guide the application of this framework in an objective manner. The method and criteria were applied across the program areas to identify three priority tiers (1 – high; 2 – medium; and 3 – low). The complete framework, including the methodology and criteria, can be found in Annex II.

102. The Programmatic Priorities Stratification Framework was refined during 2015-2016 by PASB in collaboration with the Strategic Plan Advisory Group (SPAG)[2] in response to a request by Member States (Resolution CD53.R3 [2014]). After conducting a thorough review of various priority-setting methods, the SPAG recommended use of the PAHO-adapted Hanlon method, with improvements in line with PAHO's strategic planning and technical cooperation purposes. The refinements included a revised PAHO-Hanlon equation with new and better-defined components and criteria, as well as development of guidelines, tools, and training to ensure a consistent and more systematic and objective application of the methodology. The methodology was tested by the SPAG and PASB technical team.

103. In 2016 the 55th Directing Council approved the policy document that guides the application of the PAHO-Hanlon method for the development of the Program and Budgets and future Strategic Plans (Resolution CD55.R2 [2016]).

104. The methodology and procedures were applied by countries and territories and involved individual assessments by senior public health officials during the consultations with national health authorities for the development of the PAHO Program and Budget 2018-2019.

105. Table 3 presents the consolidated regional results of the programmatic priorities stratification exercises conducted by 47 countries and territories. It organizes the 27 program areas[3] to which the methodology applies into three priority tiers. In

[2] At the request of Member States, the Director established the SPAG in October 2014 to work with PASB on the refinement of the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan 2014-2019. The SPAG included 12 members designated by the ministries of health of the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The group was chaired by Mexico and co-chaired by Ecuador. Canada served as the technical lead for the methodology review.

[3] Seven program areas are excluded due to their scope: 5.5 (Emergency core services); 5.7 (Outbreak and Crisis Response); 6.1 (Leadership and Governance); 6.2 (Transparency, Accountability, and Risk Management); 6.3 (Strategic Planning, Resource Coordination, and Reporting); 6.4 (Management and Administration); and 6.5 (Strategic Communication).

accordance with the PAHO Strategic Plan Programmatic Priorities Stratification Framework, these results will guide the development of the Program and Budget as well as the overall allocation and mobilization of resources. It is noted that individual country results will inform planning and implementation of the Organization's technical cooperation.

106. The results show that program areas with broader scope—those oriented toward health systems and public health interventions—were ranked in the top tier. This is a reflection, in part, of the implementation of the refined PAHO-Hanlon methodology, which aimed to address Member States' concerns that disease-oriented programs had received higher ratings in the original PAHO-Hanlon method. Such broad program areas offer an opportunity to address other program areas with a more specific scope in the lower tiers through integrated approaches geared toward strengthening the health system response. This is an important consideration in the design and implementation of PAHO's technical cooperation programs. It is worth noting that Program Areas 2.1 (NCDs and risk factors), 3.1 (women, maternal, newborn, child, and adolescent health, and sexual and reproductive health), and 1.3 (malaria and other vector-borne diseases) have been consistently ranked in tier 1 in the various prioritization exercises conducted with Member States since 2013. This speaks to the ongoing challenges related to these program areas and to Member States' expectations that PAHO will provide technical cooperation to address the situation.

107. It is important to emphasize that all 27 program areas constitute priorities for the Organization. Nonetheless, the program areas in the top two tiers are the ones recognized by most countries and territories as the biggest challenges across the Region where PAHO's technical cooperation is most needed. The program areas in the lower tier, on the other hand, are those where fewer countries and territories see the problem as overwhelming, compared to areas in the top tiers, or where countries have national capacity or support from other partners to address the problem. It should be kept in mind that the stratification results vary from country to country.

Table 3. Stratification of Programmatic Priorities – Regional Perspective

Number	Program Area	Tier
2.1	Noncommunicable diseases and risks factors	High (1)
3.1	Women, maternal, newborn, child, and adolescent health, and sexual and reproductive health	
4.5	Human resources for health	
1.3	Malaria and other vector-borne diseases (including dengue and Chagas)	
4.4	Health systems information and evidence	
1.1	HIV/AIDS, STIs, and viral hepatitis	
4.1	Health governance and financing, national health policies, strategies and plans	
4.2	People-centered, integrated, quality health services	
5.2	Country health emergency preparedness and the International Health Regulations (2005)	
5.6	Disaster risk reduction and special projects	Medium (2)
3.4	Social determinants of health	
2.5	Nutrition	
2.2	Mental health and substance use disorders	
2.3	Violence and injuries	
3.5	Health and the environment	
1.5	Vaccine-preventable diseases (including maintenance of polio eradication)	
1.6	Antimicrobial resistance	
4.3	Access to medical products and strengthening regulatory capacity	
5.1	Infectious hazard management	Low (3)
5.4	Emergency Operations	
5.3	Health emergency information and risk assessment	
3.2	Ageing and health	
1.7	Food Safety	
2.4	Disabilities and rehabilitation	
1.2	Tuberculosis	
3.3	Gender, equity, human rights, and ethnicity	
1.4	Neglected tropical and zoonotic diseases	

VI. Categories, Program Areas, and Outcomes

Category 1 - Communicable Diseases

Reducing the burden of communicable diseases, including HIV/AIDS, sexually transmitted infections, and viral hepatitis; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; vaccine-preventable diseases; and foodborne diseases, as well as the impact of antimicrobial resistance.

Scope

108. Prevalent infectious diseases, as well as newly reemerging communicable diseases, result in significant morbidity and mortality in the Region of the Americas, which can dramatically increase during times of outbreaks (e.g., dengue). These diseases are a crisis for the developing world, exacerbating poverty, inequities, and ill health. They also present substantial challenges for developed countries by placing an unnecessary burden on health and social systems, national security, and the economy. This category covers the following program areas: *(a)* HIV/AIDS, sexually transmitted infections, and viral hepatitis; *(b)* tuberculosis; *(c)* malaria and other vector-borne diseases (including dengue and Chagas); *(d)* neglected, tropical, and zoonotic diseases; *(e)* vaccine-preventable diseases (including maintenance of polio eradication); *(f)* food safety; and *(g)* antimicrobial resistance.

Context

1.1 HIV/AIDS, Sexually Transmitted Infections, and Viral Hepatitis

109. In 2011 an estimated 1.4 million people in Latin America and 230,000 in the Caribbean were living with HIV. The Region has made significant progress in reducing new HIV infections and AIDS-related mortality. Approximately 83,000 people were newly infected with HIV in Latin America in 2011, compared to 93,000 in 2001, and AIDS-related deaths declined by 10%, from 60,000 to 54,000. During the same period the Caribbean had a decline in new infections from 22,000 to 13,000, and a 50% reduction in AIDS-related deaths. Significant progress was also made in expanding access to antiretroviral therapies (ART): estimated treatment coverage in LAC was 68% in 2011. The Region was the first to formally commit to the elimination of mother-to-child transmission of HIV in a dual approach that embraces the existing commitment to eliminate congenital syphilis.

110. However, most countries in the Region have not yet achieved universal access to ART. The persistent verticality and financial vulnerability of the HIV response, especially treatment programs, threatens efforts to maintain these achievements and cover the remaining gaps toward universal access. Key populations, including men who have

sex with men (MSM), sex workers, and transgender people, remain disproportionately affected by the epidemic. Stigma and discrimination, as well as the limited capacity of the health sector to provide adequate services for these groups, continue to be major challenges for development of an adequate response. Also, progress toward strengthening strategic information systems and integrating them in health information systems has been inconsistent, and this continues to hamper evidence-based programming and monitoring of progress.

111. The HIV-related technical cooperation strategy has four priorities or flagships:

(a) Strengthening and expanding treatment programs through the promotion of evidence-based technical and programmatic options based on public health principles and articulated across the five pillars of the Treatment 2.0 Initiative.

(b) Elimination of mother-to-child transmission of HIV and congenital syphilis through the promotion, strengthening, and integration of HIV, sexual and reproductive health, and maternal, neonatal, and child health (MNCH) services; early enrollment in antenatal care; and early detection and treatment for pregnant women infected with HIV or syphilis and exposed infants.

(c) Advocacy for policy and priority setting, fostering of a supportive environment for outreach to key populations, measures to address stigma and discrimination, promotion of a human rights-based approach to the HIV response, development of packages of services (blueprints), capacity building of service providers, and fostering of community involvement.

(d) Strengthening of health information systems, promotion and support for a longitudinal approach through case-based surveillance and continuum of care monitoring, analysis and dissemination of regional information, and implementation of a regional strategy for prevention, surveillance, and monitoring of HIV drug resistance. An emphasis on health system strengthening and primary health care is incorporated in all the flagships.

112. Annually, an estimated 89 million new cases of sexually transmitted infections, including syphilis, chlamydia, gonorrhea, and human papillomaviruses (HPV), occur among people aged 15-49 years in the Region. In addition to causing mortality directly, these STIs contribute to a range of negative health outcomes, including infertility, stillbirths, ectopic pregnancy, and cancers. Some STIs, in particular those causing genital ulcerations, increase the risk of acquisition or transmission of HIV infection. Data limitations and lack of comprehensive national strategies for STI prevention, diagnosis, and treatment compromise the capacity of the Region to adequately target and address STIs.

113. The scope and performance of STI control efforts in the Region are variable, and PAHO's support for strengthening of national programs is critical. PAHO's technical support will focus on strengthening the normative and strategic information functions of the national programs. This will include strengthening the Gonococcal Antimicrobial

Surveillance Programme (GASP). It will also include providing support to countries for the development or updating of national strategies and guidelines for STI prevention and management based on the data generated by GASP and other STI surveillance, and on available global and regional normative guidance.

114. People with HIV infection and other immune-compromised groups (such as pregnant women and people with chronic conditions) are disproportionately affected by viral hepatitis, which can cause serious liver complications and increase the risk of death. Approximately one-third of the world's population has had contact with or has contracted infection with the hepatitis B virus (HBV). In the Americas, the estimated prevalence of hepatitis B infection ranges from below 2% to 4%. Additionally, an estimated 7 million to 9 million adults in LAC are infected with the hepatitis C virus (HCV). Among health workers in Latin America and the Caribbean, an estimated 65% to 80% of hepatitis B infections and around 55% of hepatitis C infections are due to needlestick injuries. Superinfection with hepatitis D also occurs in the Region, where it particularly affects indigenous peoples in the Amazonian region who are at genetic risk. Also, despite mainly low prevalence rates, outbreaks of hepatitis A and E have been reported in some countries, pointing to the need for better data and surveillance of these groups of diseases. Hepatitis A clinical cases are shifting from young to middle-aged and older people, raising the potential for worse clinical scenarios and higher fatalities. The work on viral hepatitis will focus on education and advocacy, surveillance and monitoring, diagnosis, case management and treatment, and priority research.

1.2 Tuberculosis

115. Major progress has been made in the Americas since the implementation of WHO's Stop TB Strategy, which allowed expansion of diagnosis and treatment of both sensitive and resistant tuberculosis, whether or not associated with HIV infection. Tuberculosis incidence is now declining in the Region, but at a rate of only 3% per year. For the Americas in 2011, WHO estimated 268,000 new TB cases and 21,000 deaths due to TB, excluding co-infections with HIV. During that year 218,000 new TB cases were reported. Compared with the estimates, the cases reported represented a case detection rate of 81%.

116. The TB epidemic is intensified by poverty, migration, and other social vulnerabilities. In addition, the rise of NCDs, including diabetes and tobacco-associated disease, means that more immune-compromised individuals are at risk of falling ill with tuberculosis. These social and medical risk factors converge in slum areas of the cities, where existing social inequities limit access to health services, especially for women, children, elders, and vulnerable populations (such as drug users, homeless, mentally ill, and ethnic minorities). There is a need to integrate basic health programs and services to facilitate access to early TB diagnosis and treatment. Coupled with increasing community, civil society, and private sector engagement, this can ensure more effective use of new diagnostics and medicines now available or in the pipeline for the prevention

and treatment of tuberculosis, multidrug-resistant tuberculosis (MDR-TB), and HIV-associated tuberculosis (TB-HIV).

117. PAHO's normative, surveillance, technical support, and partnership roles are crucial in controlling the TB epidemic. The Regional Plan for Tuberculosis Control focuses on strengthening national capacity to implement the global TB strategy in Member States, attempting to reach vulnerable populations through the introduction of national frameworks for TB control. The program will also update and consolidate emerging policies and technical guidance and adapt them to national contexts. As a result, technical cooperation to support national TB programs will reinforce the use of rapid diagnostic tools and improved laboratory practices, strengthened delivery of care for MDR-TB patients, integrated community-based management of TB, adequate access to new guidelines and tools, increased access to quality first- and second-line drugs, and strengthened surveillance systems complemented by improved analysis and use of data.

1.3 Malaria and Other Vector-borne Diseases

118. Mortality rates for malaria have fallen by more than 25% globally since 2000. In the Americas, mortality decreased by 67% between 2000 and 2011, while morbidity (i.e., total confirmed cases) declined by 58%. However, reaching the goals set for 2015 will require a massive expansion of access to malaria prevention, especially through sustainable vector control, and to quality-assured diagnostic testing and effective antimalarial treatment. There is a risk of malaria resurgence due to increasing resistance to artemisinin and insecticides and decreasing international funding for prevention and control. This demands sustained strategic investments from development partners and from countries where malaria is endemic. Strengthened surveillance systems are needed to target limited resources appropriately and to evaluate the progress and impact of control measures.

119. Aligned with the global technical strategy for malaria control and elimination (2016-2025), PAHO's work in this area will guide countries and other stakeholders in sustaining and building on the successes of the past decade. Support to malaria-endemic countries will include capacity building for malaria prevention, control, and elimination; strengthening of surveillance; and identification of both threats and new opportunities for malaria control and elimination. PAHO will also update policy and technical guidance on vector control, diagnostic testing, and antimalarial treatment. In addition, the Organization reinforces its strong commitment to preventing reintroduction of local transmission in areas previously declared malaria-free.

120. Dengue is an endemic disease with epidemic cycles that are associated with social determinants such as population growth, poverty, and limited access to basic services. Since 2003, 45 countries and territories of the Americas have reported 8.6 million cases and 4,400 deaths. Dengue is a disease that historically causes severe negative political, economic, and social impacts in countries. Currently, technical cooperation is directed toward strengthening national capacities for comprehensive surveillance, patient care,

and early detection, preparedness, and control of outbreaks within the framework of the Integrated Management Strategy for Dengue Prevention and Control (IMS-Dengue) and the WHO Global Strategy 2012-2020.

121. Chagas is the most prevalent tropical communicable disease in Latin America, with an annual incidence of 28,000 cases. It affects an estimated 8 million people and causes on average 12,000 deaths per year. More needs to be done to prevent this disease from further expanding and to find, diagnose, and treat already infected patients. Furthermore, significant intercountry coordination and technical work will be required to sustain the successes achieved in eliminating this vector-borne disease from many endemic territories and to maintain quality blood screening in all the countries. The Strategy and Plan of Action for Chagas Disease Prevention, Control and Care, supported by subregional intercountry initiatives, has been effective in reducing morbidity, mortality, and human suffering from Chagas, as well as efficient in saving countries' resources by reducing direct and indirect costs associated with this disease.

1.4 Neglected, Tropical, and Zoonotic Diseases

122. In Latin America and the Caribbean, neglected infectious diseases (NIDs) affect vulnerable poor populations, including indigenous and Afro-descendant groups as well as people living in rural and periurban areas who frequently have difficulties accessing health services. It is estimated that the Region of the Americas has 8.8% of the global NIDs, a figure that reflects the 40% of the LAC population (approximately 200 million people) living in poverty. Certain NIDs are also reported in the United States and Canada, but with generally lower prevalence.

123. The PAHO regional "road map" for five NIDs provides guidelines for accelerating the work to overcome the impact of neglected and tropical diseases in LAC. It sets out a timetable for the control and, where appropriate, elimination of 12 specific diseases. As part of this strategy, the donation of drugs and the support of different partners has made it feasible to implement large-scale preventive chemotherapy and adequate case treatment; this is already having a positive and measurable impact in affected countries. Sustaining the current momentum for tackling these diseases requires not only commodities and financing but also political support. PAHO will focus on expanding preventive, innovative, and intensified disease management and increasing access to essential medicines for neglected, tropical, and zoonotic diseases. Additionally, strengthening national capacity for disease surveillance, quality and timely monitoring of progress, and documentation and certification/verification of the elimination of selected diseases will remain an area of focus.

124. Zoonoses occur in all countries of the Region and mainly affect vulnerable human populations with limited access to quality health services, as well as those exposed to animals and animal products in poor sanitary conditions. As most zoonotic diseases are neglected, data on the burden of disease are limited. However, current evidence indicates that in the Americas, 70% of the recorded infectious disease events are zoonoses and/or

communicable diseases common to human and animals. Most zoonoses of production animals are endemic in the Region, while zoonoses of companion and wild animals are being detected with greater frequency; one example is the spread of human rabies transmitted by hematophagous bats. Despite widespread elimination of human rabies transmitted by dogs in the Region, pockets of disease remain. PAHO/WHO interventions to prevent these diseases in humans are multisectoral and require effective and integrated surveillance and control activities on the part of veterinary and food inspection programs, coordinated with the public health sector. The engagement of nongovernmental organizations, local governments, and communities for the early detection and treatment of human cases is also essential.

1.5 Vaccine-Preventable Diseases

125. The Region has been recognized for its global leadership in immunizations and for paving the way for innovation and further advances in this area. The vast array of program achievements includes the elimination of smallpox, polio, measles, and rubella; immunization coverage rates that are among the highest in the world; rapid advances in the introduction of new vaccines; leadership in promoting evidence-based decision making; the procurement of quality affordable vaccines through the PAHO Revolving Fund; the development and use of computerized immunization registries; and the expansion of Vaccination Week in the Americas to World Immunization Week (in 2012). The immunization program has effectively evolved from a program directed to children to one that targets the entire family.

126. Nonetheless, much work remains to be done to maintain these achievements, to address the unfinished agenda of expanding the benefits of immunization, and to face several new and emerging challenges.

127. The high average coverage levels for the Region hide sharp inequalities within and between countries. Haiti remains the only country in the Region that has not yet eliminated neonatal tetanus as a public health problem, and the country lacks a consolidated and strong national immunization program. The process of documentation and verification of measles and rubella in the Region has unmasked important problems with vaccine-preventable disease (VPD) surveillance; these problems need to be addressed in order to maintain the Region’s status as free of those VPDs already eliminated. Sustainable introduction of new vaccines (e.g., malaria and dengue) poses a challenge to immunization programs, requiring substantial budget increases and a significant expansion of the cold chain. Haiti has also experienced challenges with the availability and use of vaccines to address serious and complex public health problems, such as cholera.

128. After more than 20 years without cases, the Region is still at risk of receiving an importation of wild poliovirus or of a circulating vaccine-derived poliovirus (cVDPV). The plan of action to maintain the Americas free of poliomyelitis provides a framework for the pre- and post-elimination eras, as well as for the transition between these eras. The

plan articulates a comprehensive strategy to enhance all aspects of community protection and epidemiologic surveillance.

1.6 Antimicrobial Resistance

129. Antimicrobial resistance threatens the sustainability of an effective, global public health response to the enduring threat from infectious diseases. The trends toward increasing antimicrobial resistance are undermining hard-won achievements of the Millennium Development Goals and put at risk the provision of high-quality, universal health coverage. Effective antimicrobial medicines are essential components of both preventive and curative regimens, protecting patients from potentially fatal diseases and ensuring that complex procedures, such as surgery and chemotherapy, can be provided at an acceptable level of risk. Because resistance to antimicrobial medicines is largely due to the inappropriate use of these drugs in human medicine, animal medicine, animal feed, agriculture, and aquaculture, it is urgent to respond on a global scale, using a multisectoral approach.

130. Alert to this crisis, WHO has defined its work on antimicrobial resistance, including antibiotic resistance, in the global action plan on antimicrobial resistance, which the Member States adopted in May 2015 in Resolution WHA68.7. Similarly, the PAHO Directing Council approved the regional Plan of Action on Antimicrobial Resistance (Resolution CD54.R15 [2015]). Following the adoption by the United Nations General Assembly in September 2016 of a political declaration on antimicrobial resistance, Member States committed to develop multisectoral national action plans on antimicrobial resistance in line with the WHO global action plan on the issue. Endorsing a concerted "One Health" approach, which linked various sectors and actors in defense of human, animal, and environmental health, they also committed to mobilize adequate, predictable, and sustainable resources to implement those programs, and pledged to raise awareness of the phenomenon around the world.

131. PAHO will support Member States to meet their commitments to develop multisectoral national action plans on antimicrobial resistance and will focus on ensuring full-scale implementation of such plans with Member States, as well as the Regional Plan of Action on Antimicrobial Resistance; improving surveillance of antimicrobial resistance; fostering evidence-based interventions for its containment; and collaborating with the Food and Agriculture Organization (FAO) and World Organisation for Animal Health (OIE) to ensure that risks of the development and spread of antimicrobial resistance at the human-animal interface are minimized.

1.7 Food Safety

132. In recent times, in both developing and industrialized countries, there has been a growing demand for expertise in the control of food safety and zoonotic diseases in emergency and disaster situations. This knowledge, which is part of the field of

veterinary public health (VPH), is fundamental for preparedness, surveillance, and effective response to public health emergencies related to food safety.

133. Food contamination with microbial agents and chemicals (including antimicrobials) is associated with illnesses ranging from diarrheal diseases to various forms of cancer; it thus represents an important public health risk. PAHO has had a regional information system for foodborne disease (FBD) outbreaks in Latin America and the Caribbean since 1993. A study of these outbreaks reported by 22 countries from 1993 to 2010 found that of the 9,180 outbreaks where the causative agent was identified, 69% were bacterial and 9.7% viral; 9.5% were caused by ocean toxins, 2.5% by chemical contaminants, 1.8% by parasites, and 0.5% by vegetable toxins. Although data on foodborne diseases in LAC are limited by underreporting, these figures show the importance of the problem. The United States alone accounts for 47.8 million cases of FBD each year. WHO also estimates that, depending on the country, 15% to 79% of all cases of diarrhea worldwide are due to contaminated food. Studies in the Region of the Americas show that the relative frequency of diarrheal diseases attributable to foodborne pathogens varies from 26% to 36%.

134. A multisectoral, transdisciplinary approach is necessary to ensure food safety while effectively managing the health risks for humans, animals, plants, and the environment. Intersectoral public policies, strategies, and plans for health, agriculture, and the environment are critical to strengthening food safety systems to ensure safe, healthy food, from farm to fork. This should include consumer protection, with an emphasis on poor and vulnerable populations.

Key Stakeholders' Analysis

135. The surveillance, promotion, prevention, diagnosis, treatment, control, and elimination of communicable diseases will be achieved through joint efforts with new and existing partners, both within and outside the health sector. PAHO will continue to foster collaborations with various UN agencies, major foundations, WHO Collaborating Centers, multilateral and bilateral agencies, scientific institutions, and other key strategic partners that share the same vision of reducing the burden of communicable diseases at the regional and global levels. These efforts will utilize available alliance-building tools such as technical cooperation agreements, interagency coordinating committees (ICC), public-private partnerships, technical cooperation among countries (TCC), letters of agreement, and so on.

136. The current panorama of strategic partners includes: Bill and Melinda Gates Foundation (BMGF), Canadian International Development Agency (CIDA), Canadian Society for International Health (CSIH), Caribbean Public Health Agency (CARPHA), Centers for Disease Control and Prevention (CDC), Codex Alimentarius Commission (CAC), Common Market of the South (MERCOSUR), Development Bank of Latin America (CAF), Food and Agriculture Organization of the United Nations (FAO), GAVI Alliance, Global Alliance for Rabies Control (GARC), Global Fund to Fight AIDS,

Tuberculosis and Malaria (GFATM), Green Light Committee (GLC) Initiative, Inter-American Development Bank (IDB), Inter-American Institute for Cooperation on Agriculture (IICA), International Association of Providers of AIDS Care (IAPAC), International Food Safety Authorities Network (INFOSAN), Joint United Nations Programme on HIV/AIDS (UNAIDS), Measles & Rubella Initiative, Oswaldo Cruz Foundation (Fiocruz), Program for Appropriate Technology in Health (PATH), Public Health Agency of Canada (PHAC), Regional International Organization for Plant Protection and Animal Health (OIRSA), Sabin Vaccine Institute (SVI), Spanish Agency for International Development Cooperation (AECID), Task Force for Global Health (TFGH), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), United States Department of Health and Human Services (HHS), United States President's Emergency Plan for AIDS Relief (PEPFAR), the tripartite WHO-FAO-OIE One Health initiative, World Organisation for Animal Health (OIE), and World Society for the Protection of Animals (WSPA).

Strategies for Technical Cooperation

137. Supporting national capacity building and self-sustainability:

(a) Provide technical cooperation and support to Member States that is aligned with PAHO/WHO Governing Bodies' mandates and resolutions, global and regional frameworks, and evidence-based recommendations provided by recognized regional strategic and technical advisory groups.

(b) Prioritize vulnerable populations and high-risk groups in the technical cooperation provided.

(c) Scale up effective interventions focused on the surveillance, promotion, prevention, diagnosis, treatment, control, and elimination of communicable diseases.

(d) Underscore national and local capacity building at all levels, as well as effective intercountry collaboration, in order to achieve a sustainable and positive impact on health and social programs.

(e) Promote and support the adoption and use of newly developed, accessible, and effective technology that accelerates the efforts to reach health goals in the countries and the Region.

(f) Develop and implement effective strategies for sunsetting and sustainability of related programs at national level, such as moving from focused support to selected key countries to higher-level regional technical cooperation.

138. Developing norms and standards:

(a) Build upon PAHO's technical expertise, which is grounded in scientific evidence and applied knowledge, in setting and adapting regional norms and standards.

(b) Work in collaboration with Member States to generate evidence for developing regional guidelines, tools, and methodologies.

(c) Foster stakeholder buy-in and country ownership of regional norms and standards that are established in the area of communicable diseases, facilitating their widespread dissemination, use, and adaptation at all levels.

(d) Ensure that elements of supervision, monitoring, and evaluation are incorporated into programs at all levels.

(e) Develop multisectoral policies and science-based measures to prevent exposure to contaminants through the food chain and ensure the safety of new technologies.

139. Shaping the research agenda:

(a) Identify key health-related challenges in need of operational or knowledge-based answers.

(b) Promote operational research and the appropriate use of the results to reduce morbidity, mortality, and the burden caused by infectious diseases in the Region.

(c) Support the establishment of mechanisms for the collection, analysis, preparation, dissemination, and use of strategic information to contribute to the body of knowledge on best practices for the surveillance, prevention, control, and elimination of communicable diseases.

Cross-Cutting Themes and Strategic Approaches in Health

140. The surveillance, promotion, prevention, treatment, diagnosis, control, and elimination of communicable diseases in the Americas present many opportunities for inter-programmatic work to ensure an integrated approach in program development and delivery. These transversal collaborations occur between the program areas of Category 1, as well as between the various categories. Furthermore, all programmatic areas within Category 1 are closely related to the work performed in Category 5 (Health Emergencies), specifically with respect to efforts to provide an integrated approach to the prevention, early detection, immediate response, and reporting of communicable diseases that fall under the 2005 International Health Regulations.

141. In the area of HIV/AIDS, STIs, and viral hepatitis, work contributes to and benefits from Category 2 (Noncommunicable Diseases and Risk Factors); Category 3 (Determinants of Health and Promoting Health throughout the Life Course), because the prevention of mother-to-child transmission will provide opportunities for access to HIV and other health services for women at various stages of life; Category 4 (Health Systems), through improved health infrastructure and increased access to treatment; and Category 5 (Health Emergencies).

142. The area of tuberculosis is linked to Categories 2 and 4. In the case of linkage to Category 2, individuals with certain noncommunicable diseases, such as diabetes, may

have underactive immune systems that increase their risk of contracting tuberculosis. Similarly, with respect to Category 4, the foundation of an efficient TB program relies on the adequate functioning of the primary health care system to diagnose and treat patients, followed by a selective but efficient referral and counter-referral system.

143. The program area of neglected, tropical, and zoonotic diseases is linked to Category 3, as interventions to prevent and treat schistosomiasis, trachoma, soil-transmitted helminthiasis, and other neglected diseases will have a positive impact on maternal and child health outcomes.

144. In the area of vaccine-preventable diseases, there are opportunities for inter-programmatic work with Category 2, to address issues related to HPV and hepatitis B vaccines; Category 3, where the administration of traditional and new vaccines contributes to improved health throughout the life course; Category 4, as immunization is a vehicle for reaching vulnerable populations with other health interventions and also provides opportunities to link immunization registries, birth registration, and other health statistics into a comprehensive health information system; and Category 5, for the close monitoring of VPD surveillance to ensure timely detection and response to outbreaks in the Region and for the strengthening of laboratory capacity.

145. Within Category 1, work on viral hepatitis is closely tied to efforts on HIV/AIDS and STIs because of the issue of co-infection; strategies regarding blood safety, injection safety, and promotion of safer sex practices also relate to both areas. Within Category 2, hepatitis is more likely to occur among immune-compromised patients, including chronic disease carriers. This program area also requires opportunities for inter-programmatic collaboration with Categories 3, 4, and 5.

146. The cross-cutting themes of gender, equity, human rights, and ethnicity are incorporated into Category 1 to improve health outcomes.

(a) Interventions to combat communicable diseases are tailored to respond to issues of gender and cultural diversity by building upon an understanding of men and women across all ages, of their cultural heritages, and of the factors that influence their health situation. This work also includes the collection and reporting of data disaggregated by age, sex, and other relevant variables.

(b) The focus on the prevention, treatment, and control of communicable diseases, particularly in areas of greatest need, supports ideals of equity in health and poverty reduction to reach vulnerable populations with integrated health interventions that prevent extreme misfortune when illness occurs.

(c) A human rights approach is particularly relevant to the program areas of HIV/AIDS, STIs, and viral hepatitis; tuberculosis; neglected, tropical, and zoonotic diseases; and foodborne diseases. Careful attention must be paid to promoting interventions that combat stigma and discrimination.

147. Strategic approaches in health, namely social determinants, primary health care, health promotion, and social protection, are strongly integrated into the work of Category 1.

(a) Population growth, poverty, migration, inadequate living conditions, and the lack of basic services are factors that impede efforts to prevent, treat, and control communicable diseases (neglected, tropical, and zoonotic diseases, for instance). Social determinants thus contribute to negative health outcomes that accentuate inequities in health. Interventions implemented by the program areas will build upon existing best practices to address social determinants head-on for improved health outcomes.

(b) Many interventions aligned with the work of the various program areas occur at the primary health care level and provide an entry point for families to access other quality health services (e.g., immunizations), as well as additional opportunities to receive health education. Incorporation of these interventions at the PHC level also facilitates access to early diagnosis and treatment of communicable diseases (e.g., malaria and TB).

(c) Prevention of communicable diseases is aligned with the principles of social protection in health by limiting exposure to infectious agents that may lead to sickness, disability, or increased poverty, particularly among marginalized and vulnerable populations.

Assumptions and Risks

Assumptions:

(a) Countries sustain their commitments of political, human, and financial resources for prevention, early detection, diagnosis, treatment, and control of communicable diseases, and for universal and equitable access to immunization.

(b) Committed resources are delivered and accessed in a timely manner, and there is decreasing dependency on external funds to implement necessary actions.

(c) Member States fully utilize the PAHO Revolving Fund for procurement of vaccines and the PAHO Strategic Fund for the procurement of medicines and medical supplies for NIDs.

(d) Fully operational surveillance systems collect relevant data in order to ascertain gains and gaps. Key knowledge gaps are addressed, and evidence-based policy development and program implementation are pursued.

(e) Efforts are coordinated, synergistic, and optimizing (as opposed to disjointed, contradicting, and duplicative).

(f) Legal and normative environments are conducive to augmented access and utilization of HIV/STI services.

(g) Effective measures are in place to mitigate the impact of catastrophic events.

Risks:

(a) A shift in health priorities at the global, regional, or national level results in diminished financial support for communicable disease and immunization programs.

(b) Parallel, uncoordinated health agendas compete for priority and resources.

(c) Legal and normative instruments hamper access to and/or utilization of health care systems.

(d) Mobility of people across borders contributes to the complexity of disease prevention, control, and elimination.

(e) Emergencies, disasters, and pandemics divert resources allocated to key communicable disease programs and make it difficult or impossible to collect and collate strategic information.

(f) Stigma and discrimination increase toward persons with HIV/AIDS.

(g) NIDs continue to be given very low priority in the government agendas of certain countries and partners.

(h) There is a shortage of drugs used to treat NIDs and zoonotic diseases in the Region, resulting from insufficiency of available raw materials.

(i) Investment in immunization activities is low or insufficient, putting the goal of universal coverage in jeopardy.

Category 1. Communicable Diseases: Program Areas and Outcomes

1.1 HIV/AIDS, STIs, and Viral Hepatitis

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 1.1 Increased access to key interventions for HIV, STIs, and viral hepatitis prevention and treatment	OCM 1.1.1	Number of countries and territories that have 80% coverage of antiretroviral therapies (ART) in eligible populations**	6	22
	OCM 1.1.2	Number of countries and territories with at least 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission of HIV	0	24

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

** Until mid-2013, the eligibility criteria were persons living with HIV with a CD4 count of 350/ml or less. Based on the new WHO guidelines published in June 2013, the recommended threshold for initiation of ART has increased to a CD4 count of 500/ml or less, meaning that the number of eligible persons (denominator) will increase.

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
	OCM 1.1.3	Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women	0	22
	OCM 1.1.4	Number of countries and territories with at least 95% coverage of routine infant vaccination for hepatitis B (below 1 year of age)	15	25
	OCM 1.1.5	Number of countries and territories that include in their national essential medicines lists one or more drugs recommended by WHO for hepatitis C treatment	8	15

1.2 Tuberculosis

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.2 Increased number of tuberculosis patients successfully diagnosed and treated	OCM 1.2.1	Cumulative number of TB bacteriologically confirmed patients successfully treated in programs that have adopted the WHO recommended strategy since 1995	1,450,000 patients	2,500,000 patients
	OCM 1.2.2	Annual number of tuberculosis patients with confirmed or presumptive MDR-TB, based on WHO definitions (2013), including rifampicin-resistant cases, placed on MDR-TB treatment in the Americas	2,960 patients	5,490 patients
	OCM 1.2.3	Percentage of new TB patients diagnosed in relation to the total number of TB incident cases	79%	90%

1.3 Malaria and Other Vector-borne Disease

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.3 Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases	OCM 1.3.1	Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (based on PAHO/WHO recommendations)	85%	95%
	OCM 1.3.2	Number of countries and territories with installed capacity to eliminate malaria	10	21
	OCM 1.3.3	Number of countries and territories with installed capacity for the management of all dengue cases	14	30
	OCM 1.3.4	Number of countries and territories where the entire endemic territory or territorial unit has a domestic infestation index (by the main triatomine vector species or by the substitute vector, as the case may be) of less than or equal to 1%	17	21

1.4 Neglected, Tropical, and Zoonotic Diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.4 Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of neglected, tropical, and zoonotic diseases	OCM 1.4.1	Number of countries with annual increase in the proportion of diagnosed and treated cases of leishmaniasis, as per the recommended treatment in the PAHO/WHO guidelines	0	12
	OCM 1.4.2	Number of endemic countries and territories with high burden of leprosy that have reduced by 35% the rate of new cases with grade-2 disabilities per 100,000 population as compared to their own baseline 2012 data	0/10	10/10
	OCM 1.4.3	Number of endemic countries having achieved the recommended treatment target coverage (65% or more) of population at risk of lymphatic filariasis	1/4	4/4
	OCM 1.4.4	Number of endemic countries having achieved the recommended treatment target coverage (85% or more for each round of treatment) of population at risk of onchocerciasis	1/2	2/2
	OCM 1.4.5	Number of endemic countries having achieved the recommended treatment target coverage (80% or more) of population at risk of trachoma that could lead to blindness	0/3	3/3

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
	OCM 1.4.6	Number of endemic countries having achieved the recommended treatment target coverage (75% or more) of population at risk of schistosomiasis	0/2	2/2
	OCM 1.4.7	Number of endemic countries having achieved the recommended treatment target coverage (75% or more) of population at risk of soil-transmitted helminthiasis	5/24	16/24
	OCM 1.4.8	Number of countries and territories with established capacity and effective processes to eliminate human rabies transmitted by dogs	28	35

1.5 Vaccine-Preventable Diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.5 Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases	OCM 1.5.1	Regional average coverage with three doses of diphtheria, tetanus, and pertussis-containing vaccine	92%	94%
	OCM 1.5.2	Number of countries and territories with reestablishment of endemic transmission of measles and rubella virus	0	0
	OCM 1.5.3	Number of countries and territories that have introduced one or more new vaccines	34	51
	OCM 1.5.4	Number of countries and territories reporting cases of paralysis due to wild or circulating vaccine-derived poliovirus (cVDPV) in the preceding 12 months	0	0

1.6 Antimicrobial Resistance

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.6 Increased national capacity to decrease the risk and prevent the spread of multidrug-resistant infections	OCM 1.6.1	Number of countries with increased antimicrobial resistance (AMR) surveillance capacity to decrease the risk and prevent the spread of multidrug-resistant infections	20	30

1.7 Food Safety

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 1.7 Number of countries that have the capacity to mitigate risks to food safety and respond to outbreaks	OCM 1.7.1	Number of countries and territories that have adequate mechanisms in place for preventing or mitigating risks to food safety and for responding to outbreaks, including among marginalized populations	4	20

Category 2 - Noncommunicable Diseases and Risk Factors

Reducing the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of noncommunicable diseases and their risk factors.

Scope

148. PAHO, together with partner organizations in various sectors, will address the burden of noncommunicable diseases with a focus on cardiovascular diseases (in particular hypertension), cancer, diabetes, lung disease, and chronic renal disease. Emphasis will be placed on the common risk factors of tobacco use, harmful use of alcohol, unhealthy diet, salt consumption, physical inactivity, and obesity. In the NCD response, PAHO will also focus on nutrition and other NCD-related conditions, including mental health, violence and injuries, and disabilities and rehabilitation. The primary aims of the work in this category will be to address the underlying determinants of NCDs, including socioeconomic, environmental, and occupational factors across the life course, as well as to strengthen the primary care response to NCDs, risk factors, and related conditions. The specific approaches are set out in the various PAHO/WHO mandates related to NCDs, including the regional Plan of Action for the Prevention and Control of Noncommunicable Diseases 2013-2019.

Context

2.1 Noncommunicable Diseases and Risk Factors

149. Over 75% of all deaths in the Americas are caused by NCDs, which are highly preventable and can be controlled through public policies and regulations, health services, and lifestyle interventions. Of particular concern is the burden of premature deaths from NCDs: in the Americas every year, over 1.5 million people under 70 years of age die from NCDs, which has serious implications for social and economic development. Because the epidemic of NCDs is driven by globalization, urbanization, demographic trends, and socioeconomic conditions, interventions are required not only from the health sector but from other government sectors such as agriculture, education, transport, labor, environment, and trade, as well as from civil society and the private sector. Cardiovascular diseases, diabetes, and cancer are all rising problems in the Region of the Americas, and with an aging and growing population, the situation is expected to worsen. Thus, policies and services to reduce the major risk factors and promote health in communities, workplaces, schools, and other settings are urgently needed. And to better control NCDs, health systems and services need to be strengthened, particularly at the primary level of care, for screening, early detection, and management of NCDs and risk factors, ensuring access to medicines, technologies, and continuous quality of care.

150. Tobacco use is one of the most important NCD risk factors. The prevalence of adult smoking in the Region of the Americas is 22%, and 16% of total mortality in adults is attributable to tobacco. The consumption gap between males and females is narrowing, especially among adolescents. Tobacco use also reflects social inequalities, with greater prevalence among lower-income and lower-education population groups. In the Region, 29 countries have ratified the WHO Framework Convention on Tobacco Control (FCTC). Although some 20 countries have passed legislation complying with at least one of the treaty mandates, much more progress is needed. Tobacco industry interference remains a major challenge in the Region, holding back progress in implementation of the WHO FCTC.

151. Reports indicate that reducing tobacco consumption by 20% and salt intake by 15%, while treating patients at high risk of CVDs with a combination of appropriate drugs, could prevent up to 3.4 million deaths in the Region at reasonable cost in 10 years. Such evidence strengthens the argument that countries, guided by well-informed leadership within the ministries of health, can continue to advocate for multisectoral policies that promote responsible, prevention-based individual self-care and improve the availability of essential medicines.

152. Alcohol consumption is another leading risk factor for NCDs, responsible for at least 347,000 deaths in 2004 in the Region and the loss of over 13 million disability-adjusted life years (DALYs). Average per capita consumption is estimated at 8.7 liters among those over 15 years of age, compared to the global average of 6.1 liters per person per year. In 2005, about 17.9% of men and 4.5% of women in the Region engaged in heavy episodic drinking (binge drinking) on a weekly basis. The expansion of the alcoholic beverage industry in the Region and its aggressive marketing and promotion in the absence of effective regulatory control remains a significant obstacle to the adoption of an effective response.

153. At the regional level, rapid and deleterious changes are taking place in food consumption. These shifts affect broad sectors of the population, especially low-income and less-educated segments. Consumption of high-calorie processed foods rich in fats, sugars, and salt is increasing, while fruit and vegetable consumption is decreasing. These changing dietary patterns are accompanied by a reduction in physical activity. The result is an alarming epidemic of **overweight and obesity.** Regionwide estimates indicate that between 50% and 60% of all adults, over one-third of all adolescents, and between 7% and 12% of all children under 5 are either overweight (BMI >25) or obese (BMI >30). Even worse, forecasts indicate that this figure will rapidly rise, reaching 289 million people (39% of the total population) by 2015. In almost all countries, the problem is greater among women.

154. Obesity is linked to several NCDs. An analysis of 57 prospective studies points out that every excess 5 kg/m2 on the body mass index (BMI) is associated with an increase in mortality of nearly 30% (40% from CVDs, 60%-120% from diabetes-related complications, 10% from cancer, and 20% from chronic respiratory illnesses).

155. The Region's rapid urbanization, rising salaries, and economic growth are underlying contributors to the unhealthy diets and sedentary lifestyles that in turn have produced the obesity problem. Factors include the globalized marketing of processed foods and sugary drinks, the tremendous popularity of electronic entertainment and computers, the centrality of the private automobile in urban planning and design, and the growing fear of street crime that keeps many people inside their homes. With the adoption of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS), attention has turned to the critical importance of the food environment as it influences preferences, purchasing decisions, and eating behavior.

2.2 Mental Health and Psychoactive Substance Use Disorders

156. Mental, neurological, and psychoactive substance abuse disorders represent an important cause of morbidity, mortality, and disability. Eight priority conditions make the largest contribution to morbidity in the majority of developing countries: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. In the Region, the conditions that require particular attention include depression, disorders due to alcohol use, dementia, and mental health conditions of children and adolescents, including suicide prevention. These are major determinants and causes of morbidity. PAHO will focus on four areas: *(a)* information and surveillance, broadening the evidence base on mental health; *(b)* development of policies, plans, and legal instruments, with particular emphasis on protection of human rights; *(c)* development and integration of the mental health component of primary care; and *(d)* provision of mental health care and psychosocial support in disasters and humanitarian emergencies. In this regard, the restructuring of mental health services should continue as a priority in Latin America and the Caribbean.

2.3 Violence and Injuries

157. Violence and injuries represent a major cause of morbidity and mortality in the Americas, with homicides being the first cause of mortality among men aged 15-29 and the second cause of among women in the same age group. Road traffic injuries are the leading cause of death in children aged 5-14 years and the second cause in the group aged 15-44 years. For each person who dies as a result of violence and injuries, many more suffer long-term physical and mental health consequences. Different forms of violence affect populations in distinct ways. While most attacks against men, including young men, are carried out by a stranger or an acquaintance, women are more likely to suffer violence at the hands of their husband or intimate partner, and children are more likely to be abused by adults close to them.

158. Violence poses considerable direct and indirect costs to societies. It drains health, social, and justice sector budgets with expenditures for treating survivors and apprehending and prosecuting perpetrators. Violence also reduces productivity, increases absenteeism, and poses considerable intergenerational costs from the impacts of violence

on survivors' children. Additionally, fear of violence can exacerbate inequalities by isolating the poor in their homes and the rich in their segregated spaces, affecting the well-being and social fabric of families and communities.

2.4 Disabilities and Rehabilitation

159. In the Americas an estimated 140 million to 180 million people were living with some form of disability in 2010. This number is expected to increase due to population growth, aging, rise of NCDs, accidents, disasters, violence, poor diet, and psychoactive substance abuse. Limited resources, inappropriate policies, limited access to health services and rehabilitation, and inaccessible transportation represent significant challenges for people with disabilities. Ocular, hearing, and oral health need to be addressed, given that about 80% of blindness in the Americas is avoidable, and dental caries affect more than 90% of the Region's population.

160. PAHO will contribute to the improvement of health and living conditions for people with disabilities through technical cooperation and promotion of community participation, as well as through a rights-based approach. Access to health services, including rehabilitation services, will be strengthened for persons with disabilities. This will include generating synergies between related health programs for health promotion and prevention of disabilities, strengthening capacity of health human resources, providing social protection for people with disabilities, and improving information on disabilities within health information systems.

2.5 Nutrition

161. Poor nutrition results in stunted child growth and contributes to overweight and obesity throughout the life course. This in turn is an important risk factor for three of the four major NCDs: cardiovascular diseases, cancers, and diabetes. Conditions related to undernutrition and overweight/obesity impose a burden on individuals, communities, and the health system, and impede human development and equity; preventing these conditions is central to the achievement of regional and global development goals. Regional targets have been set for exclusive breastfeeding and for reduction of child stunting, overweight, and women's anemia.

162. PAHO will support strengthening of the evidence base for effective nutrition interventions, assist in the development and evaluation of policies and programs, and provide the leadership, practical knowledge, and capacities required to scale up actions. The Organization will provide technical cooperation for improving environments—for example, to support breastfeeding in hospitals or healthy meals and recreation in schools. PAHO will engage the private sector in the areas of staple food fortification and product reformulation and will provide frameworks for regulations in the areas of food labeling and marketing of foods and beverages to children. All these actions will make use of multisectoral approaches involving key actors such as the ministries of education,

agriculture, and the environment. Lastly, PAHO will monitor progress toward achievement of agreed nutrition targets by Member States.

Key Stakeholders' Analysis

163. The main stakeholders for this category include the ministers of health and national health authorities responsible for NCDs and risk factors, nutrition, mental health, violence and injuries, disabilities, and rehabilitation, including ocular, oral, and hearing programs. Because a whole-of-government approach is required to address NCDs and their risk factors, key stakeholders also include those from sectors outside of health, such as agriculture, education, transport, labor, environment, and trade. PAHO also partners on these program areas with stakeholders outside of government, including civil society actors (nongovernmental organizations, international organizations, professional associations, and academia) as well as the private sector.

164. PAHO has strong partnerships with WHO Collaborating Centers related to the category, and also with numerous professional associations, academics, nongovernmental organizations, and private sector organizations working in the area of NCDs. This collaboration takes place principally through the Pan American Forum for Action on NCDs (PAFNCD), but these linkages are also well established in other initiatives linked to the specific program areas within the category. The Healthy Caribbean Coalition, the Latin America Coalition for Health, and the Framework Convention Alliance are key civil society coalitions with which PAHO collaborates, particularly for social mobilization and communications around NCD and risk factor prevention and control.

165. PAHO is also collaborating with United Nations agencies, including the International Telecommunications Union, UNICEF, UNDP, United Nations Population Fund (UNFPA), and United Nations Office on Drugs and Crime, to scale up joint programming for NCDs and risk factors at regional and national levels.

166. Through its strong links to governments, PAHO has supported the various political declarations on NCDs. These include the Declaration of the High-level Meeting of the UN General Assembly on Prevention and Control of Noncommunicable Diseases; the Port-of-Spain Declaration on NCDs; the Andean ministers of health resolution on NCDs and NCD surveillance (REMSAA XXXIV/5 and REMSAA XXXII, 2011); the UNASUR resolution on NCDs; and the Central America and Dominican Republic Ministers of Health Declaration of Antigua, Guatemala, on NCDs, endorsed by the presidents of the Central American Integration System.

167. PAHO will continue to build and expand capacities within ministries of health to improve the multi-stakeholder response, effectiveness, and impact of national policies, programs, and services that relate to NCDs and their risk factors.

Strategies for Technical Cooperation

168. Priority will be placed on putting into action the various mandates and resolutions on NCDs, risk factors, and related conditions, particularly the WHO Framework Convention on Tobacco Control (a legally binding global treaty) and the regional Plan of Action for the Prevention and Control of Noncommunicable Diseases, in keeping with efforts toward the achievement of global targets and indicators set forth in the NCD Global Monitoring Framework. PAHO will lead, together with Member States, a multisector response, articulating policy and regulatory options to address the broader physical, social, and economic environmental conditions that support healthy nutrition, risk factor reduction, mental health, violence prevention, disability and rehabilitation, and management of NCDs. This will involve developing effective partnerships and exercising a leadership and coordination role with the relevant United Nations funds, programs, and agencies. PAHO's work will draw heavily on its normative and capacity-building competencies.

169. PAHO will support Member States in their efforts to establish national plans and strengthen policies, programs, and services, emphasizing the primary health care approach to NCDs, risk factors, and related conditions. The focus will be on prevention throughout the life course and on screening and early detection of cancer, diabetes, and cardiovascular diseases and their risk factors. Additional priorities will include improving the quality of care, increasing access to affordable diagnosis and treatment, reducing the suffering of people living with disabilities and chronic diseases, and supporting strategies and technologies suitable for primary health care settings and workplaces in resource-constrained settings. PAHO will also support information, surveillance, and research, broadening the evidence base to support national policies, strategies, and laws, with a focus on protection of rights. Work in the area of mental health will include provision of mental and psychosocial support in humanitarian emergencies.

Cross-Cutting Themes and Strategic Approaches in Health

170. Category 2 and its program areas will require inter-programmatic work with all other categories, especially Category 1 (Communicable Diseases), Category 3 (Determinants of Health and Promoting Health throughout the Life Course), and Category 4 (Health Systems). Linkages with Category 1 include co-morbidities (for example, tuberculosis and diabetes, HIV/AIDS and mental health) and vaccines to prevent some types of cancers (hepatitis B vaccine for liver cancer, HPV vaccine for cervical cancer). With respect to Category 3, there are strong linkages between neonatal and early childhood mortality and morbidity and promotion of healthy nutrition (particularly breastfeeding) as a means to prevent NCDs. The strategies to prevent and control NCDs also support active and healthy aging. The multisectoral actions required for NCD prevention are those that address the social determinants of health as well as environmental threats to health and gender equity. The linkages with Category 4 are particularly strong, since a primary care approach, people-centered care, and access to medical technologies are all essential for NCD management. The issues covered under

Category 2 require strong multisectoral collaboration in order to address the underlying causes of NCDs and associated risk factors in a more effective manner.

171. Addressing the social determinants of health plays a critical role in the strategy to respond to the burden of NCDs, risk factors, and related conditions. Health promotion strategies are an essential component of NCD prevention; especially important is childhood and adolescent health promotion to inculcate, in the early stages of life, healthy ways of living. Primary health care is another essential component of the management of NCDs and risk factors, mental health, disabilities and rehabilitation, and violence/injury prevention. PAHO will integrate NCD and risk factor management interventions as part of overall efforts to strengthen health systems based on the primary care approach. Equitable care for NCDs, risk factors, and related conditions requires social protection in health; therefore, prevention and control of NCDs and risk factors should be included in social protection packages.

172. PAHO's cross-cutting themes of gender, equity, human rights, and ethnicity will be taken into consideration in achieving all of the outcomes and outcome indicators noted below.

Assumptions and Risks

Assumptions:

(a) Countries and territories in the Region recognize the concept of health as a state of complete physical, mental, and social well-being.

(b) Member States sustain and increase their commitments under the WHO and PAHO NCD action plans, also taking into account other mandates related to NCDs and their risk factors, such as UN conventions and mandates on alcohol, tobacco, unhealthy diet, physical activity, mental health, violence, road safety, disabilities, and nutrition. Of particular note are countries' obligations under the WHO Framework Convention on Tobacco Control.

(c) Countries and territories prioritize the implementation of national action plans to address NCDs, mental health, and risk factors, including an increase in financial and human resources for their implementation, in line with PAHO/WHO guidelines.

(d) Effective multisectoral, multidisciplinary collaborations and partnerships are established in relation to policies, mechanisms, networks, and actions, involving all stakeholders at national, regional, and international levels.

(e) Countries and territories and PAHO improve their health information systems to adequately measure and monitor NCDs and their risk factors.

(f) An integrated health system response to NCDs and risk factors is centered on primary health care interventions.

(g) The community-based approach to mental health is adopted by the countries and territories.

Risks:

(a) Competing national priorities reduce the attention given to NCDs and their risk factors, including interventions for mental health and disabilities at the primary health care level.

(b) Investment in prevention and control of NCDs is insufficient at national and international levels, jeopardizing the implementation of the global NCD strategy and the proposed regional NCD plan of action for 2013-2019.

(c) Low regulatory capacity at the national level allows the tobacco, alcohol, processed food, and sugary beverage industries to interfere and hinder progress in countries.

(d) There is limited enforcement of legislation dealing with NCD risk factors (including road safety and violence) at country level.

(e) The aggregation of data and the limited availability of information on NCDs and their risk factors hide important equity aspects of these diseases and conditions, weakening evidence-based interventions.

(f) The complexity of monitoring and reporting systems, including the variety of methodologies used, reduces the capacity of countries and territories to report their progress in addressing NCDs and risk factors.

(g) Low priority is given to violence prevention efforts, both because the consequences of violence are often invisible in current health statistics and because evaluating progress is equally challenging.

Category 2. Noncommunicable Diseases and Risk Factors: Program Areas and Outcomes

2.1 Noncommunicable Diseases and Risk Factors

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 2.1 Increased access to interventions to prevent and manage noncommunicable diseases and their risks factors	OCM 2.1.1	Reduce harmful use of alcohol, as appropriate within the national context**		
		2.1.1a Total (recorded and unrecorded) alcohol per capita (APC) consumption among persons 15+ years of age within a calendar year, in liters of pure alcohol, as appropriate, within the national context	8.4 liters/person/year (2003-2005)	5% reduction
		2.1.1b Prevalence of alcohol use disorders among adolescents and adults, as appropriate, within the national context	6.0% for ICD 10 codes (2.6% for harmful use and 3.4% for alcohol dependence) in 2010	5% reduction
		2.1.1c Age-standardized prevalence of heavy episodic drinking (HED)	13.7%	5% reduction
	OCM 2.1.2	Prevalence of current tobacco use		
		2.1.2a Prevalence of current tobacco use among adolescents 13-15 years of age	TBD by WHO	TBD by WHO
		2.1.2b Age-standardized prevalence of current tobacco use (18+ years of age)	21%	17% (to achieve the global target of 30% reduction by 2025)
	OCM 2.1.3	Prevalence of insufficient physical activity		
		2.1.3a Prevalence of insufficient physical activity in adolescents 13-17 years of age	The last country reported prevalence of insufficient physical activity between 2009 and 2012	A reduction of 5% with respect to the country baseline prevalence value by 2016-2019
		2.1.3b Age-standardized prevalence of insufficient physical activity in adults	The last country reported prevalence of insufficient physical activity between 2009 and 2012	A reduction of 5% with respect to the country baseline prevalence value by 2016-2019

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

** Countries will select indicator(s) of harmful use of alcohol as appropriate to national context and in line with WHO's global strategy to reduce the harmful use of alcohol. Indicators may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality, among others.

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
	OCM 2.1.4	Percentage of controlled hypertension at population level (<140/90 mmHg) among persons 18+ years of age***	15%	35%
	OCM 2.1.5	Age-standardized prevalence of raised blood glucose/diabetes among persons 18+ years of age	18.8%	18.8% (same level, to contribute to the global target to halt the rise in diabetes and obesity by 2025)
	OCM 2.1.6	Number of countries and territories with a halt in the rise of obesity at current national levels		
		2.1.6a Prevalence of overweight and obesity in adolescents 13-17 years of age	To be determined based on WHO Global Monitoring Framework	To be determined based on WHO Global Monitoring Framework
		2.1.6b Prevalence of overweight and obesity in adults (men and women 18+ years of age)	To be determined based on WHO Global Monitoring Framework	To be determined based on WHO Global Monitoring Framework
	OCM 2.1.7	Age-standardized mean population intake of salt (sodium chloride) per day, in grams, in persons 18+ years of age	11.5 grams (2010)	7 grams (to achieve the global target of 30% relative reduction by 2025)
	OCM 2.1.8	Number of countries and territories that have a cervical cancer screening program which achieves 70% coverage, as measured by the proportion of women 30-49 years of age who have been screened for cervical cancer at least once, or more often, and for younger or older age groups according to national programs or policies, by 2019	5	15
	OCM 2.1.9	Number of countries and territories with a prevalence rate of treated end-stage renal disease of at least 700 patients per million population	8	17

*** By measuring the percentage of controlled hypertension at population level among persons 18+ years of age, countries will be able to address in a comprehensive manner the first and most prevalent risk factor for NCDs in the Region. Hypertension is a cause of premature mortality due to stroke, cardiovascular diseases, and chronic kidney disease. By using this indicator, the Region will also be able to report to WHO's indicator regarding prevalence of raised blood pressure.

2.2 Mental Health and Psychoactive Substance Use Disorders

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 2.2 Increased service coverage for mental health and psychoactive substance use disorders	OCM 2.2.1	Number of countries and territories that have increased the rate of consultations through mental health outpatient treatment facilities above the regional average of 975 per 100,000 population	19	30

2.3 Violence and Injuries

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 2.3 Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women, and youth	OCM 2.3.1	Number of countries and territories with at least 70% use of seat belts by all passengers	4	7
	OCM 2.3.2	Number of countries and territories that use a public health perspective in an integrated approach to violence prevention	3	To be determined based on the 2014 WHO report on the global situation of violence prevention

2.4 Disabilities and Rehabilitation

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 2.4 Increased access to social and health services for people with disabilities, including prevention	OCM 2.4.1	Number of countries that have attained at least 12% access to habilitation and rehabilitation services and social services for persons with disabilities	0	16
	OCM 2.4.2	Number of countries and territories reaching cataract surgical rate of 2,000/million population/year	19	25

2.5 Nutrition

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 2.5 Nutritional risk factors reduced	OCM 2.5.1	Percentage of children less than 5 years of age who are stunted	13.5% (2010)	7.5%
	2.5.2	Percentage of women of reproductive age (15-49 years) with anemia	22.5% (2010)	18%
	2.5.3	Percentage of children less than 5 years of age who are overweight	7% (2008-2012)	7% (2016-2019)

Category 3 - Determinants of Health and Promoting Health throughout the Life Course

Promoting good health at key stages of life, taking into account the need to address the social determinants of health (societal conditions in which people are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

Scope

173. This category brings together strategies for promoting health and well-being from preconception to old age. It is concerned with *(a)* health as an outcome of all policies; *(b)* health in relation to development, including the environment; and *(c)* the social determinants of health, which embrace gender, equity, human rights, and ethnicity mainstreaming and capacity building.

174. The category is by its nature cross-cutting and is critical for addressing the social determinants of health and equity in order to improve health outcomes in the Region. It addresses population health needs with a special focus on key stages in life. This approach enables the development of integrated strategies that respond to evolving needs and changing demographics, to epidemiological, social, cultural, environmental, and behavioral factors, and to health inequities and equity gaps. The life course approach considers how multiple determinants interact and affect health throughout life and across generations. Health is considered as a dynamic continuum rather than as a series of isolated health states. The approach highlights the importance of transitions, linking each stage to the next. It defines protective and risk factors and prioritizes investment in health care and social determinants, gender, human rights promotion and protection, and ethnic/racial approaches in health. Moreover, the work undertaken in this category contributes to the achievement of the Millennium Development Goals, especially MDG 3 (promote gender equality and empower women), MDG 4 (reduce child mortality), and MDG 5 (improve maternal health). It is also consistent with universal and regional human rights treaties and standards and responds to the vision of the post-2015 development agenda.

Context

175. In the Region of the Americas, life expectancy at birth has increased from 69.2 in 1980 to 76.1 in 2011. Despite much progress, stark inequities persist, and glowing indicators often mask significant differences within and between countries. The Region has experienced a demographic transition and rapid urbanization, and has a high degree of ethnic diversity. Racial/ethnic minority populations (including indigenous people, Afro-descendants, and Roma, among others) face higher rates of poverty and limited access to health services. Gender also interacts with other determinants of health to

influence health status. Populations facing inequalities based on gender, ethnicity, age, place of residence, religion, language, sexual orientation, or other factors tend to have higher vulnerabilities and worse health outcomes. Targeted measures are needed to reduce these health inequities.

176. The approach based on social determinants of health looks at the whole picture in each country, addressing the interrelated factors that affect health and well-being. It allows public health professionals to look outside the health care systems for solutions to health inequities. Moreover, it provides a framework to improve the health of people while encouraging equitable opportunities across the life course, promoting civil society participation and community empowerment.

177. Health and human rights law, as enshrined in universal and regional human rights conventions and standards, offers a unifying conceptual and legal framework in which to focus strategies on vulnerable groups, as well as a mechanism by which to evaluate success and clarify the accountability and responsibilities of different stakeholders.

178. Although many countries have made significant progress in reducing maternal mortality, national averages conceal inequities. Each day in the Region, about 30 women die from causes related to pregnancy or childbirth. Improved data collection and information systems are needed to better monitor maternal health. Vulnerable groups (rural populations, indigenous groups, adolescents) require targeted actions based on gender, equity, human rights, and social determinants of health. Efforts to reduce maternal mortality should include strategies to improve quality of care and address severe maternal morbidity ("near miss").

179. The overuse of cesarean sections (CS) has become a global public health problem. A recent study found that of the 18.5 million CS deliveries performed worldwide in 2008, 73% (13.5 million) were performed in 69 countries with CS rates at or above 15%. Studies have found no additional benefit for the mother or baby in countries with CS rates above 15%; rather, such high rates have been associated with negative maternal and child health outcomes. On the other hand, CS rates under 10% are considered to reflect underuse.

180. Comprehensive and integrated approaches to sexual and reproductive health are needed in the Region. This involves an assessment of the needs of women throughout the life course, including the preconception, prenatal, childbirth, postpartum, and menopause stages of life. Consideration should be given to the inclusion of contraception and abortion in the development and implementation of health care interventions. Other challenges affecting women in the Region include HIV/AIDS feminization, mental health, gynecological cancers, and domestic, intimate partner, and sexual violence. An emerging issue in women's health care policies is the interface with noncommunicable diseases such as obesity, hypertension, and diabetes, now major causes of the disease burden for women.

181. The children of the Americas are the Region's greatest asset, and the recognition and protection of their distinct needs and human rights is essential for effective development. Member States have made great strides in reducing child mortality and morbidity and have achieved better integration of child health services in health facilities. However, to make such integration even more effective, national health policies, strategies, and plans, as well as legislation and regulations, must use an intersectoral, inter-programmatic, and life course approach.

182. Although there have been significant reductions in child mortality, persistent challenges need to be addressed. Neonatal mortality is the main component of infant mortality and under-5 mortality, and its leading causes are preventable. Each year, 210,000 children in the Region die before their fifth birthday, more than 60% of them during the first month of life.

183. Conditions at birth and in the early stages of life strongly influence health and development throughout the life course. Various adverse conditions in the early years are associated with negative impacts on growth, development, and sensory capabilities, which in turn affect the individual's quality of life and ability to work and learn. This ultimately affects the country's human capital. There is also evidence concerning the contribution of certain childhood conditions to the development of chronic diseases in adulthood.

184. Social exclusion and inequalities constitute one of the greatest challenges to child health in the Region. Poverty and deprivation during early childhood can compromise a child's development and future learning, as 80 percent of the brain's capacity develops before 3 years of age. However, early childhood development programs have low coverage, and many child survival strategies still use a vertical approach that fails to consider environmental conditions and other social determinants of health. Countries face challenges in scaling up health service delivery strategies, both clinical and community-based, to achieve health goals, and in estimating the resource requirements and financial implications of these strategies, especially for excluded populations.

185. The adolescent and youth population currently accounts for 26% of the Region's total population, the largest that this cohort has ever been in relation to other age groups. The adolescent fertility rate (73.4 per 1,000 adolescent females 15-19 years of age) remains high compared to the global level (52.7 per 1,000). Twenty-one percent of adolescents are considered overweight, and 6% are obese; at the same time, anemia continues to be a significant problem among young women. In addition, violence and psychoactive substance use among youth are worrisome problems in the Region. The disproportionate impact of these issues on low-income, cross-border, and ethnic minority young people will be a focus of research and intervention.

186. Healthy, independent older persons contribute to the welfare of their households and communities. Ten years from now, the Region will have twice as many older persons (over age 65) as in the year 2000. Although adults who reach age 60 have an additional

life expectancy of about 21 years, 10 of these years are typically spent in poor health. Older adults face social and economic inequities along with multiple chronic conditions and disabilities that are complicated by lack of social and health protection and poor access to quality services. The availability of household resources to support the elderly has rapidly declined, and therefore more older adults will not have this type of care available. Timely and adequate interventions will make it possible to address these challenges and increase the contributions of older persons to social and economic development.

187. Environmental factors influence the health of individuals and of populations. According to estimates, environmental determinants of health are responsible for as much as 25% of the global burden of disease and cause approximately 1 million deaths in the Americas annually. The principal environmental determinants of health in the Region include indoor air pollution from burning of solid fuels; ambient particulate matter and ozone pollution; residential radon; household hazardous exposure to metals, especially lead, mercury, and methyl mercury; pesticides; hazardous wastes; lack of sustainable access to safe drinking water and basic sanitation; and major occupational risk factors. Environmental determinants of health show strongly inequitable distribution, interacting with other inequalities in health. The environmental burden of disease and its unfair distribution in the Region represents a major threat to health equity, universal health coverage, economic security and growth, sustainable human development, regional governance, and the attainment of global development goals.

3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health

188. Effective interventions exist for improving the health of women and children and reducing maternal, neonatal, and child mortality. The challenges are to implement and expand those interventions, making them accessible to all during preconception, pregnancy, childbirth, and the early years of life, and ensuring quality of care. Half of maternal deaths, one-third of neonatal deaths, and one-third of stillbirths, as well as most of the complications that can lead to death of the mother or the newborn infant, occur in the 24 hours around delivery. It is also within this period that the most effective interventions to save the lives of mothers and babies can be delivered: management of labor, administration of oxytocin after delivery, resuscitation of the neonate, early initiation of breastfeeding, and interventions for children with birth defects. Work in this area receives high-level commitment through its inclusion in MDGs 4 and 5; it is also a focus of the Commission on Information and Accountability for Women's and Children's Health.

189. Family planning can prevent up to one-third of maternal deaths, but in 2012 more than 200 million women had unmet needs for contraception. The implementation of sexual and reproductive health (SRH) policies, as part of reproductive health rights, needs to be consolidated and strengthened in the Region. Significant challenges include ensuring family planning supplies; universalization of emergency contraception; ensuring

availability of male and female sterilization services; expanding health services capacity to address infertility; ensuring abortion care in cases permitted by law, particularly in pregnancies resulting from sexual violence; and integrating SRH programs with hypertension, diabetes, and mental health services, given the high burden of these diseases.

190. During the period 2014-2019, PASB will continue promoting effective interventions to decrease under-5 mortality rates in developing countries to levels approaching those in wealthier countries and to reduce disparities between the poorest and wealthiest children within nations. Particular attention will be given to treatment of pneumonia and diarrhea and to effective coordination with related vaccine-preventable diseases and environmental programs.

191. For adolescents, the work will focus on investment in protective factors at the individual, family, and community levels to promote and protect healthy behaviors and prevent risk factors. Priority will be given to poor adolescents in vulnerable situations and to the areas of sexual and reproductive health, intimate partner and sexual violence, mental health, nutrition, accidents, psychoactive substance use and abuse, and noncommunicable diseases, within a human rights framework.

192. A big challenge in the Region is to implement health promotion and preventive services that maintain the quality of life and wellness of adults (18-65 years of age), especially for male populations. The common denominator during this stage of life is work, which provides income to support families, confers social status, and promotes personal and professional growth. Targeting this "working age" is important in order to promote healthy lifestyles and control risk factors that can lead to diseases and disorders in later stages of life. A wide variety of risk factors affect adult health, including behaviors, habits, culture, and social determinants of health. Some risks relate to working conditions (such as exposure to physical, chemical, or biological hazards) or the terms of employment (contracts, salaries, schedules, social benefits, etc.). Furthermore, certain types of work may promote unhealthy habits, such as too little physical activity or poor diet, among others. Preventive and clinical services, including routine disease screening and scheduled immunizations, are key to improving adult health and preventing premature death and disability.

3.2 Aging and Health

193. The life course approach to promoting health favors more active and healthy aging. In the period 2014-2019, PASB will prioritize the health of the 150 million older persons currently living in the Region and of the additional 50 million who will enter old age by 2025. These efforts will focus on maintaining their functional ability to live actively and independently in their communities, reducing disability rates and the demand for long-term care, health services, and social assistance; promoting the health of older persons in public policy, with priority to mental health; adapting health systems and

supporting human resources development to meet the challenges associated with aging; and generating the information necessary to implement and evaluate interventions.

3.3 Gender, Equity, Human Rights, and Ethnicity

194. Gender equality in health is a progressive goal to ensure that women and men, in a context of sexual and ethnic diversity, have equal opportunities to access the resources necessary to protect and promote their health. Preconditions for achieving gender equality include the State's fulfillment of its obligations to ensure the right to health and address gender inequities.

195. The rights of children to the highest attainable standard of health, and to participate in matters that affect their health, are recognized through the United Nations Convention on the Rights of the Child. These rights are respected in the development of policies and programs.

196. A synergistic approach will be used in the institutional mainstreaming of gender, equity, human rights, and ethnicity at all levels of the Organization. This involves designing and establishing structural mechanisms that enable programmatic mainstreaming (policies, plans, and laws) to succeed, and that support countries in the achievement of gender, equity, and ethnic equality and the realization of the right to health and related human rights. In this regard, the challenges for PAHO and the Member States include developing sufficient expertise regarding instruments of human rights law and accountability mechanisms applicable to the life course, social determinants, gender, equity, and cultural diversity, and their integration within health systems.

3.4 Social Determinants of Health

197. Work on the social determinants of health affects all PAHO areas of operation. During 2014-2019, PAHO will continue to focus on the social determinants and their links with health promotion, addressing equity across all five programmatic categories of the Strategic Plan (excluding Category 6, Leadership, Governance, and Enabling Functions). In addition, capacity building on mainstreaming the social determinants of health approach will continue in PASB and in Member States. Tools and guidelines are needed to implement Health in All Policies with the objective of building greater awareness of the value added through the social determinants of health approach and its link to health promotion, which encourages increased community participation and empowerment for health. PASB will also develop a standard set of indicators to monitor action on social determinants of health and to implement and monitor the joint work plan on social determinants with partners within and outside the health sector. This will require collecting disaggregated data to improve the analysis and understanding of inequities and social gradients in health in the Region, as well as within countries.

198. Health in All Policies draws from national and international developments in the area of health policy and comprehensive health care, including the Alma Ata Declaration,

the Ottawa Charter, the Universal Declaration of Human Rights, and the Rio Political Declaration on Social Determinants of Health. The Rio Political Declaration, adopted in 2011 by the World Conference on Social Determinants of Health, expresses worldwide commitment to implement the social determinants approach to health. This allows countries in the Region to build momentum for developing their own national action plans and multisectoral strategies dedicated to reducing inequities.

199. Finally, as articulated in the Rio Political Declaration, PAHO will focus on the need for better coordination and guidance of the growing number of actors in the health sector, an area generally referred to as health governance. The social determinants approach to health promotes governance through partnerships and networks with different sectors of society, aimed at addressing the stark inequities in the Region through concrete actions and consensus-based public policies. The goal is to attain the highest possible level of health for all and the implementation of universal and regional human rights law treaties and standards applicable to health.

3.5 Health and the Environment

200. Action on the environmental determinants of health is imperative to build inclusive, healthy, and safe societies in which people can fulfill their potential and lead long, healthy, dignified, and productive lives. This requires specific action to address environmental inequalities in health. Consistent with the large body of global and regional commitments, agreements, and mandates on issues pertaining to environmental health, PAHO's technical cooperation in this priority area will focus on: *(a)* strengthening the national health authorities' stewardship of environmental health; *(b)* increasing institutional capacities in environmental health, including professional competencies in the assessment of environmental health risks and impacts, in monitoring environmental inequalities in health, and in the generation of an evidence base to inform policy; *(c)* advancing the maintenance and promotion of environmental health, with emphasis on the implementation of primary environmental services at the local level; *(d)* promoting actions to reduce environmental inequalities and their impact on health through actions that span environmental and social gradients as well as those that target vulnerable populations; and *(e)* strengthening specific programs that address current and emerging environmental threats with local health impacts, such as climate change, loss of biodiversity, ecosystem depletion, water scarcity, and desertification.

Key Stakeholders' Analysis

201. The work in Category 3 will be undertaken within the context of the UN Secretary-General's Global Strategy for Women's and Children's Health and the Every Woman Every Child Initiative. Partners and collaborators will include H4+ (WHO, UNICEF, UNFPA, the World Bank, UNAIDS, UN Women); the Partnership for Maternal, Newborn and Child Health; other United Nations partners such as UNDP and the United Nations Population Division; the Organization of American States (OAS); academic and research institutions; civil society and development organizations; the

UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the GAVI Alliance. These partnerships will ensure complementarity and accelerate action in the final push toward achieving MDGs 3, 4, and 5.

202. One of the overarching goals of the post-2015 development agenda is maximizing health at all stages of life. Work in this category is essential for this goal, as is achieving universal health coverage. Critical to these are the social determinants of health approach and health promotion throughout the life course.

203. With experience gained in 2012-2013 through the work of the UN Platform on Social Determinants of Health (International Labour Organization, UNAIDS, UNDP, UNFPA, UNICEF, and WHO), the Organization is well placed to advocate for action on social determinants, including their integration into the post-2015 development agenda, as well as to provide technical support to Member States in this area. A network of institutions will be established to strengthen capacities of Member States to implement the five action areas enshrined in the Rio Political Declaration on Social Determinants of Health.

204. PAHO will maintain its role within UN-Water, strengthen its collaboration with UNICEF on global monitoring of water and sanitation, and lead an initiative for ensuring water quality through a new collaborative framework with UN-HABITAT on urban environmental health issues. The Organization will continue to host the secretariat for, and participate in, the Inter-Organization Programme for the Sound Management of Chemicals. PAHO will further strengthen the representation of health within the overall United Nations response to climate change through the High-Level Committee on Programmes of the United Nations System Chief Executives Board for Coordination. The Organization will provide technical health input to programs under the United Nations Framework Convention on Climate Change and to specific partnerships with other organizations in the United Nations system.

Strategies for Technical Cooperation

(a) Ensure the availability of data for measurement of trends related to social determinants of health, human rights, and ethnicity and gender equality as they relate to health in the Region.

(b) Strengthen surveillance, monitoring, and evaluation systems to expand the research and evidence base for policy planning and evaluation through adequate investment, capacity strengthening, and effective partnership between the academic and public sectors.

(c) Advocate with governments to prioritize a healthy life course using a framework of social determinants, human rights, cultural diversity, and gender equality in

health, through education, policies, and a communication plan, emphasizing intersectoral action and public-private partnerships.

(d) Strengthen national strategies and plans to address health in all public policies, involving civil society and relevant stakeholders through community-based initiatives.

(e) Support the incorporation of gender equality, ethnic/racial equality, poverty reduction, and human rights perspectives into preparation of health guidelines, policy making, and program implementation to address the root causes of health inequities, discrimination, and inequality with regard to the most vulnerable groups.

(f) Implement existing regional plans and strategies agreed with Member States, including PAHO Governing Bodies resolutions, that relate to health throughout the life course, social determinants, human rights, cultural diversity, gender equality in health, and the environment, and that integrate interventions on the main health issues using promotion and prevention strategies.

(g) Contribute to health systems strengthening by:

i. Integrating and harmonizing programs and interventions along a continuum of care that runs throughout the life course and spans the home, the community, and different levels of the health system and services.

ii. Expanding, integrating, and reorienting services for the delivery of gender-sensitive, cost-effective interventions throughout the life course using social determinants, human rights, and gender equality in health frameworks, through prevention, diagnosis, treatment, care, and support, ensuring services for hard-to-reach populations and vulnerable groups, including indigenous populations.

iii. Building capacity of the public health workforce to provide public health interventions and high-quality health care in response to new demands linked to demographic and epidemiological trends.

iv. Promoting community-based interventions and supporting appropriate care in the home throughout the life course.

(h) Establish and maintain effective coordination with other partners across all relevant sectors at the country, subregional, and regional levels and promote partnerships with bilateral and UN agencies to harmonize actions that scale up interventions and maximize the use of resources, strengthening the network of WHO Collaborating Centers in the Americas.

(i) Foster transfer of technology and new modalities of technical cooperation (e.g., South-to-South), leveraging and mobilizing technical expertise across the Region and fostering the exchange of lessons learned among Member States.

(j) Strengthen the strategic alliance between the health and environment ministries to build stronger links between the health and environmental sectors in planning and implementation of national policies.

(k) Mobilize resources for all the strategic approaches to improve health throughout the life course.

(l) Ensure that technical cooperation is tailored to the needs of the Member States and their populations, focusing technical cooperation on the key countries as defined in this Strategic Plan and on the priority countries identified for this category.

Cross-Cutting Themes and Strategic Approaches in Health

205. This category has many linkages with other PAHO areas of work. There are special working relationships with communicable diseases and vaccines, nutrition, food safety, and integrated, people-centered health services that provide primary health care for reducing maternal and child mortality and morbidity throughout the life course. There are also links between programs dealing with risk behaviors in adolescence and with NCDs in adults. PASB's response to the health needs of older populations is multifaceted and involves all parts of the Organization. Particularly important will be close collaboration with health analysis and NCDs and mental health along the life course, and older people's access to health care and long-term care and prevention of disabilities. Equally important is the link with efforts to ensure the health of women, children, and the elderly during emergency situations.

206. Additionally, by its very nature, work in this category—namely, efforts to support health across the life course and cross-cutting themes such as gender, equity, human rights, and ethnicity—contributes to, and benefits from, work in all other categories. The category will serve as the hub to ensure that technical work in these cross-cutting areas is mainstreamed across all program areas. In addition, intersectoral collaboration for addressing the social and environmental determinants of health will need to be promoted.

Assumptions and Risks

Assumptions:

(a) Member States sustain a commitment to address the health inequity gap through action on the social determinants of health, including implementation of the Rio Political Declaration and monitoring of its progress.

(b) The health sector sustains its leadership in implementing the Health in All Policies Framework for Country Action.

(c) Political commitments are made at the regional and country levels with regard to sexual and reproductive health rights as well as health throughout the life course, cross-cutting themes, and social determinants of health.

(d) Comprehensive approaches and coordination mechanisms are in place within and across categories and with other UN agencies to improve the health of vulnerable populations.

(e) Inter-programmatic work is designed to leverage health system interventions.

(f) Health information systems have the capacity to monitor the health situation of all population groups.

(g) Countries are willing to make and sustain legislative and policy changes aimed at breaking down barriers to access to health care and contraceptive methods, especially among young people.

(h) Evidence-based interventions are available at the country level, with appropriate tools for implementation.

(i) A comprehensive approach to active aging incorporates not only the physical health of older adults, but also human rights, mental health, social determinants, and other relevant programs.

(j) Regional and multisectoral collaboration contributes to the development of new programs and to sharing of best practices among Member States.

(k) Health systems are prepared to provide clinical services, preventive services, and health promotion to workers and working-age populations.

(l) There is collaboration with other UN agencies to address environmental and workers' health.

(m) Countries strengthen their policy and legislative frameworks on environmental health and workers' health.

Risks:

(a) Competing priorities, disasters and epidemics, political turmoil, or civil unrest limit the resources for program areas in this category, compromising the achievement of results.

(b) There is an erosion of political will to support work on the social determinants of health and limited capacity to integrate the social determinants into health programs.

(c) Interventions at the primary health level are undermined by frequent rotation of personnel and lack of a critical mass of health care providers.

(d) Information systems produce limited disaggregated data and scarce data on the social determinants of health.

(e) There is limited engagement of key stakeholders at all stages of decision making around family planning, from policies to program implementation, for social and religion reasons. The multisectoral approach is not used to ensure access to family planning. Most countries do not have adequate monitoring and evaluation systems

to identify the major barriers to family planning and the groups with least access to these services, such as teenagers, indigenous people, and rural dwellers.

(f) The health workforce is not prepared for the development of new active aging programs.

(g) There is limited use of evidence-based programs that have been adapted to local contexts and are relevant to local populations.

(h) Although health priorities at the global, regional, and national levels prioritize the cross-cutting themes, they are easily overshadowed or sidestepped when challenged by national and international interest groups. There is limited knowledge and consensus among partners on definitions, frameworks, and strategies for the cross-cutting themes.

(i) Harmful laws and policies based on gender identities, gender expressions, age, ethnicity, and/or sexual orientation impede initiatives to respect, promote, and protect human rights in the context of health.

(j) Outdated policies and laws, and limited enforcement of existing policies and laws, make it difficult to effectively address environmental and workers' health.

Category 3. Determinants of Health and Promoting Health throughout the Life Course: Program Areas and Outcomes

3.1 Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 3.1 Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults	OCM 3.1.1	Percentage of unmet need with respect to modern methods of family planning	15%	11%
	OCM 3.1.2	Percentage of deliveries attended by trained personnel	95%	97%
	OCM 3.1.3	Percentage of mothers and newborns receiving postpartum care within seven days of childbirth	40%	60%
	OCM 3.1.4	Percentage of infants under 6 months of age who are exclusively breastfed	38%	44%
	OCM 3.1.5	Percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics	29%	40%
	OCM 3.1.6	Specific fertility rate in women 15-19 years of age**	60 per 1,000	52 per 1,000
	OCM 3.1.7	Number of countries and territories that adhere to PAHO's recommendation to conduct periodic medical occupational evaluations (PMOE) among the adult working population (18-65 years of age)	3	10

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

** PAHO will also measure the percentage of adolescent mothers below 15 years of age.

3.2 Aging and Health

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 3.2 Increased access to interventions for older adults to maintain an independent life	OCM 3.2.1	Number of countries and territories with at least one evidence-based self-care program for older adults living with multiple chronic conditions	1 (2015)	15

3.3 Gender, Equity, Human Rights, and Ethnicity

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 3.3 Increased country capacity to integrate gender, equity, human rights, and ethnicity in health	OCM 3.3.1	Number of countries and territories with an institutional response that addresses inequities in health: gender, equity, human rights, and ethnicity	32	39

3.4 Social Determinants of Health

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 3.4 Increased leadership of the health sector in addressing the social determinants of health	OCM 3.4.1	Number of countries and territories implementing at least two of the five pillars of the Rio Political Declaration on Social Determinants of Health	13	27

3.5 Health and the Environment

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 3.5 Reduced environmental and occupational threats to health	OCM 3.5.1	Number of countries and territories with a significant disparity (>5%) that have reduced the gap between urban and rural populations' access to improved water sources	9	24
	OCM 3.5.2	Proportion of the population with access to improved sanitation	88%	92%
	OCM 3.5.3	Number of countries and territories in which the proportion of population relying on solid fuels is reduced by 5%	14	20
	OCM 3.5.4	Number of countries and territories with capacity to address workers' (occupational) health with emphasis on critical economic sectors and occupational diseases	11	24
	OCM 3.5.5	Number of countries and territories with capacity to address environmental health	11	24

Category 4 - Health Systems

Strengthening health systems based on primary care; focusing health governance and financing toward progressive realization of universal access to health and universal health coverage; organizing people-centered, integrated service delivery; promoting access to and rational use of health technologies; strengthening health information and research systems and the integration of evidence into health policies and health care; facilitating transfer of knowledge and technologies; and developing human resources for health.

Scope

207. Universal access to health and universal health coverage ("universal health")[4] is one of the most powerful ideas in public health. It combines two fundamental components: *(a)* access to the quality services needed to achieve good health for every individual and community, including promotion, prevention, treatment, rehabilitation, and palliative/long-term care, along with actions to address the determinants of health; and *(b)* financial mechanisms, policies, and regulations required to guarantee financial protection and prevent ill health from leading to or worsening poverty.

208. Advancing universal health coverage means promoting universal access to well-trained and motivated health care workers and to safe and effective health technologies, including medicines and other medical products, through well-organized delivery networks. It means building and maintaining strong health systems based on primary health care and grounded in a sound legal, institutional, and organizational foundation. Work in these areas must be guided by innovation, scientific evidence, and relevant knowledge. PAHO Member States are diverse in size, resources, and levels of development; universal health provides a powerful unifying concept to guide health and development and to advance health equity in the coming years. PAHO's leadership, both technical and political, will be crucial in championing universal health and enabling countries to achieve it.

[4] PAHO definition: "Universal access to health and universal health coverage imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, affordable, effective, quality medicines, while ensuring that the use of these services does not expose users to financial hardship, especially groups in conditions of vulnerability" (Strategy for Universal Access to Health and Universal Health Coverage, Document CD53/5, Rev. 2, adopted through Resolution CD53.R14 [2014]).

Context

4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans

209. Health systems in the Region face two main organizational challenges: segmentation due to different funding and affiliation schemes, and fragmentation due to provision of care by many different institutions and facilities that often are not integrated into networks. Other problems include lack of clear national health priorities and goals; absence of comparable data; weak service management and regulatory capacities; and deficiencies in the availability, distribution, and quality of the health workforce. These problems contribute to inequities in health, inefficiency in health care services, and gaps in effective access to high-quality health services, including medical products and other health technologies.

210. While the 2012 Mid-term Evaluation of the Health Agenda for the Americas documents important progress in strategic health planning in a great majority of the countries in the Region, the strengthening of this function in the health sector is critical for effective leadership and governance. A key challenge related to leadership and governance of the health sector is insufficient access to and use of scientific knowledge to better understand the effects of public health programs and services.

211. Access to health services is only one of a number of determinants of health. There is a strong relationship between universal health and the social, environmental, and economic pillars of sustainable development. Consequently, millions of people in the Region do not have a guaranteed right to health, and resources are not used effectively to implement proven interventions to address health priorities and improve health outcomes. The most affected populations are those that are most vulnerable, historically excluded, and poor, such as indigenous and Afro-descendant people. Policies and legal frameworks promoting equity in access to health care and health technologies are being addressed throughout the Region, along with social protection mechanisms to reduce or eliminate financial barriers.

212. Universal health is conceived not as a minimum set of services but as an active process of progressive realization. It must be advanced in three dimensions: *(a)* the range of good-quality services that are effectively available to people; *(b)* the proportion of the costs of those services that is covered; and *(c)* the proportion of the population that is covered by the health services. Results of the Mid-term Evaluation of the Health Agenda for the Americas show progress in the steering role of national health authorities and suggest continued efforts strengthen all three dimensions. The development of good governance in health, as a process to build a common vision and align efforts, is essential for universal health. The proposed political strategy, which links health to broader social and economic goals, implies the implementation of evidence-based social protection policies with specific financial mechanisms geared to universal health.

4.2 People-Centered, Integrated, Quality Health Services

213. In the Americas, fragmentation of health services is a common constraint. Fragmented systems are characterized by limited coordination across the different levels and points of care, duplication of services and infrastructure, unutilized and underutilized productive capacity, and the provision of health services at the least appropriate locations, particularly hospitals. From the people's perspective, fragmentation means limited access to services, loss of continuity of care, and failure of services to meet users' needs.

214. Universal health coverage implies a people-centered model of care and the development of comprehensive care networks to meet the needs and demands of the entire population throughout the life course. Transforming the way that care is provided will ensure access to effective, comprehensive health services, including vertical health programs, across the health care continuum. People-centered, integrated service delivery focuses on the health needs and expectations of people and communities, rather than solely on diseases. Meanwhile, evidence-informed policies make use of the best scientific evidence and other forms of knowledge in a systematic manner and promote appropriate and efficient approaches to improving health care and policies for health. Both aspects play a crucial role in shaping health policy and health services.

4.3 Access to Medical Products and Strengthening of Regulatory Capacity

215. Health technologies, including medicines and other medical products, are indispensable in the provision of health services, from prevention to palliative care. Improving access to health technologies is an essential step toward achieving universal health, and an indispensable part of this is developing and implementing policies to strengthen governance and management of health technologies. Important disparities exist in access to medicines and other health technologies between countries in the Americas and between different socioeconomic groups within the same country. In most low- and middle-income countries, health technologies constitute the largest public expenditure in health after personnel costs, as well as the largest household health expenditure. The inappropriate and irrational use of medicines and other health technologies not only inflates health care costs but also diminishes the quality of care, jeopardizes patient safety, and compromises overall health outcomes.

216. While some countries of the Region have strengthened their capacity for technological innovation in health, many innovation priorities are yet to be addressed. Newer health technologies are becoming available, but they often cost more than those they replace. Therefore, health technology assessments (HTA) should guide decision making regarding the acquisition of new technologies and their implementation within health services, and practice guidelines should be prepared to improve quality of care and optimize resources for health. Appropriate regulatory capacity is required to ensure the availability of safe, quality, and effective medicines and other health technologies, and strengthening such capacity has become a priority for countries of the Americas in their quest to advance toward universal health.

4.4 Health Systems Information and Evidence

217. Health information is a key input that supports all aspects of health action, including research, planning, operations, surveillance, monitoring, and evaluation, as well as prioritization and decision making. However, disparities persist between countries regarding the coverage and reliability of health information systems and the timeliness and quality of the information they provide. Countries also differ in their research and analytical capacities to produce health data and use it to analyze the causes of problems and the best available options for addressing them. Communities need to play a more active role in the generation and dissemination of evidence to better guide actions aimed at improving the health status of the population.

218. Improving the living conditions of the population and reducing inequities in health outcomes requires actions to strengthen the capacity for health situation analysis, to improve generation and sharing of evidence, and to facilitate its translation into policies and its application to public health practice. Scientific evidence and health information must be integrated into decision-making processes at all levels of the health system in order to achieve evidence-based health care and evidence-informed policy making. PASB will continue to develop guidelines and tools, produce multilingual and multiformat information products, promote sustainable access to up-to-date scientific and technical knowledge by PASB staff and national health care professionals, and contribute to the empowerment of patients through reliable information. In addition, PASB will manage and support knowledge networks, translating evidence into policies and practices and promoting the appropriate use of information and communication technologies (ICT).

219. Health information is a basic right of people. The development and use of ICT, the broadening of digital literacy, and the expansion of access to scientific knowledge and training can all help increase people's access to quality health information. In particular, the development and use of eHealth and mHealth, using electronic communications and mobile devices, have the potential to change the way health services are delivered. The development and implementation of national eHealth strategies will be critical for optimization of the health benefit offered by new information technologies.

4.5 Human Resources for Health

220. Human resources—professionals, scientists, technicians, auxiliaries, and community health workers—are the backbone of health systems and services. As such, they are central to the achievement of universal health coverage. Without proper attention, however, the health workforce can become a principal obstacle to the achievement of universal health. Many countries in the Region suffer critical shortages of health personnel at the national level, defined as fewer than 25 health workers per 10,000 inhabitants. Almost all the countries have a scarcity of health workers in certain districts or communities, typically urban fringe or rural communities populated by indigenous people or other groups with socioeconomic or cultural differences. In the medium term,

increasing demands related to noncommunicable diseases and population aging, combined with financial pressures on health systems, will intensify tensions around the availability, distribution, composition, competencies, management, and performance of health human resources. An additional problem in many countries is outmigration of the health workforce.

221. The health workforce is also a key political actor, with enough power to change the way health policies are formulated and applied. The effectiveness of health care depends greatly on the performance of the health workforce and consequently on its financing, training, selection, contracting, and development by means of comprehensive career pathways. High-quality, people-centered, integrated health services need the right mix of health care workers, with the right skills, in the right place, at the right time. Strengthening the management and development of human resources in health should be part of health public policies. Twenty of the 30 countries that participated in the Mid-term Evaluation of the Health Agenda for the Americas in 2012 reported including this area of work in their national health plans. Because human resources for health can significantly affect population health status, they should be seen as essential workers and not as a flexible resource that can easily be cut in response to a budget shortfall. Health workers are the head, heart, and hands of the health system.

Key Stakeholders' Analysis

222. The health sector has many stakeholders at the global, regional, national, and local levels. Also, in recent years an increasing number of players have emerged in the field of international health; this has fostered constructive cooperation but also competition for resources and for influence on health policy. Improving health and health equity in the Americas requires a shared vision, a rights-based approach, and the alignment of all efforts toward the achievement of common goals.

223. In championing universal health and supporting Member States in their efforts to attain this goal, PASB will continue its collaboration with the public sector, the private sector, and civil society. Within the public sector, PASB will continue engaging allies in cooperative actions across multiple sectors, including education, agriculture, environment, planning, finance, the legislature, and the judiciary. To avoid duplication, optimize the use of resources, and increase synergies, PASB will continue to strengthen coordination with other agencies of the UN and inter-American systems and enhance the harmonization and alignment of the three levels of WHO.

224. PASB will engage with a host of strategic partners involved in the different program areas under this category. They include, among others, the Bill and Melinda Gates Foundation, Canadian International Development Agency (CIDA), Caribbean Public Health Agency (CARPHA), Escuela Andaluza de Salud Pública (EASP), GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Government of Brazil, Health Canada, Inter-American Development Bank (IDB), Oswaldo Cruz Foundation (Fiocruz), Public Health Agency of Canada (PHAC), RAD-AID

International, Spanish Agency for International Development Cooperation (AECID), UK Department of Health, U.S. Agency for International Development (USAID), U.S. Department of Health and Human Services (HHS), U.S. Food and Drug Administration (FDA), and World Bank. Finally, PASB will strengthen its relationships and partnerships with WHO Collaborating Centers related to the category, as well as its relationships with numerous professional and academic associations, nongovernmental organizations, and private sector organizations in the area of health systems.

Strategies for Technical Cooperation

(a) Establish partnerships and networks with all branches of government, civil society, universities, research centers, collaborating centers, professional associations, donors, and others to champion universal health coverage.

(b) Apply the primary health care-based approach to health systems transformation as defined in the 2007 PAHO position paper, "Renewing Primary Health Care in the Americas." A PHC-based health system entails an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal, while maximizing equity and solidarity. Such a system is guided by the principles of responsiveness to people's needs, quality, government accountability, social justice, sustainability, social participation, and intersectoral coordination.

(c) Translate research into public health policies that support universal health, implementing PAHO's Policy on Research for Health, the WHO Strategy on Research for Health, and the WHO Strategy on Health Policy and Systems Research. Build and sustain the necessary capacity for conducting research on issues of national and regional interest in the areas of public health, health policies and regulation, and health systems, and translate the findings into policy and practice.

(d) Build capacity for strengthening the steering role of national health authorities and brokering alliances between government institutions and other relevant stakeholders and partners in order to enhance country ownership of national goals and objectives.

(e) Build capacity of the national health authorities for the definition, implementation, monitoring, and evaluation of national health strategies and plans, supported by multisectoral policies and national investments.

(f) Strengthen parliamentary capacity, at both regional and national levels, for developing legislation to achieve universal health.

(g) Promote institutional development and evidence-informed policy options to build legal frameworks and financial mechanisms that increase social protection in health.

(h) Expand the use of information and communication technologies and social media for virtual collaboration and increased outreach of technical cooperation efforts,

making use of regional initiatives such as the Primary Health Care Collaborative Network, the Regional Platform on Access and Innovation for Health Technologies, the Virtual Campus for Public Health, and the Regional Observatory of Human Resources in Health.

(i) Provide advocacy and support to Member States in the reorganization of health care by applying the Integrated Health Services Delivery Networks framework (PAHO 2010) and strengthening management and leadership capacities.

(j) Strengthen institutions at the national, subregional, and regional levels and promote a public health approach to development, innovation, incorporation, assessment, regulation, management, and rational use of health technologies with a view to ensuring patient safety and quality of care. Implement the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, and strengthen the Health Technology Assessment Network of the Americas and the PAHO Strategic Fund for medicines and public health supplies.

(k) Develop and apply evidence-based international norms and standards, methods, analytical tools, and policy options for health systems, services, and health technologies, including health analysis, research, and design and evaluation of interventions. Expand knowledge translation platforms that introduce a systematic approach to policy development informed by evidence. Use validated systems to address unjustified or unwanted variations in health care.

(l) Consolidate, maintain, and expand regional initiatives for the strengthening of information systems and information sharing, such as the Regional Plan of Action for Strengthening Vital and Health Statistics (PEVS) and the Regional Core Health Data and Country Profile Initiative. Promote the mapping of national health research systems and other tools to support health research governance and the PAHO Health Information Platform.

(m) Implement the regional strategies and action plans on eHealth and Knowledge Management and Communications to contribute to the realization of societies that are more informed, equitable, competitive, and democratic.

(n) Develop and implement evidence-based policy options and tools to address the five challenges in human resources development for health set out by the Toronto Call to Action for a Decade of Human Resources in Health in the Americas.

Cross-Cutting Themes and Strategic Approaches in Health

225. Health systems and services are the means to combat disease, promote physical and mental health, and lengthen life. They must guarantee the right to health without discrimination of any kind. They are also a means to promote social and economic development. Building and maintaining strong health systems based on primary health care is the way to achieve and sustain better health outcomes, improve equity and social protection in health, and enhance people’s satisfaction with their health care. Inter-programmatic work and intersectoral collaboration are inherent parts of the PHC strategy.

Constraints at the system and service levels can make it difficult to improve health outcomes, and understanding and addressing these constraints requires dialogue and collaboration with experts in all other areas of work. Improving health outcomes with equity requires application of the human rights, gender, and cultural diversity approaches in the development of health systems and above all in assessing their performance.

226. Integration of services across the whole health care continuum and better links between medical, social, and long-term care offer significant benefits in addressing communicable and noncommunicable diseases, maternal and child health, and the health of aging populations. The growing burden of noncommunicable diseases will have devastating health consequences for individuals, families, and communities and threatens to overwhelm health systems. Public health emergencies, disasters, neglected diseases, and emerging threats to population health require responsive health systems. Multisectoral action is needed to address these burdens and threats and to improve health outcomes with equity.

227. Building robust health systems for universal health is everybody's business. It is also a means to achieve the expected outcomes in the other categories of work—for example, to build capacity and tools for policy coherence in order to mainstream the social determinants of health, or to develop the core capacities required by Member States to comply with the International Health Regulations (such as national legislation, policy, financing, coordination, human resources, and laboratories, among others).

Assumptions and Risks

Assumptions:

(a) Social and political stability continues in the Region, with priority given to public investments in health.

(b) All relevant stakeholders, at the national, subregional, and regional levels, are committed to achieving health equity.

(c) Dynamic leadership ensures increased harmonization and alignment of cooperation in health.

(d) Member States and development partners make increasing use of quality data for resource allocation, priority setting, and policy and program development.

(e) Countries update their policies, plans, legislative and regulatory frameworks, and health systems to support universal health coverage and guarantee the right to health.

(f) Countries implement a people-centered model of care as one of the main reforms to improve the quality of health services and increase user satisfaction.

(g) Access to quality medical products and health technologies continues to be an important strategic issue for national health authorities, with a focus on strengthening regulatory frameworks and procurement systems.

(h) Regional, subregional, and national efforts to promote development of the health workforce continue, in line with the Toronto Call to Action.

(i) Cross-sector and interagency partnerships in support of health workforce development continue to promote the active participation of all direct stakeholders, including civil society, professional associations, and the private sector.

Risks:

(a) Reduction of external funding from donors and limited national fiscal space to increase public health expenditure compromises the sustainability of equity-enhancing public policies.

(b) There is a reduction in the resources allocated to systemwide approaches, along with weak intersectoral coordination.

(c) Short-term solutions are prioritized over investments in long-term, sustainable measures to guarantee universal health coverage and patients' rights.

(d) The persistence of segmentation hinders the efficiency of the health care delivery system and erodes its potential to reduce exclusion.

(e) The persistence of fragmentation in health services limits the achievement of more equitable health results better aligned with people's needs and expectations.

(f) Investments in technology and infrastructure are made without proper assessments and evaluation of needs.

(g) Negotiation and implementation of free trade agreements hampers access to medical products and technologies in the Region.

(h) Limited international and national investments are made in health information systems, research, and integration of evidence into practice, especially in middle-income countries, where the majority of the Region's poor reside.

(i) Financing of health workforce development decreases to such a low level that it affects budgets and incentives for deployment to underserved areas.

(j) Countries affected by a human resources crisis remain unable to take the lead and manage responses on their own.

(k) Market forces continue to exert pressure for the exodus of health professionals to other countries ("brain drain") and to urban areas, as well as to other professions.

Category 4. Health Systems: Program Areas and Outcomes

4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 4.1 Increased national capacity for achieving universal access to health and universal health coverage	OCM 4.1.1	Number of countries and territories that have implemented actions toward the progressive realization of universal access to health and universal health coverage	3 (2015)	12
	OCM 4.1.2	Number of countries and territories with public expenditure in health of at least 6% of GDP	7	20

4.2 People-Centered, Integrated, Quality Health Services

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 4.2 Increased access to people-centered, integrated, quality health services	OCM 4.2.1	Number of countries that have reduced by at least 10% hospitalizations for ambulatory care sensitive conditions	6 (2015)	19

4.3 Access to Medical Products and Strengthening of Regulatory Capacity

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 4.3 Improved access to and rational use of safe, effective, and quality medicines, medical products, and health technologies	OCM 4.3.1	Number of countries that ensure access to medicines included in the national essential medicines list without any payment at the point of care/service/ dispensing of the medicine	1	14
	OCM 4.3.2	Number of countries and territories that have achieved or increased their regulatory capacity with a view to achieving the status of functional regulatory authority of medicines and other health technologies	7	35

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

4.4 Health Systems Information and Evidence

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 4.4 All countries have functioning health information and health research systems	OCM 4.4.1	Number of countries and territories meeting the coverage and quality goals of the PAHO Regional Plan of Action for Strengthening Vital and Health Statistics	14	35
	OCM 4.4.2	Number of countries and territories with functional mechanisms for governance of health research	5	26

4.5 Human Resources for Health

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 4.5 Adequate availability of a competent, culturally appropriate, well regulated, well distributed, and fairly treated health workforce	OCM 4.5.1	Number of countries and territories with at least 25 health workers (doctors, nurses, and midwives) per 10,000 population	25	31
	OCM 4.5.2	Number of countries and territories with national training programs on public health and intercultural competencies for primary health care workers	8	23
	OCM 4.5.3	Number of countries and territories that have reduced by 50% the gap in the density of health workers (doctors, nurses and midwives) between subnational jurisdictions (province, state, department, territory, district, etc.) that have a lower density of health workers than the national density	11	19

Category 5 - Health Emergencies

Reducing mortality, morbidity, and societal disruption resulting from emergencies and disasters through the detection, management, and mitigation of high-threat pathogens, together with all-hazards risk reduction, preparedness, response, and early recovery activities that build resilience and use a multisectoral approach to contribute to health security.

Scope

228. This category focuses on strengthening capacities to carry out prevention, risk reduction, preparedness, surveillance, response, and early recovery for emergencies and disasters related to any hazard (natural, human-made, biological, chemical, radiological, and others), and, when national capacities are overwhelmed, to lead and coordinate the international health response to contain disasters, including outbreaks, and to provide effective relief and recovery to affected populations.

Context

5.1 Infectious Hazard Management

229. Epidemic- and pandemic-prone diseases pose an ongoing and continuous threat to global and regional health security and to sustainable socioeconomic development. The need for comprehensive surveillance and a collective rapid response in the Region, especially to potential pandemics and outbreaks, is a major challenge due to high population movements, changes in environmental settings including deforestation, and climate change, among other factors. Diseases of animal origin can cause epidemics and/or pandemics, creating a need for effective risk management of emerging zoonoses that can cause public health emergencies.

230. PAHO will support countries in the surveillance, prevention, and control of high-risk diseases of pandemic and epidemic potential (e.g., viral hemorrhagic fevers, influenza and coronaviruses, arthropod-borne viruses, and bacterial diseases). It will do so through forecasting, characterization of diseases and infectious risks, and development of evidence-based strategies to predict, prevent, detect, and respond to infectious hazards. This includes developing and supporting prevention and control strategies, tools, and capacities for high-threat infectious hazards; establishing and maintaining expert networks to leverage international expertise to detect, understand, and manage new or emerging high-threat infectious hazards; as well as providing technical support under the Pandemic Influenza Preparedness (PIP) Framework.

5.2 Country Health Emergency Preparedness and the International Health Regulations (2005)

231. IHR States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2016 showed steady improvements at the regional level in all core capacities. However, the status of the core capacities across the subregions continues to be heterogeneous, with the lowest scores consistently registered in the Caribbean subregion. When the States Parties Annual Reports in their current format were instituted for reporting to the 64th World Health Assembly in 2011, the response rate was 51% (18 of 35 States Parties in the Americas). In 2016, for the first time, the response rate was 100%, with all 35 States Parties in the Americas reporting to the 69th World Health Assembly. Comparing the most recent reports with the States Parties Annual Reports submitted to the 68th World Health Assembly in 2015, variations in regional average scores are in the range of 10 percentage points in the case of all capacities other than points of entry, for which an 18 percentage point improvement was registered. With the exception of the capacities to respond to events associated with chemical (57%) and radiation-related (55%) hazards, the regional average score for all remaining capacities is close to or above 75%. The highest score is for surveillance (92%).

232. The health sector has the responsibility to monitor, anticipate, and mitigate the health consequences of all types of emergencies and disasters. Toward this end, it must strengthen its capacity to respond with effective and timely interventions. A major challenge is readiness. The regular operating infrastructure, personnel, and organization of the health services need the flexibility and capacity to immediately shift into emergency response; their ability to do so depends upon laboratory capacity, monitoring systems, personal protective equipment, human resources, and community participation, among other aspects.

233. The aim of this program area is to ensure that all countries of the Region have capabilities for all-hazards health emergency and disaster risk management, including the core capacities needed to fulfill their responsibilities under the International Health Regulations (2005). These cover national legislation, policy, and financing; coordination and National Focal Point communications; surveillance and risk communication; preparedness and response; infection prevention and control; human resources; and laboratory capacity building and networking. Work in this program area aims to build the capacity of countries to protect the physical, mental, and social well-being of their populations and recover rapidly from emergencies and disasters. This requires adequate national leadership and sustained capacity of the health sector to build the resilience of countries and territories.

5.3 Health Emergency Information and Risk Assessment

234. This program area aims to provide authoritative information for public health decision making in emergencies. This includes identifying new public health events, assessing risks to public health, conducting epidemiological surveillance and field

investigations, monitoring public health interventions, and communicating public health information to technical partners.

235. PASB's capacity to provide actionable information and technical advice to national authorities about public health events that could pose a risk to international public health depends on timely notification and transparency by Member States in sharing information with PAHO, as well as on PAHO's capacity to maintain communication 24/7 with the National Focal Points (NFPs). During 2014-2015, 24/7 epidemiologic monitoring and response actions were maintained throughout the biennium to rapidly inform Member States about threats or public health risks, such as the Zika virus, which evolved into a Public Health Emergency of International Concern during 2016. During this period, 38 alerts and epidemiological updates were disseminated to Member States; 31 event updates (10 related to Zika virus) were posted on the Event Information Site for IHR NFPs; and 594 email communications were sent to Member States about threats or public health risks. Intensified monitoring was also provided during the Brazil 2014 World Cup, resulting in the communication of 177 public health events, of which 52% corresponded to infectious diseases. The majority of potential public health emergencies were risk-assessed and communicated from PAHO to the IHR NFPs within 48 hours. PASB detected possible causes of delays in sharing information and applied the appropriate measures to improve the coordination with Member States and/or WHO Headquarters.

236. PASB will continue to develop its ability to coordinate regional efforts to strengthen all aspects of activities for the systematic detection, verification, and risk assessment of events, including capacity-building training, coordination, and quality information for all acute public health events. Exchange of experiences among Member States will be facilitated, aimed at increasing the timeliness and transparency of information sharing related to public health events of potential international concern and strengthening communication channels between NFPs for international contact tracing purposes.

5.4 Emergency Operations

237. Between 2011 and 2015, almost one-quarter of the world's disasters occurred in the Americas (418 of 1,719). Between 2014 and 2015, 39.9 million people were affected in the Region. The economic impact of these disasters on the Region during the period 2011-2015 exceeded $256 billion, equivalent to 31.6% of the world's total disaster-related losses. Over the past few decades, the Latin American and Caribbean (LAC) region has been the scene of some of the deadliest disasters, including the Haiti earthquake and cholera epidemic. The Region was also the epicenter of a new type of crisis with the emergence of the new A(H1N1) virus and the first pandemic under the International Health Regulations, as well as the recent emergence of a debilitating strain of the Zika virus.

238. It has become more common for LAC countries to manage the response to a minor emergency or small-scale disaster using their own resources (human and other), without seeking aid from the international community. However, countries will continue to require international aid and PASB support for larger and medium-size disasters. When national capacities are overwhelmed, PASB will lead and coordinate the international health response to contain disasters, including outbreaks, and to provide effective relief and recovery to affected populations. Accordingly, PAHO must continuously enhance its capacity to initiate assistance in the shortest time possible.

239. PASB will therefore continue to enhance its systems and processes to ensure a more predictable and effective response to health emergencies. Three key aspects of this effort are *(a)* strengthening PAHO's own operational capacities, *(b)* expanding and strengthening international capacities for emergency response through partnership, and *(c)* supporting national authorities as they coordinate the international response to health emergencies in their countries.

5.5 Emergency Core Services

240. This area covers development of capacities, policies, procedures, and systems that are standardized across PASB and that support effective management and sustainable staffing and financing of the emergencies program, while ensuring inter-operability and consistency during coordinated emergency response efforts undertaken through partnerships. This area of work encompasses administration, communications, resource mobilization and grant management, strategic planning, financial and human resources management, security, and staff health and well-being.

5.6 Disaster Risk Reduction and Special Projects

241. Of the nearly 18,000 health facilities in the Region, 77% are located in disaster-prone zones. Between 2000 and 2009, more than 45 million people in the Americas remained without health care for months, and sometimes even years, because of damage to hospitals and other health facilities caused by natural hazards.

242. PAHO will coordinate implementation of the Plan of Action on Disaster Risk Reduction 2016–2021, which aims to protect the lives of patients and health workers, shield health equipment and supplies from disasters, and ensure that the health services continue operating effectively during and after emergencies and disasters in order to save lives, reduce disabilities, and enable the health sector to fulfill its continuing responsibilities.

243. PAHO works with countries in the implementation of special projects like Safe Hospitals, Smart Hospitals, and Internally Displaced Populations, among others, to build countries' capacity to protect the physical, mental, and social well-being of their populations and to recover rapidly from emergencies and disasters. A Special Project on

High Vulnerability Countries focuses on strengthening national leadership and sustained capacity of the health sector to build the resilience of those countries and territories.

5.7 Outbreak and Crisis Response

244. The influenza A (H1N1) pandemic in 2009 and the devastating earthquake in Haiti in 2010, followed by the Haitian cholera epidemic, resulted in enormous emergency response operations that were among the most complicated and challenging ever undertaken by the countries affected, by first responders, and by the entire international community.

245. For the most part, the countries in the Region can now respond to minor disasters in a self-sufficient manner. That said, external assistance will always be necessary during major disasters. The Organization will continue to play an important role in assisting countries and territories in responding to major disasters, guided by the PASB Institutional Response to Emergencies and Disasters policy; thus PAHO must continuously enhance its capacity to initiate assistance in the shortest time possible. Particular attention should be given to ensuring equitable access to health by the most vulnerable populations, including children and the elderly, indigenous communities, and pregnant women, among others.

Key Stakeholders' Analysis

246. Participation of stakeholders, particularly the ministries of health and the national emergency management institutions, is essential in order to implement the planned activities and achieve outputs and outcomes in this category. All national and international health-related institutions play a key role in strengthening countries' capacities to reduce the risks of, prepare for, respond to, and recover from public health emergencies and disasters.

247. The UN International Strategy for Disaster Reduction, the UN Office for the Coordination of Humanitarian Affairs, and the Inter-Agency Standing Committee are in charge of coordinating global efforts to reduce mortality, morbidity, and societal disruption from disasters. They regularly include health-related priorities in their deliberations, decisions, and guidelines. Current activities that are part of existing multilateral, international, and regional frameworks and mechanisms will be fully implemented, particularly those of the International Health Regulations (2005), the Pandemic Influenza Preparedness Framework, the Global Action Plan for Influenza Vaccines, the Hyogo Framework for Action 2005-2015, the United Nations Transformative Agenda, the International Association for Conflict Management, and the Global Polio Eradication Initiative, as well as chemical conventions and global and regional platforms for disaster risk reduction. Major networks such as the Global Outbreak Alert and Response Network, the Global Influenza Surveillance and Response System, the Inter-Agency Standing Committee's Global Health Cluster and regional response teams will be maintained and strengthened.

248. Many universities, centers of excellence, and professional associations, among others, implement research and training activities on management of public health emergencies. These contribute to the development, dissemination, and application of policies, strategies, action plans, technical guidelines, and publications by PAHO Member States and PASB.

Strategies for Technical Cooperation

249. The approach to emergency risk management must be comprehensive, efficient, and effective. Building resilience and protecting populations requires a holistic, coordinated, multi-hazard approach, applied within PASB and across Member States and the international health community. For optimal impact, this approach must be integrated into comprehensive national plans for emergency risk management that involve all sectors.

250. The leadership role of the ministries of health will be supported through an increased focus on capacity building for the incorporation of preparedness, surveillance, and response criteria into national policies, plans, norms, standards, and budgets. New emphasis will be placed on the development of linkages with research and academic institutions to better understand the potential impacts of specific hazards such as pandemic influenza, earthquakes, floods, hurricanes, chemical and radiologic emergencies, foodborne illnesses, and climate change. Integration of disaster risk reduction in the health sector is essential in order to protect the health services (in terms of both physical infrastructure and functions) and ensure their continuity during and after emergencies.

251. Emphasis will be placed on the use of existing and new health partnerships and disaster management networks, within and external to the health sector, involving other public sector agencies and the private sector. Collaborative activities will include advocacy, information management, resource mobilization, and national and international agreements to reduce the risks of disasters and emergencies and ensure timely and effective health interventions during and after these events. PASB will foster intercountry collaboration, building on countries' specific experiences and capacities. PASB will also increase political awareness on the relevance of infection prevention and control programs within the framework of IHR core capacities.

252. PASB will build internal capacity to further improve its coordinated response mechanisms to prepare for disasters and emergencies and efficiently assist countries when required. In addition, it will implement *(a)* WHO standard operating procedures for the management of acute public health threats across the Organization, including strengthening WHO's organization-wide event management system and ensuring operational capacity at all times, and *(b)* the policies and procedures set forth in the PAHO Institutional Response to Emergencies and Disasters. A lessons-learned approach will be adopted to revise and update the Organization's emergency and disaster policies, procedures, technical guidelines, and other tools and adjust its strategies when needed.

Cross-Cutting Themes and Strategic Approaches in Health

253. Joint planning and execution between all program areas within Category 5 is essential to implement the Strategic Plan. Specific references to cross-cutting themes and strategic approaches are reflected in the descriptions below of linkages with the other categories of work and their specific program areas.

254. This category has particularly strong linkage with Category 1, which is concerned with reducing the burden of communicable diseases. The surveillance and control of these diseases is a major aspect of PAHO's response to humanitarian emergencies and of its responsibilities under the IHR (2005). The Organization's contribution includes expert guidance on the management of pneumonia, diarrheal diseases, vaccine-preventable diseases, malaria, dengue, viral hepatitis, tuberculosis, and HIV infection in such settings.

255. As far as Category 2, concerned with noncommunicable diseases, coordination with the program area on mental health is necessary to prepare for and respond to the mental health and psychosocial needs of populations affected by disasters and emergencies. As injuries and violence usually increase in emergency contexts, Category 5 has strong links with this program area, which includes prevention of injuries and violence and provision of trauma care. An adequate disaster response will diminish long-term disabilities when appropriate strategies are in place. Strategies to prevent foodborne diseases will also help avoid chronic disabilities such as reactive arthritis or uremic hemolytic syndrome as well as growth retardation associated with diarrhea, an important contributor to stunting in children under age 5. Close links exist between food safety and nutrition in an emergency preparedness context.

256. The Category 3 principles of human rights, equity, gender and ethnic equality, sustainable development, human security, and accountability inform all of the Organization's emergency work. In times of disaster, collaboration is required with program areas addressing the life course, especially with respect to protection and continuous care of pregnant women, children, and the elderly. Elderly populations, in particular, may have reduced mobility and capacity to adapt. Gender roles require explicit consideration in emergency plans and programs. Moreover, risks are distributed along a social gradient, and interventions should especially consider those populations that are marginalized, culturally different, or in situations of vulnerability. The building of community resources to address emergencies is part of the participatory process that must inform a coherent State protection action. Emergency response needs the institutional capacity to identify and manage environmental sanitation, chemical and radiologic threats, and the impact from climate change.

257. The capacities required for risk reduction, disaster preparedness, response, and recovery, and to comply with the IHR, are fundamental components of Category 4 (Health Systems). A strong link with national health policies, strategies, and plans is needed to facilitate the implementation of resolutions and mandates regarding the IHR 2005, the Plan of Action on Safe Hospitals, and the United Nations reform in the area of

disaster management. Full alignment with the integrated, people-centered health services approach is key to providing humanitarian assistance and outbreak response. Access to medical products and strengthening of regulatory capacity, particularly in relation to radiologic emergencies and laboratories, are key aspects in relation to emergency preparedness, IHR, and crisis response. Health system information and evidence will provide critical data to elaborate risk assessments, monitor progress, generate science-based intervention measures, and implement emergency response. One of the pillars of emergency preparedness is to strengthen the capabilities of human resources in health in order to implement timely and adequate response to the public health consequences of emergencies and disasters.

258. With respect to Category 6, PASB will use partnerships to provide support to countries in enhancing their emergency risk management capacities. WHO will strengthen its interaction with other organizations in the United Nations system and with multilateral, bilateral, and regional agencies. Emergency response requires a specific risk communication strategy, built by those responsible for management of the response, and a well-defined set of communication channels, messages, and methods for reaching target groups. A large part of the work of Category 5 depends on organizational leadership processes related to strategic planning, resource mobilization, and resource management (especially access to extrabudgetary resources). The development, negotiation, and implementation of new approaches to financing, designed to increase the predictability, flexibility, and sustainability of PAHO's financing, is therefore central to the work in this category. Critical to the effective and efficient functioning of Category 5 is the existence and application of flexible, achievement-oriented administrative processes, especially for work in emergency contexts.

Assumptions and Risks

Assumptions:

(a) Transparent reporting is done on the actual status of national IHR core capacities in the countries, independently of any political influence.

(b) Sufficient staff, funding, and capacities are in place at the country, regional, and Headquarters levels of PAHO/WHO to enable the Organization to expand and integrate a comprehensive, efficient, and effective multi-hazard approach to emergency preparedness, alert, and response capacities.

(c) Key partners and networks within and external to the health sector provide support to implement intercountry collaboration and increase political awareness of the importance of the IHR framework and of the prevention of exposure to contaminants through the food chain.

(d) Emergency and disaster risk management remains a health sector priority, and ministries of health and other partners are willing to engage with PAHO in this area of work.

(e) Senior managers in country, regional, and global offices give sufficient priority to work in this category, allowing PAHO to build its internal capacity to efficiently assist countries in managing acute public health threats.

(f) National and regional technical departments participate in preparation of surge rosters and other readiness activities and show willingness to comply with a core set of standards required to meet or exceed minimum capacities to manage public health risks associated with emergencies.

Risks:

(a) Insufficient priority is given by countries or the Organization to this category of work, contributing to loss of funding.

(b) There is a failure to establish strong partnerships with other agencies involved in country-level emergency preparedness, alert, and response mechanisms.

(c) Weaknesses in verification mechanisms make it difficult to assess the actual achievement of the IHR core capacities, and States Parties have limited ability to maintain these capacities.

(d) There is an inability to recruit strong technical staff at national and subnational levels to implement plans and apply the required information-gathering tools.

(e) Lack of consensus impedes the completion of an emergency and disaster risk management framework for health.

(f) Political instability and deterioration in the security situation constrain operations within the health sector.

(g) There is limited contribution by other categories of work and technical departments to surge and readiness activities.

(h) There is confusion between short-term emergency preparedness/readiness interventions and longer-term development of core response capacities.

(i) Ongoing planning and implementation efforts are derailed by the occurrence of health emergencies or disasters.

(j) Different grades of preparedness across the Region jeopardize overall health security.

(k) There is ineffective communication during times of emergency due to competing and conflicting messages between the political and technical levels.

Category 5. Health Emergencies: Program Areas and Outcomes

5.1 Infectious Hazard Management

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 5.1 Countries' capacities strengthened to build resilience and adequate preparedness to mount a rapid, predictable, and effective response to major epidemics and pandemics	OCM 5.1.1	Number of countries and territories with installed capacity to effectively respond to major epidemics and pandemics	6/35	35/35

5.2 Country Health Emergency Preparedness and the International Health Regulations (2005)

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.2 Countries have an all-hazards health emergency risk management program for a disaster-resilient health sector, with emphasis on vulnerable populations	OCM 5.2.1	Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies	19	36
	5.2.2	Number of States Parties meeting and sustaining International Health Regulations (2005) core capacities	6/35	35/35

5.3 Health Emergency Information and Risk Assessment

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.3 PAHO capacities strengthened for timely situation analysis, risk assessment, and response monitoring of all major health threats and events	OCM 5.3.1	Percentage of acute public health events for which a risk assessment is completed within 72 hours	60%	100%

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

5.4 Emergency Operations

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.4 Improved access of emergency-affected populations to an essential package of life-saving health services	OCM 5.4.1	Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies	50%	75%

5.5 Emergency Core Services**

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.5 PAHO Health Emergencies Program well-resourced and efficient to support national health emergency programs	OCM 5.5.1	Percentage of core requirements funded by PAHO/WHO core resources or multiyear funding agreements	N/A	50%

** In line with outcome E.5 of the WHO Programme Budget (document A70/7), this indicator refers to the Bureau's capacity to implement the PAHO health emergencies program in support of the countries, with specific financing for this program. The indicator's technical specifications will include details on aspects of measurement.

5.6 Disaster Risk Reduction and Special Projects

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.6 Countries have an all-hazards health emergency and disaster risk reduction program for a disaster-resilient health sector	OCM 5.6.1	Number of countries and territories implementing disaster risk reduction interventions in the health sector that increase community resilience	11	35

5.7 Outbreak and Crisis Response

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 5.7 All countries adequately respond to threats and emergencies with public health consequences	OCM 5.7.1	Percentage of countries and territories that have demonstrated adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset	100% (2015)	100%

Category 6 - Leadership, Governance, and Enabling Functions

Fostering organizational leadership and governance and implementing the enabling functions that are required to maintain the integrity and efficient functioning of the Organization to deliver effectively on its mandates.

Scope

259. This category includes functions and services that contribute to strengthening PAHO's leadership and governance, as well as transparency, accountability, and risk management. It also seeks to enhance strategic planning, resource coordination, resource mobilization and reporting, management and administration, and strategic communications. The work in this category will continue to strengthen PAHO's leading role in the Region to enable the many different actors to play active and effective roles in contributing to the health of all people. It will also result in an Organization that is responsive and transparent, and will enhance the work of PASB in supporting the delivery of technical cooperation in all categories in an effective and efficient manner. The work in this category will be important to improve coordination with national authorities, UN agencies and other intergovernmental organizations, public-private partnerships, and civil society in line with the UN Quadrennial Comprehensive Policy Review of operational activities for development of the United Nations system.

Context

6.1 Leadership and Governance

260. In the Organization's efforts to champion health and address the health inequities of the Region, PASB must exercise keen leadership in collaboration with countries and partners. Consequently, this program area addresses the following functions: *(a)* reinforcing leadership in health to support Member States in their governance role within the framework of WHO and UN reform; *(b)* coordinating and convening relevant stakeholders in health to ensure good governance and accountability to Member States; *(c)* reinforcing Member States' efforts to fulfill regional priorities in health, as detailed in this Plan as well as within the Health Agenda for the Americas 2008-2017; and *(d)* strengthening country presence to efficiently and effectively address national health needs. These efforts should lead to intersectoral action that moves from a focus on disease to a focus on well-being and sustainable development, using a rights-based approach.

261. Political leadership and stewardship will continue to be required to effectively manage the increasingly complex relationships with the growing number of actors and stakeholders in the international health environment. The increasing number of players in health is a continuing trend that is not expected to wane in the foreseeable future. It has led to new partnerships, alliances, financing channels, and sources of technical support.

At the same time, it creates challenges related to duplication of efforts, high transaction costs, varying accountability requirements, and inconsistent alignment with approved national and regional priorities, such as those defined in the Health Agenda for the Americas 2008-2017. In this complex context, access to quality health services and products will necessarily require an understanding of national and local laws and a formulation of those laws to include economic, social, and cultural factors (such as education, housing, social security, conservation of food, labor, the enjoyment of scientific progress, etc.). At the same time, consistency with international law and treaty obligations must be ensured.

262. Some emerging economies are increasing their financial and technical support for health beyond their national programs as part of a growing trend in South-South and similar forms of cooperation. Recognizing the rich expertise to be found in Member States, PAHO is increasingly drawing upon this resource to support technical cooperation. This Pan American approach is key in reinforcing the work of Member States and of the Organization.

263. PAHO must be able to respond to the evolving needs of the countries and adapt to external changes such as those stemming from WHO and UN reform. It therefore needs to continue efforts to increase the effectiveness of its engagement with other stakeholders, strengthen the negotiation capacity of health actors, invest in health diplomacy, and utilize its leadership position to enhance coherence among the many actors involved in health at the global, regional, subregional, and national levels. This coherence may be evident, when appropriate, within the UN Development Assistance Framework (UNDAF) or other similar initiatives. In this regard, the Organization will need to reinforce and refine its work across the three functional levels—national, subregional, and regional—and increase the harmonization and coordination with WHO.

264. The following nine overarching PASB leadership priorities will ensure that necessary emphasis is given to key areas in the Strategic Plan 2014-2019, enabling the Plan to attain its anticipated results in an effective and efficient manner. PASB will advocate for these priorities to be addressed at the highest political levels and for the necessary actions at the national, subregional, and regional levels. In doing so, the Bureau will refine existing strategies, including the implementation of new modalities of technical cooperation, and build capacity in health diplomacy and health governance. Particular attention will be given to strengthening Member States' capacities to generate alliances and strategic partnerships to include Health in All Policies and to manage horizontal cooperation in health. The effectiveness of these leadership priorities will be measured through the progress made toward the achievement of the outcomes and impact goals set in the Strategic Plan.

(a) Strengthen the health sector's capacity to address the social determinants of health, utilizing the Health in All Policies strategy and promoting increased community participation and empowerment.

(b) Catalyze the progressive realization of universal access to health and universal health coverage, including promotion and preventive interventions, with emphasis on the eight key countries.

(c) Increase intersectoral and multisectoral action for prevention and care of noncommunicable diseases.

(d) Enhance the core capacities of countries to implement the International Health Regulations (2005).

(e) Accelerate actions for the elimination of priority communicable diseases in the Region.

(f) Conclude work on the health-related MDGs, influence the integration of health in the 2030 Agenda for Sustainable Development, and support countries in the achievement of the health-related Sustainable Development Goals.

(g) Strengthen the health sector's capacity to generate information and evidence to measure and demonstrate progress on healthy living and well-being.

(h) Leverage the knowledge and expertise in countries of the Region for the provision of technical cooperation, sharing successful experiences and lessons learned.

(i) Increase accountability, transparency, efficiency, and effectiveness of the Bureau's operations.

265. To ensure that PAHO remains relevant as a leading public health organization that is responsive to its Member States, strengthening the governance of the Organization is an ongoing priority. This requires the continuous engagement and oversight of Member States through the formal mechanisms of the PAHO Governing Bodies and through close collaboration at country level.

266. The Organization's mission will be strengthened and promoted while safeguarding its privileges, immunities, and status as an international public health organization. Promoting good governance and ensuring respect for and compliance with the Organization's Constitution, rules, and regulations will serve to protect the Organization's name and integrity.

6.2 Transparency, Accountability, and Risk Management

267. Managerial transparency, accountability, and risk management are key aspects of effective and efficient management and instill trust and confidence in the work of the Organization on the part of our Member States, donors, stakeholders, and partners. Toward this end, PAHO will strengthen existing mechanisms and introduce new measures designed to ensure that the Organization continues to be accountable, transparent, and adept at effectively managing risks.

268. Evaluation is a key aspect of addressing transparency and accountability, and facilitates conformity with best practice. PAHO/WHO will work to foster a culture of

evaluation and its proactive use throughout the Organization. This entails providing a consolidated institutional framework for evaluation across the different levels, in keeping with the norms and standards of the United Nations Evaluation Group. PAHO will address its specific needs in this area within the context of the WHO evaluation policy. In addition, PAHO will continue to strengthen a culture of evaluation as an integral component of operational planning, backed by a quality assurance system to promote best practices. A coordinated approach to and ownership of the evaluation function will be promoted at all levels of the Organization. Objective evaluation will be facilitated, in line with a proposed PAHO evaluation policy, and will be supported by tools such as clear guidelines.

269. The internal audit function in PAHO has been significantly strengthened in the past few years. The Organization will continue to perform audits of its operations, at Headquarters and in the PAHO/WHO Representative Offices, that take into account specific risk factors. The Ethics Office will continue to focus on strengthening standards of ethical behavior by staff and will perform risk assessments to identify any vulnerabilities that may affect the image and reputation of the Organization. Specific emphasis will be given to the elaboration of a new conflicts of interest and financial disclosure program. As the coordinator of PAHO's Integrity and Conflict Management System, the Ethics Office will also lead efforts to further strengthen the internal justice system in PAHO.

270. Managing risks is an important area of focus. PAHO is continuously exposed to risks of varying types, including those related to its technical work in public health; its financing; its procurement activities on behalf of Member States; its relationships with the private sector, nongovernmental organizations, and other institutions; and the political and governance context. All have the potential to affect the Organization's effectiveness and reputation. This approach requires established processes to be put in place and monitored to ensure that all risks are properly identified and managed and reported regularly to PAHO's senior management to enable informed decisions and actions to be taken on a timely basis.

271. To ensure the effective working of the risk management system and of compliance and control activities, PAHO will operationalize an Enterprise Risk Management (ERM) system at all levels of the Organization. This is aligned with the work being done by the WHO Independent Expert Oversight Advisory Committee.

6.3 Strategic Planning, Resource Coordination, and Reporting

272. This program area encompasses policy development, strategic and operational planning, budget management, performance, monitoring and assessment, and reporting at all levels. It also covers the financing and management of resources to ensure coherence, synergy, and alignment between the different parts of the Bureau in response to the priorities established in the Strategic Plan. PASB continues to advance and consolidate Results-based Management as the central operating framework for the improvement of

organizational effectiveness, efficiency, alignment with results, and accountability. Especially important is the development, negotiation, and implementation of new approaches to resource mobilization and partnerships, designed to increase the predictability, flexibility, and sustainability of PAHO's financing, using a programmatic approach, while respecting the Organization's normative legal framework.

6.4 Management and Administration

273. This program area covers the core administrative services that underpin the effective and efficient functioning of PAHO: finance, human resources, information technology, procurement, and operations support. The Bureau will seek to implement a modern management information system that can simplify administrative processes and improve performance controls and indicators. This will result in improved efficiency, transparency, accountability, decentralization, and delegation of authority. Furthermore, it will ensure that decision making and resource allocation occur closer to where programs are implemented. In addition, managerial and administrative capacities and competencies will be strengthened at all levels of PASB.

274. The adequacy of the financial control framework, as a specific aspect of risk management, is a particular priority. PAHO will improve and enhance mechanisms that will allow it to state, with confidence and on time, how all resources invested in the Organization are being utilized to achieve the anticipated results set out in the Strategic Plan and the corresponding Program and Budget.

275. The focus on human resources is also in line with the overall management reform. This seeks to ensure that PAHO is able to recruit the right staff and deploy them where they are needed; manage staff contracts in line with existing rules and in ways that encourage mobility and career development; use succession planning to promote the continuity of essential functions; and ensure that the Organization has human resources policies and systems in place that allow it to respond rapidly to changing circumstances and public health needs.

276. Procurement is a key component of the mission of the Organization. Among other things, it supports technical cooperation through the procurement of goods and services on behalf of Member States, ensuring their access to affordable drugs, vaccines, and other public health supplies. The Organization has procurement policies and procedures and organizational planning systems in place to ensure appropriate management of strategic and transactional activities and to allow rapid response in case of emergencies.

277. PAHO will ensure a safe and healthy working environment for its staff through the effective and efficient provision of operational and logistics support, infrastructure maintenance, and asset management, including compliance with United Nations Minimum Operating Security Standards (MOSS) and Minimum Operating Residential Security Standards (MORSS).

278. Finally, the development and implementation of policies and services for information technology will continue to ensure fully functional infrastructure, applications, networks and communications, end-user support, and business continuity.

6.5 Strategic Communications

279. Work in the area of strategic communications will be based on two interlinked objectives. On one hand, PAHO plays a crucial role in providing the public with timely and accurate health information, including during emergencies. On the other hand, PAHO needs to better communicate its own work and impact, including regional progress on health issues and continuing regional needs, to increase its visibility and strategic positioning as a leading health organization.

280. The ever-growing demand for information on health requires PAHO to communicate internally and externally in a timely and consistent way. It also requires the provision of essential health knowledge and advocacy material to Member States, health partners, and other stakeholders, including civil society.

281. PAHO will take a more proactive approach to working with its staff and with the media to better explain the Organization's role and impact on people's health. This will be achieved through implementation of the Knowledge Management and Communications Strategy across all levels of the Organization. Furthermore, PAHO will enhance its capacity to provide health information by using innovative communications to reach a broader audience.

282. Key elements of this program area include developing, managing, and sharing evidence-based information and knowledge produced by PAHO Member States and PASB; providing technical cooperation on knowledge management and communications; facilitating communications between PAHO and its partners and stakeholders, including the UN and inter-American systems, the general public, and specialized audiences, enhancing the image and protecting the reputation of the Organization; and using communications to promote the individual, social, and political changes necessary for improvements and maintenance of health and well-being.

Key Stakeholders' Analysis

283. Participation and engagement of a broad spectrum of stakeholders is necessary to achieve many of the outcomes and outputs in this category and to support the implementation of the Strategic Plan. PASB must ensure continuous interaction and communication with health authorities, government sectors outside health, development partners, civil society, the news media, and other public and private sector stakeholders, while providing them with clear and compelling information about PAHO's role, achievements, and accountability. This is critical to motivating and enabling them to effectively support and collaborate with the Organization. In addition, these stakeholders look to PASB to provide leadership in defining, explaining, and promoting public health

principles and goals, which in turn will enhance their own ability to support and promote these principles and goals.

284. Recognizing the Organization's role within WHO and the United Nations, it is anticipated that there will be ongoing and increased coordination, harmonization, and communication with these systems. The Organization will make positive contributions to successful implementation of the institutional reforms being undertaken in WHO and the UN. With specific efforts underway on programmatic priority setting and managerial reform, the Organization's interactions with the WHO and UN family will be particularly important. At the country level this will include active engagement with the UN Country Team; at the regional level it will also include the ongoing collaboration between UN agencies to provide synergistic support; and at the global level PAHO will continue to participate in the rich policy and technical dialogues. In order to advance collective health outcomes, it will be important to continue to strengthen relationships with subregional integration entities and with other agencies and specialized organizations of the inter-American system.

285. With a view to implementing new modalities of technical cooperation, country-based and intercountry collaboration and partnerships will promote intersectoral and multisectoral approaches. These will involve not only the ministries of health but also key public and private sector stakeholders outside of the health sector. Reaching out to involve these other actors will be key to ensure sufficient attention to the social determinants of health and support efforts toward universal health coverage.

286. PAHO's activities are carried out within a challenging economic environment in which there is significant competition for resources. Nonetheless, the Organization continues to demonstrate important results to partners. This contributes to ongoing engagement and collaboration that in turn helps ensure sustainable resources for the implementation of PAHO's Strategic Plan, in line with the RBM framework. In this regard, the Organization must be poised to broaden country-based and intercountry collaboration, foster new partnerships, and reinforce existing alliances in support of the regional public health agenda.

287. Taking into account the persistent health inequities between and within countries in the Region, the Organization will continue to reinforce and develop financing modalities with Member States, both to support collaboration within individual countries and to focus strategic attention on regional public health issues. Engagement with key regional and subregional financial institutions will be important to this process.

288. PASB should continue engaging Member States to ensure that they fully benefit from the Organization's procurement services as part of PAHO's technical cooperation. In the process, there is need to ensure an understanding of the procurement strategy, rules, and procedures, including the Organization's role as a strategic interlocutor in the elaboration of country health and procurement programs. At the same time, PAHO should continue its support and full engagement with the UN family through continued

collaboration on initiatives and joint projects, such as participation in the UN global management reform; harmonization of processes and good practices for procurement of goods and services; and enforcement of UN agency collaboration at country level by implementing common procurement guidelines.

Strategies for Delivering on Leadership, Governance, and Enabling Functions

289. The main strategies for delivering the leadership, governance, and enabling functions include the following:

(a) Lead, direct, and coordinate with WHO, Member States, and the UN and inter-American systems, and with other partners, stakeholders, and the general public, to ensure greater responsiveness to the health needs of Member States, while advancing regional and global health mandates.

(b) Continue to support and coordinate the development of Country Cooperation Strategies that are closely aligned with national health policies, strategies, and plans, and with UN Development Assistance Frameworks, to reflect greater harmonization.

(c) Promote intersectoral and multisectoral approaches to build institutional capacity and leadership among Member States for their role in health governance.

(d) Guarantee that Member States and other partners are fully engaged and committed to the effort to ensure sustainable resources for the implementation of PAHO's Strategic Plan, through a programmatic approach based on RBM.

(e) Strengthen the appropriate competencies among PAHO staff for launching new approaches in health diplomacy and new partnerships.

(f) Ensure implementation of a modern management information system so that administrative processes are simplified and performance indicators and controls improved, resulting in increased efficiency, transparency, accountability, decentralization, and delegation of authority.

(g) Build institutional capacity for implementing the ERM system.

(h) Strengthen managerial and administrative capacities and competencies at all levels of PASB.

(i) Strengthen human resources strategic planning, focusing on succession planning, staff placement based on competency and needs, staff mobility, and staff development.

(j) Build and sustain the capacity of the Bureau to implement internal communications and knowledge management strategies.

Cross-Cutting Themes

290. Building on existing policies and practices, the cross-cutting themes of gender, equity, human rights, and ethnicity will be applied throughout the work of this category as necessary, but especially in matters related to human resources management and the internal justice system. In addition, the Organization will apply the System-wide Action Plan on Gender Equality and Women's Empowerment recently adopted by the United Nations (UN-SWAP).

291. Through the work included in this category, the Bureau will support the work of the other categories to enable achievement of their results. In this way, Category 6 is linked to all other categories.

Assumptions and Risks

Assumptions:

(a) The Organization is able to mobilize the necessary contributions from Member States and from traditional and nontraditional partners in a timely manner. The level of funding received from WHO is in line with the approved budget.

(b) Clear policies and rules of governance, responsibility, and accountability are in place to effectively implement programs in an increasingly decentralized manner.

(c) There is successful implementation of the WHO and UN institutional reforms and an increased coordination and harmonization with these systems at the global, regional, and country levels.

(d) Clear legal agreements with Member States and stakeholders are in place to avoid conflicts of interest, high transaction costs, and legal risks to the Organization, governments, international organizations, partners, and donors, while ensuring accountability.

(e) There is an increasingly positive perception of PAHO's role as a leader and key partner for health development in the Region.

(f) The Organization's accountability continues to be strengthened in the context of the Results-based Management framework.

Risks:

(a) Further reductions in the assignment of resources from WHO severely compromise the ability of PAHO to deliver the results set out in the Strategic Plan.

(b) There is a continuing decline in the level of international assistance to the Region.

(c) There is a shortfall of political will to implement the Strategic Plan in the Region.

(d) Limited PAHO presence in strategic forums undermines the coordination with national authorities, UN agencies and other intergovernmental organizations, public-private partnerships, and civil society in line with the UN Quadrennial Comprehensive Policy Review.

(e) Resources mobilized have limited flexibility, compromising the Organization's ability to focus on the priorities agreed by Member States in the SP.

(f) Potential conflicts of interest with private partners affect the image and reputation of the Organization.

(g) Failure to implement a modern management information system delays the simplification of administrative processes and prevents the use of more efficient and cost-saving measures.

(h) The limited availability and reliability of information impedes timely decision making.

Category 6. Leadership, Governance, and Enabling Functions: Program Areas and Outcomes

6.1 Leadership and Governance

Outcome	Ind. #	Outcome Indicators	Baseline 2013*	Target 2019 (baseline +)*
OCM 6.1 Greater coherence in regional health, with PAHO/WHO playing a leading role in enabling the many different actors to contribute effectively to the health of all people in the Americas	OCM 6.1.1	Level of satisfaction of stakeholders with PAHO/WHO's leading role on global and regional health issues	High (based on composite rating from Stakeholder Perception Survey, November 2012)	High (based on the Stakeholder Perception Survey 2019)
	OCM 6.1.2	Number of countries that reflect in their national health and/or development strategies or plans the regional health priorities defined in the PAHO Strategic Plan 2014-2019	13/35 (2015)	20/35
	OCM 6.1.3	Number of regional initiatives or action plans of the Inter-American and United Nations systems dealing with health and development designed and/or implemented with PAHO support to advance the health priorities of the Region	7 (2015)	8

* The baseline year is 2013 or the year for which the most recent data are available. The year is listed for those indicators without 2013 data. The targets for 2019 include the 2013 baseline. This applies to all baselines and targets in this category.

6.2 Transparency, Accountability, and Risk Management

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 6.2 PAHO operates in an accountable and transparent manner and has well-functioning risk management and evaluation frameworks	OCM 6.2.1	Proportion of corporate risks with approved response plans implemented	80% (2015)	100%

6.3 Strategic Planning, Resource Coordination, and Reporting

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 6.3 Financing and resource allocation aligned with priorities and health needs of the Member States in a Results-based Management framework	OCM 6.3.1	Percentage of approved PAHO budget funded	90% (based on Program and Budget Assessment 2012-2013)	100%
	OCM 6.3.2	Percentage of outcome indicator targets of the PAHO Strategic Plan 2014-2019 achieved	91% (based on the final assessment of the Strategic Plan 2008-2013 as a proxy)	≥90%

6.4 Management and Administration

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 6.4 Effective management and administration across the three levels of the Organization	OCM 6.4.1	Proportion of management and administration metrics (as developed in Service Level Agreements) achieved	80% (2015)	95%

6.5 Strategic Communication

Outcome	Ind. #	Outcome Indicators	Baseline 2013	Target 2019 (baseline +)
OCM 6.5 Improved public and stakeholders' understanding of the work of PAHO/WHO	OCM 6.5.1	Percentage of Member States and other stakeholder representatives evaluating PAHO/WHO's performance as excellent or good	77%	100% (WHO Stakeholder Perception Survey, 2019)

VII. Ensuring Efficient and Effective Implementation of the Plan

292. This section notes several broad factors that may have a bearing on efficient, effective implementation of the Plan: technical cooperation strategies, roles and responsibilities of PAHO and Member States, funding, and risk management.

293. In an effort to remain relevant and responsive to Member States while continuing to play a leadership role in the Region, the Organization will employ innovative approaches in its collaboration with Member States and partners. The Strategic Plan 2014-2019 is the reference framework that will guide PAHO's interventions for advancing the public health agenda of the Region. In order to achieve the anticipated results in the Strategic Plan, the Organization will explore new modalities of technical cooperation and expand its partnership base at the national, subregional, and regional levels. Special attention will be given to building and leveraging national expertise in countries of the Region and sharing successful experiences and lessons learned. PAHO will promote and support the implementation of cost-effective interventions, available best buys, and appropriate tools, according to the context of the countries.

294. As outlined in the results chain, the commitment and collaboration of Member States, PASB, and partners will be required to successfully achieve the results set out in the Strategic Plan 2014-2019. Emphasis will be placed on clarifying the joint actions necessary to achieve the Plan's outcomes and bring about the expected impacts.

295. Based on historical level of funding available for the Strategic Plan 2008-2013 and on projections going forward, the resource envelope for the implementation of the Strategic Plan 2014-2019 is estimated at $1.8 billion. This estimate is presented to give Member States and partners a sense of the magnitude of resources that will be required over the six-year period of the Plan to enable achievement of its anticipated results. In order to obtain the necessary resources to implement the Plan, PAHO will need to devise a robust resource mobilization strategy. Toward this end, special attention will be paid to PAHO's programmatic approach, as guided by the Plan, with a view to obtaining the necessary resources with sufficient flexibility to allow for achievement of the Plan's anticipated outcomes.

296. Regular Budget (RB), Voluntary Contributions (VC), National Voluntary Contributions (NVC), and funds from WHO will be included in the Program and Budgets. It is important to note that the Strategic Plan 2014-2019 is being implemented under the new PAHO Budget Policy, which incorporates the principles of equity and Pan American solidarity and places special emphasis on country presence and results-based budgeting. An important consideration is how to incorporate NVCs and deal with them in relation to funding the Plan's categories and outcomes.

297. PASB will apply its Enterprise Risk Management framework to identify the risks and implement mitigation measures that increase the likelihood of achieving the anticipated results of the Strategic Plan 2014-2019. The ERM framework is based on the ISO 31000 international standard and includes a methodology for integrating risk management across all levels of the Organization in a proactive, continuous, and systematic process. The aim is to enable the Organization to identify and manage risks in a timely fashion and to successfully take advantage of opportunities that may arise. The ERM framework will be applied to the Strategic Plan 2014-2019, to Program and Budgets 2014-2015, 2016-2017, and 2018-2019, and to operational planning across all PASB offices.

VIII. Monitoring, Assessment, and Reporting

298. Monitoring, assessment, and reporting is an integral part of PAHO's Results-based Management framework. In keeping with this framework and with the Organization's commitment to improving accountability and transparency, this section outlines the joint process for monitoring implementation of the PAHO Strategic Plan 2014-2019 and its corresponding Program and Budgets.

299. PAHO's performance will be assessed by measuring progress toward the attainment of the impact goals and outcomes set out in the Strategic Plan 2014-2019.

300. The overall performance of the Strategic Plan will be assessed using the defined indicators. Such an assessment will require monitoring and reporting by both PAHO Member States and PASB.

301. The first amended version of the Strategic Plan included a set of revised indicators; these were the result of collaboration with Member States through the Countries Working Group (CWG), established by the 153rd Session of the Executive Committee and composed of 12 Member States,[5] and PASB. The CWG and PASB refined the definition and baseline and target values of the indicators. This built on the consultative process undertaken with countries and territories in the development of the original Strategic Plan 2014-2019 approved by the 52nd Directing Council in 2013.

302. The second amended version includes new outcome indicators to account for the revisions in Category 5 and the addition of Program Area 1.6, as well as a new indicator for hepatitis in Program Area 1.1.

303. A compendium of indicators, which provides standard definitions and measurement criteria for all indicators, has been developed in order to standardize monitoring and reporting of progress toward the achievement of the indicators' targets. The compendium also reflects the joint responsibility of Member States and PASB for the monitoring and reporting of the Strategic Plan and Program and Budget indicators. A commitment from all countries and territories to report on progress toward achievement of the indicators will be required in order to effectively monitor the implementation of the Strategic Plan and its Program and Budgets. PASB will work closely with the countries and territories in the monitoring, assessment, and reporting process.

304. Impacts, outcomes, and outputs will be assessed jointly based on data available from Member States and reported to PAHO or any other official source of information. The impact-level indicators will be monitored using the regional PAHO Core Health Data and will not require individual country monitoring. In addition, the PAHO Strategic Plan

[5] Members of the CWG included the Bahamas, Brazil, Canada, Chile, Costa Rica, Ecuador, El Salvador, Jamaica, Mexico, Paraguay, Peru, and the United States of America. The CWG was chaired by Brazil and co-chaired by El Salvador.

Monitoring System (SPMS) has been developed with input from the CWG in response to the mandate of Member States for joint monitoring and assessment of the outcome and output indicators (Resolution CD52.R8 [2013]). The system facilitates analysis of information by outcome and output indicators.

305. Monitoring and assessment for the Plan will be conducted on a biennial basis, and a report will be presented to the Governing Bodies at the end of each biennium. The end-of-biennium Program and Budgets assessment will provide a comprehensive appraisal of PAHO's performance and will include an assessment of progress made toward achieving the stated outcomes and achievement of outputs. The end-of-biennium assessments will form the basis for informing Member States on progress made in the implementation of the Strategic Plan and guide interim adjustments.

306. A final assessment will also be conducted at the end of the Strategic Plan period.

Acronyms and Abbreviations

Acronym	Description
AECID	Spanish Agency for International Development Cooperation
AIDS	acquired immunodeficiency syndrome
ALBA	Bolivarian Alliance for the Peoples of Our America
ART	antiretroviral therapies
BMGF	Bill and Melinda Gates Foundation
BMI	body mass index
BRICS	Brazil, Russia, India, China, and South Africa
BWP	Biennial Work Plan
CAF	Development Bank of Latin America
CARPHA	Caribbean Public Health Agency
CCG	Countries Consultative Group
CCS	Country Cooperation Strategy
CCTs	cross-cutting themes
CDC	U.S. Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CKD	chronic kidney disease
CSDH	Commission on Social Determinants of Health
CSIH	Canadian Society for International Health
CVD	cardiovascular disease
cVDPV	circulating vaccine-derived poliovirus
CWG	Countries Working Group
DALYs	disability-adjusted life years
DPAS	diet, physical activity and health
EASP	Escuela Andaluza de Salud Pública
EC	Executive Committee
eHealth	electronic health

Acronym	Description
ERM	Enterprise Risk Management
FAO	Food and Agriculture Organization of the United Nations
FBD	foodborne disease
FCTC	WHO Framework Convention on Tobacco Control
FDA	U.S. Food and Drug Administration
Fiocruz	Oswaldo Cruz Foundation
GARC	Global Alliance for Rabies Control
GASP	Gonococcal Antimicrobial Surveillance Programme
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLC	Green Light Committee
GOARN	Global Outbreak Alert and Response Network
GPW	WHO General Programme of Work
H1N1	pandemic influenza A
HAA	Health Agenda for the Americas 2008-2017
HBV	hepatitis B virus
HCV	hepatitis C virus
HDI	Human Development Index
HHS	United States Department of Health and Human Services
HIV	human immunodeficiency virus
HNI	Health Needs Index
HPV	human papillomavirus
HRH	human resources for health
HTA	health technology assessment
IAPAC	International Association of Providers of AIDS Care
ICC	interagency coordinating committee
ICT	information and communication technologies

Acronym	Description
IDB	Inter-American Development Bank
IHR	International Health Regulations
IICA	Inter-American Institute for Cooperation on Agriculture
IMR	Infant Mortality Rate
IMS-Dengue	Integrated Management Strategy for Dengue Prevention and Control
LAC	Latin America and the Caribbean
MAHR	Mortality Amenable to Health Care
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
MERCOSUR	Common Market of the South
mHealth	mobile health (via mobile telephones, tablets, etc.)
MMR	Maternal Mortality Ratio
MNCH	maternal, neonatal, and child health
MORSS	Minimum Operating Residential Security Standards
MOSS	Minimum Operating Security Standards
MSM	men who have sex with men
NCD	noncommunicable disease
NID	neglected infectious disease
NVC	National Voluntary Contributions
OCM	Outcome
OECD	Organisation for Economic Co-operation and Development
OIE	World Organisation for Animal Health
OIRSA	Regional International Organization for Plant Protection and Animal Health
OPT	Output
PAFNCD	Pan American Forum for Action on NCDs
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau

Acronym	Description
PATH	Program for Appropriate Technology in Health
PB 2014-2015	PAHO Program and Budget 2014-2015
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHAC	Public Health Agency of Canada
PHC	primary health care
PMA	performance monitoring and assessment
PMIS	PASB Management Information System
PNMR	premature noncommunicable disease mortality rate
PRS	Priority Rating System
RB	Regular Budget
RBM	Results-based Management
REMSAA	Meeting of Ministers of Health of the Andean Area
RER	Region-wide Expected Result
SP 2014-2019	Strategic Plan 2014-2019
SRH	sexual and reproductive health
SO	Strategic Objective
STI	sexually transmitted infection
SVI	Sabin Vaccine Institute
TB	Tuberculosis
TB-HIV	HIV-associated tuberculosis
TCC	technical cooperation among countries
TFGH	Task Force for Global Health
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Union of South American Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

Acronym	Description
UNICEF	United Nations Children's Fund
UN-SWAP	UN System-wide Action Plan on Gender Equality and Women's Empowerment
USAID	United States Agency for International Development
VC	Voluntary Contributions
VPD	vaccine-preventable disease
VPH	veterinary public health
WHA	World Health Assembly
WHO	World Health Organization
WSPA	World Society for the Protection of Animals

Annexes

Annex I. Key Lessons Learned from Previous Plans

1. The PAHO Strategic Plan 2014-2019 builds on PAHO's experience and lessons learned from previous plans, programs, budgets, and other high-level planning instruments and processes, including WHO planning and budgeting processes. Particular emphasis has been placed on a review of lessons learned from the PAHO Strategic Plan 2008-2013, given that this was the first plan to be implemented using the Results-based Management approach.

2. The main lessons that were considered in the development of the PAHO Strategic Plan 2014-2019 are outlined below. To guide their application to key aspects of the Plan, they have been divided into three categories: *(a)* political and strategic, *(b)* programmatic and technical, and *(c)* managerial and administrative. The application of these lessons will be essential for the successful implementation of the Plan and for continued improvement in the efficient and effective management of the Organization.

Political and Strategic

3. The PAHO Strategic Plan 2008-2013 was the first plan that was aligned with WHO's planning and budget processes (specifically the WHO Medium-term Strategic Plan 2008-2013 and its corresponding Programme Budgets). Even though the decision was made to align, for the first time, the work of the Organization with the WHO General Programme of Work, the alignment was not fully implemented across different strategic objectives. These variances with the WHO GPW created some challenges in reporting at the global level. The Strategic Plan 2014-2019 is aligned with the WHO 12th General Programme of Work, preserving regional specificities, and this alignment should facilitate monitoring and reporting on global indicators included in the 12th GPW. It will also facilitate the management of resources received from WHO and the contribution of the Region to the global health agenda.

4. The Strategic Plan 2014-2019 should be flexible enough to easily adapt to changing circumstances. The process of modifying the Strategic Plan 2008-2013 required Member States' approval for all changes, including but not limited to setting baselines and targets that were established for the whole period of implementation. The new Plan defines clearer roles and responsibilities of Member States and PASB. In this regard, it will incorporate mechanisms for making necessary adjustments to the different components of the Plan during its implementation.

5. Although a strategic document should indicate the priority areas where the Organization will direct its resources, further prioritization within areas is required to effectively address key issues. When the Strategic Plan 2008-2013 was prepared, the prioritization criteria were not evidence-based and were not developed through wide consultation; this limited subsequent acceptance of the plan. In the 2014-2019 Strategic

Plan, the criteria were developed based on a scientific method and with the involvement of staff from across PASB. The criteria and methodology were also reviewed and applied by Member States through the Countries Consultative Group (CCG).

6. Achievement of the results of the Strategic Plan should be a joint responsibility of PASB and the Member States. There is a need for a stronger engagement of Member States during all phases, from the inception of the Plan through its implementation and final evaluation. In this regard, the PAHO Strategic Plan 2014-2019 should be implemented within other strategic frameworks, including WHO's GPW and the Health Agenda for the Americas, as well as other relevant frameworks in the Region.

7. National Voluntary Contributions (i.e., voluntary contributions from Member States solely for technical cooperation in their own country) were a significant portion of the Voluntary Contributions received by the Organization during implementation of the Strategic Plan 2008-2013. Although an effort was made to ensure appropriate linkages with the strategic priorities established by Member States, there is need to explicitly identify these contributions to the overall achievement of the results. The Program and Budget 2014-2015 will indicate National Voluntary Contributions under each category and their effect on other funding sources for the Organization, as well as on the overall balance between resource levels and programmatic achievements.

Programmatic and Technical

8. The Organization has advanced in promoting and supporting the inter-programmatic work among different categories, particularly at the country level. Challenges remain at the regional level, where a fixed functional structure seems to hamper horizontal collaboration. The reduction in the number of strategic objectives—now categories—and a more flexible managerial approach are intended to address this challenge. Additional changes will be required at the operational level to encourage work across categories.

9. The strategy of cooperating through networks for the improvement of governance and leadership has been found appropriate and cost-efficient; however, it requires an institutional commitment for medium/long-term sustainability. The creation of networks should include sustainability mechanisms to ensure their success in the long term.

10. Technical cooperation projects among countries using flexible sources of funding, such as the country-variable portion of the budget, proved to be more effective than comparable projects without such flexibility. There are many country-specific factors (political will, economic constraints, and health priorities) that affect the viability of such projects, and funds therefore need to be adjusted to the specific needs of the Member States. However, this also requires the establishment of criteria to ensure an equitable approach to resource allocation among countries. Member States expressed the need for enhanced knowledge sharing among public health practitioners as well as international cooperation agencies, which led to a cross-organizational effort to create a Web-based

knowledge sharing platform where experiences and good practices in public health can be shared. The growing importance of South-South and triangular cooperation in the international dialogue has led the Organization to develop a political framework for the facilitation of cooperation among countries. This will be reviewed by the Governing Bodies in 2013 and potentially incorporated into the new Strategic Plan, if approved.

11. The subregional level of technical cooperation was introduced with the Regional Program Budget Policy in 2006. It was designed to enable the Organization to support the health plans of the subregional integration processes in the Americas, providing an additional space for cooperation and advocacy in the Region. Work at this level has given PAHO the flexibility to respond to Member States' needs while simultaneously encouraging intercountry cooperation, which is a topic of growing importance among countries in the Region. Technical cooperation at the subregional level also facilitates health policy debates at the subregional, regional, and global levels by creating a variety of diplomatic forums in which countries can contribute to supra-national health policy dialogue and diplomacy. Each subregional process offers a platform for common interests and concerns, as well as a space where innovative policies and practices can emerge through dialogue and collective exchange.

Managerial and Administrative

12. The quantity, quality, and measurability of indicators posed challenges throughout the implementation of Strategic Plan 2008-2013. The assessment in most cases focused on quantitative indicators, with limited qualitative analysis. The improvement over the years in the performance monitoring and assessment of Strategic Plan 2008-2013 demonstrated the value of conducting comprehensive qualitative analysis to better demonstrate results. However, the process was considered quite burdensome. As a result, it has been simplified: the number of indicators has been reduced and their quality improved. The indicators in Strategic Plan 2014-2019 focus on measuring advances toward improved health status in relation to the impact indicators, rather than on the assessment of processes.

13. The performance monitoring and assessment (PMA) process for Strategic Plan 2008-2013, although it was conducted at the PASB level, also covered progress by Member States. The new assessment process will clearly define the different levels of accountability. Impacts and outcomes will be assessed based on official available information systems from Member States, and output and deliverables will be under PASB's responsibility. PASB has reviewed the PMA, and a new process that combines efficiencies with flexibility for identification of challenges and performance of adjustments has been identified. A process for periodic independent evaluations should also be incorporated to ensure continuous improvement of programming and contribute to accountability, with information made available to all levels of management and to stakeholders.

14. The PAHO Strategic Plan 2008-2013 was the first plan to be fully implemented using the RBM framework. The implementation of RBM allowed the Organization to better demonstrate results and focus resource allocation while also increasing transparency and accountability. This approach has been institutionalized in PAHO to a significant extent, as reflected in the latest UN Joint Inspection Unit report. PAHO will continue to consolidate its RBM framework in order to enhance transparency and accountability, while simplifying the planning, budgeting, and PMA processes, by increasing capacity building. The new PASB Management Information System (PMIS) will further enhance the implementation of RBM across PASB. The system will generate and use performance information for accountability, reporting to external stakeholders, and providing information to internal management for monitoring, learning, and decision making.

Annex II. Programmatic Priority Stratification Framework

1. The Strategic Plan establishes this framework to serve as a key instrument for guiding planning and the allocation of all available resources to the Pan American Sanitary Bureau, including human and financial resources, and for targeting resource mobilization to implement the PAHO Strategic Plan 2014-2019. This framework is in line with the principles of the PAHO Budget Policy and with the PAHO Results-based Management framework. General principles, including criteria and a scientific method, are set out to guide the application of this framework in an objective manner.

2. This framework builds on the programmatic prioritization process of the PAHO Strategic Plan 2008-2013 and on the one used in the WHO 12th General Programme of Work 2014-2019.

3. The framework's methodology is in line with the PAHO RBM framework and thus should contribute to enhancing accountability and transparency in the allocation and mobilization of resources using a programmatic approach.

4. The methodology identifies three priority tiers: 1 – high; 2 – medium; and 3 – low. It applies to 27 program areas of the PAHO Strategic Plan in Categories 1 through 5, with the following two exclusions:

a) Category 6 (Leadership, Governance, and Enabling Functions). This category supports the delivery of technical cooperation in Categories 1 through 5, including country presence, and is dependent on flexible funding. Therefore it is important to ensure that the necessary funds are available to cover such functions. The level of funding for this category will be determined based on analyses of essential costs, efficiencies, and cost-effective measures, among others (PASB will undertake such analyses).

b) Program Areas 5.5 (Emergency Core Services) and 5.7 (Outbreak and Crisis Response). These are also excluded from the prioritization exercise. The nature of these programs implies that external relations, management, and administrative functions related to the emergency program will always be necessary. Also, adequate human, technical, and financial resources need to be constantly available for the response to outbreaks and crisis. In fact, the funds assigned to outbreaks and crisis belong to a segment of the budget that is separate from the Program and Budget, in accordance with WHO budget practice.

5. Taking into consideration that the Organization has already established the program areas, representing the priorities of the Strategic Plan 2014-2019, a minimum level of funding should be set for each program area. This will ensure a minimum coverage of the Organization to maintain the gains and institutional response capacity.

6. After the minimum level of funding has been assigned, the allocation of remaining funds will be guided by the priority stratification method and the criteria defined in this framework. This will be complemented by the criteria established in the resource coordination mechanism, including the outcome indicator gap (the distance between the baseline and the expected target to be achieved by the end of a biennium), based on the costing of the Program and Budgets. Allocation of flexible resources mobilized will be done according to the priority level and programmatic gap. This methodology provides a means to compare different health issues in a relative, not absolute, framework, as equally as possible, and in a somewhat objective manner.

Methodology

7. The refined methodology (Resolution CD55.R2) includes updates to the well-known and widely accepted Hanlon method for health priority setting. The refined PAHO-Hanlon method responds to Resolution CD53.R3 (2014), which requested the Director to continue to undertake consultations with Member States to refine the programmatic priority stratification framework and apply it to future programs and budgets.

8. The method is based on the assessment of the following components: *(a)* size or magnitude, *(b)* seriousness, *(c)* effectiveness of interventions, *(d)* inequity, and *(e)* positioning factor (see definition below of each component). It uses the following equation:

$$Basic\ Priority\ Rating\ (BPR) = \frac{(A + B + E)C}{5.25} \times F$$

where:

A = Size or magnitude (range of 0-10 points)
Prevalence or incidence of diseases or system or program deficiencies (for non-disease-oriented program areas).

B = Seriousness of the problem (range of 0-20 points)
Includes a combination of four components: B1 – urgency; B2 – severity of consequences (premature mortality, disability, burden on health services, impact on health and sustainable human development); B3 – economic loss; and B4 – negative indirect external effects (negative impact on others or possibility that the problem extends or enhances other events). The importance of the program area in question for the health system and the consequences of not intervening are considered in the scoring of this component.

C = Effectiveness of interventions (range of 0-10 points)
Availability of effective interventions to address the problems or deficiencies in systems or programs.

E = Inequity (range of 0-5 points)
According to PAHO/WHO, health inequities are unfair and unjust inequalities that are unnecessary and avoidable, occurring between groups of people both within and between countries.[6] Inequity can be measured by differential occurrence of disease and access to services or programs according to gender, ethnicity, income level, geographic location (urban vs. rural), and so forth, within and between countries.

F = Positioning Factor (range of 0.67-1.5 points)
Positioning is an institution's added value in each of the program areas being prioritized. For PAHO, this means the extent to which the Organization is uniquely positioned to collaborate with Member States to address program areas based on *(a)* political, strategic, or technical issues, and *(b)* technical cooperation at the country, subregional, or regional levels and other similar aspects, taking into consideration PAHO's six core functions. The institutional positioning factor also allows incorporation of political and strategic considerations into the prioritization process.

The **denominator** of the equation is 5.25. Mathematically, this converts the Basic Priority Rating (BPR) into a number on a scale of 0 to 100.

Application

9. Following validation of the methodology by the SPAG, it was applied by Member States as part of the national consultations for the Program and Budget 2018-2019. These results also update the programmatic priorities stratification in the second amended version of the Strategic Plan 2014-2019.

10. PAHO/WHO Representative Offices facilitated the national consultations jointly with the health authorities. The PAHO-Hanlon Priority Stratification Matrix Tool was used by senior health officials to rate the different components of the equation described above, considering the scope of each program area and the criteria for each component. Next, an overall score for each country was determined by computing the trimmed mean of the individual scores (i.e., excluding minimum and maximum values). Country and territory scores were aggregated to obtain the regional average scores of the program areas. This resulted in the three priority tiers, as outlined in the methodology above.

[6] See: Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan (CD55/7 [September 2016]). Available from: http://www2.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35730&Itemid=270&lang=en .

Annex III. List of Countries and Territories with their Acronyms

	Country	Acronym
	Member States	**35**
1	Antigua and Barbuda	ATG
2	Argentina	ARG
3	Bahamas	BHS
4	Barbados	BRB
5	Belize	BLZ
6	Bolivia (Plurinational State of)	BOL
7	Brazil	BRA
8	Canada	CAN
9	Chile	CHL
10	Colombia	COL
11	Costa Rica	CRI
12	Cuba	CUB
13	Dominica	DMA
14	Dominican Republic	DOM
15	Ecuador	ECU
16	El Salvador	SLV
17	Grenada	GRD
18	Guatemala	GTM
19	Guyana	GUY
20	Haiti	HTI
21	Honduras	HND
22	Jamaica	JAM
23	Mexico	MEX
24	Nicaragua	NIC
25	Panama	PAN
26	Paraguay	PRY
27	Peru	PER
28	Saint Kitts and Nevis	KNA
29	Saint Lucia	LCA
30	Saint Vincent and the Grenadines	VCT
31	Suriname	SUR
32	Trinidad and Tobago	TTO
33	United States of America	USA
34	Uruguay	URY
35	Venezuela (Bolivarian Republic of)	VEN

	Country	Acronym
	Associate Members	**4**
36	Aruba	ABW
37	Curaçao	CUW
38	Puerto Rico	PRI
39	Sint Maarten	SXM
	Participating States	**3**
	France	**4**
40	French Guiana	GUF
41	French St. Martin	MAF
42	Guadeloupe	GLP
43	Martinique	MTQ
	Kingdom of the Netherlands	**3**
44	Bonaire	BON
45	Saba	SAB
46	Sint Eustatius	STA
	United Kingdom of Great Britain and Northern Ireland	**6**
47	Anguilla	AIA
48	Bermuda	BMU
49	British Virgin Islands	VGB
50	Cayman Islands	CYM
51	Montserrat	MSR
52	Turks and Caicos	TCA

Annex IV. PAHO Mandates, Resolutions, Strategies, and Plans of Action

Category and Program Area		Mandates, Resolutions, Strategies and Plan of Actions
1	**Communicable Diseases**	
1.1	HIV/AIDS, STIs, and viral hepatitis	- Regional Strategic Plan for HIV/AIDS/ STIs for the Health Sector [2006-2015] (Resolution CD46.R15 [2005]) - Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis [2010-2015] (Resolution CD50.R12 [2010]) - Viral Hepatitis (Resolution WHA63.18 [2010]) - Prevention and Control of Viral Hepatitis Infection: Framework for Global Action (WHO, 2012)
1.2	Tuberculosis	- Regional Strategy for Tuberculosis Control for 2005-2015 (Resolution CD46.R12 [2005]) - Plan for Expansion of the Programmatic Management of Drug Resistant Tuberculosis: Toward Universal Access to TB-D/M/XDR in the Americas 2010-2015 (OPS, 2011)
1.3	Malaria and other vector-borne diseases (including dengue and Chagas)	- Strategy and Plan of Action for Malaria [2012-2015] (Resolution CD51.R9 [2011]) - Dengue Prevention and Control in the Americas (Resolution CSP27.R15 [2007]) - Strategy and Plan of Action for Chagas Disease Prevention, Control, and Care [2010-2013] (Resolution CD50.R17 [2010]) - Integrated Vector Management: A Comprehensive Response to Vector-borne Diseases (Document CD48/13 [2008]).
1.4	Neglected, tropical, and zoonotic diseases	- Toward the Elimination of Onchocerciasis (River Blindness) in the Americas (Resolution CD48.R10 [2008]) - Elimination of Neglected Diseases and other Poverty-Related Infections (Resolution CD49.R9 [2009]) - Control and Elimination of Five Neglected Diseases in Latin America and the Caribbean [2010–2015] (PAHO, 2010) - Neglected Tropical Diseases (Resolution WHA66.R12 [2013])
1.5	Vaccine-preventable diseases (including maintenance of polio eradication)	- Global Vaccine Action Plan (Resolution WHA65.17 [2012]) - Vaccines and Immunization (Resolution CSP26.R8 [2002]) - Strengthening Immunization Programs in the Americas (Resolution CD50.R5 [2010]) - Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome (CRS) Elimination in the Region of the Americas, 2012-2014 (Resolution CSP28.R16 [2012]) - Poliomyelitis: Intensification of the Global Eradication Initiative (Resolution WHA65.5 [2012])
1.6	Antimicrobial resistance	- Plan of Action on Antimicrobial Resistance (Resolution CD54.R15 [2015])
1.7	Food safety	- Advancing Food Safety Initiatives (Resolution WHA63.3 [2010])
2	**Noncommunicable Diseases and Risk Factors**	
2.1	Noncommunicable diseases and risk factors	- Strategy for the Prevention and Control of Noncommunicable Diseases (Resolution CSP28.R13 [2012]) - Plan of Action to Reduce the Harmful Use of Alcohol [2012-2021] (Document CD51/8 [2011]) - Regional Strategy and Plan of Action for Cervical Cancer Prevention and

Category and Program Area		Mandates, Resolutions, Strategies and Plan of Actions
		Control [2008-2015] (Document CD48/6 [2008]) - Regional Strategy and Plan of Action on Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet, Physical Activity, and Health [2006-2015] (Document CD47/17 [2006]) - Population-based and individual approaches to the prevention and management of diabetes and obesity (Resolution CD48.R9 [2008]) - WHO Framework Convention on Tobacco Control (FCTC) (WHO, 2003) - Strengthening the Capacity of Member States to Implement the Provisions and Guidelines of the WHO Framework Convention on Tobacco Control (Resolution CD50.R6 [2010]) - WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas (Resolution CD48.R2 [2008])
2.2	Mental health and psychoactive substance use disorders	- Strategy and Plan of Action on Epilepsy [2012-2021] (Document CD51/10 [2011]) - Strategy and Plan of Action on Mental Health [2009-2019] (Resolution CD49.R17 [2009]) - Plan of Action on Psychoactive Substance Use and Public Health [2012-2021] (Resolution CD51.R7 [2011]) - Comprehensive mental health action plan 2013–2020 (Resolution WHA66.R8)
2.3	Violence and injuries	- Plan of Action on Road Safety [2012-2017] (Resolution CD51.R6 [2011]) - Preventing Violence and Injuries and Promoting Safety: a Call for Action in the Region (Resolution CD48.R11 [2008])
2.4	Disabilities and rehabilitation	- Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment [2009-2013] (Resolution CD49.R11 [2009]) - Disability (Resolution WHA66.9 [2013]) - Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Health and Other Related Rights (Resolution CD47.R1 [2006])
2.5	Nutrition	- Regional Strategy and Plan of Action on Nutrition in Health and Development [2006-2015] (Resolution CD47.R8 [2006]) - Strategy and Plan of Action for the Reduction of Chronic Malnutrition, [2010-2015] (Resolution CD50.R11 [2010])
3	**Determinants of Health and Promoting Health throughout the Life Course**	
3.1	Women's, maternal, newborn, child, and adolescent, and adult health, and sexual and reproductive health	- Plan of Action on Adolescent and Youth Health [2010-2018] (Resolution CD49.R14 [2009]) - Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity [2012-2017] (Resolution CD51.R12 [2011]) - Regional Strategy for Improving Adolescent and Youth Health [2008-2018] (Resolution CD48.R5 [2008]) - Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care [2008-2015] (Resolution CD48.R4, Rev1 [2008]) - Strategy and Plan of Action for Integrated Child Health [2012-2017] (Resolution CSP28.R20 [2012])
3.2	Aging and health	- Plan of Action on the Health of Older Persons, Including Active and Healthy Aging [2009-2018] (Resolution D49.R15 [2009])
3.3	Gender, equity, human rights, and	- Plan of Action for Implementing the Gender Equality Policy [2009-2013] (Resolution CD49.R12 [2009])

Category and Program Area		Mandates, Resolutions, Strategies and Plan of Actions
	ethnicity	
3.4	Social determinants of health	- Strategy and Plan of Action on Urban Health [2013-2021] (Resolution CD51.R4 [2011])
3.5	Health and the environment	- Strategy and Plan of Action on Climate Change [2012-2017] (Resolution CD51.R15 [2011])
4	**Health Systems**	
4.1	Health governance and financing, national health policies, strategies, and plans	- Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges (Resolution CD44.R6 [2003]) - Extension of Social Protection in Health: Joint Initiatives of the Pan American Health Organization and the International Labour Organization (Resolution CSP26.R19 [2002]) - Essential Public Health Functions (Resolution CD42.R14 [2000]) - Health and International Relations: Linkages with National Health Development (Resolution CD48.R16 [2008]) - Strategy for Universal Access to Health and Universal Health Coverage (Resolution CD53.R14 [2014])
4.2	People-centered integrated, quality health services	- Regional Policy and Strategy for Ensuring Quality of Health Care, Including Patient Safety [2007-2013] (Resolution CSP27.R10 [2007]) Integrated Health Services Delivery Networks Framework, Concepts, Policy Options and a Road Map for Implementation in the Americas (PAHO, 2010) - Integrated Health Services Delivery Networks based on Primary Health Care (Resolution CD49.R22 [2009]) - Ensuring the Quality of Health Care Including Patient Safety (Resolution CE140.R18)
4.3	Access to medical products and strengthening of regulatory capacity	- Access to Medicines (Resolution CD45.R7 [2004]) - Strengthening National Regulatory Authorities for Medicines and Biologicals (Resolution CD50/R.9 [2010]) - Medical Devices (Resolution CD42.R10 [2000]) - Drug Regulatory Harmonization (Resolution CD42.R11 [2000]) - Public Health, Health Research, Production and Access to Essential Medicines (Resolution CD47.R7 [2006]) - Improving Blood Availability and Transfusion Safety in the Americas (Resolution CD48.R7 [2008]) - Public Health, Innovation and Intellectual Property-A regional perspective (Resolution CD48.R15 [2008]) - Policy Framework for Human Organ Donation and Transplantation (Resolution CD49.R18 [2009]) - Health Technology Assessment and Incorporation into Health Systems (Resolution CSP28.R9 [2012]) - Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards (Resolution CSP28.R15 [2012])
4.4	Health systems information and evidence	- Regional Plan of Action for Strengthening Vital and Health Statistics, 2008-2013 (Resolution CD48.R6 [2008]) - Strategy for Strengthening Vital and Health Statistics in Countries of the Americas, 2008-2013 (Resolution CSP27.R12 [2007]) - Strategy and Plan of Action on eHealth (2012-2017) (Resolution CD51.R5 [2011]) - Strategy and Plan of Action on Knowledge Management and

Category and Program Area		Mandates, Resolutions, Strategies and Plan of Actions
		Communications, 2013-2018 (Resolution CSP28.R2 [2012]) - Public Health, Health Research, Production and Access to Essential Medicines (Resolution CD47.R7 [2006]) - Policy on Research for Health (Resolution CD49.R10 [2009])
4.5	Human resources for health	- Toronto Call to Action for a Decade of Human Resources in Health in the Americas (2006-2015) - Development and Strengthening of Human Resources Management in the Health Sector (Resolution CD43.R6 [2001]) - Observatory of Human Resources in Health (Resolution CD45.R9 [2004]) - Strategy for Health Personnel Competency Development in Primary Health Care based Health Systems (Resolution CD50.R7 [2010]) - Regional Goals for Human Resources for Health (Resolution CSP27.R7 [2007]) - Expanded Textbook and Instructional Materials Program (PALTEX) (Resolution CSP28.R3 [2012])
5	Health Emergencies	
5.2	Country health emergency preparedness and the International Health Regulations (2005)	- Implementation of the International Health Regulations (2005) (Resolution WHA64.1 [2011]) - Revision of the International Health Regulations (Resolution WHA58.3 [2005]) - Application of the International Health Regulations (2005) (Resolution WHA59.2 [2006]) - Implementation of the International Health Regulations (2005) (Resolution WHA61.2 [2008]) - Implementation of the International Health Regulations (2005) (Resolution WHA65.23 [2012]) - International Health Security: Implementing the International Health Regulations (2005) (Resolution CSP27.R13 [2007]) - International Health Regulations (2005), Second Edition (WHO, 2008)
- 5.5	Emergency core services	- Reform of WHO's work in health emergency management, WHO Health Emergencies Programme, Report by the Director-General (Document WHA69/30 [2016])
- 5.6 -	Disaster risk reduction and special projects	- Plan of Action on Safe Hospitals (2010-2015) (Resolution CD50.R15 [2010]) - Safe Hospitals: A Regional Initiative on Disaster-resilient Health Facilities (2008-2015) (Resolution CPS27.R14 [2007]) - Coordination of International Humanitarian Assistance in Health in case of Disasters (Resolution CSP28.R19 [2012]) - Hurricanes Katrina and Rita and Disaster Preparedness in the Region of the Americas (Resolution CD46.R14 [2005]) - Disaster Preparedness and Response (Resolution CD45.R8 [2004]) - Hurricanes Georges, Mitch and Floyd (Resolution CD41.R6 [1999]) - Health Emergency Preparedness for Disasters Caused by El Niño (Resolution CD40.R13 [1997]) - Emergency Preparedness and Disaster Relief Coordination (CD31.R23 [1985]) - Emergency Preparedness Program (Resolution CD27.R40 [1980]) - Emergency Preparedness and Disaster Relief Coordination Program in the Americas (Resolution CD26.R36 [1979])

Category and Program Area		Mandates, Resolutions, Strategies and Plan of Actions
		- Plan of Action for Disaster Risk Reduction 2016 – 2021 (Resolution CD55.R10 [2016]
5.7	Outbreak crisis and response	- Coordination of International Humanitarian Assistance in Health in case of Disasters (Resolution CSP28.R19 [2012]) - Disaster Preparedness and Response (Resolution CD45.R8 [2004]) - Emergency Preparedness and Disaster Relief Coordination (Resolution CD32.R10 [1987])
6	**Leadership, Governance, and Enabling Functions**	
6.1	Leadership and governance	- United Nations Reform Process and WHO's Role in Harmonization of Operational Development Activities at Country Level (Resolution WHA58.25 [2005]) - The Busan Partnership for Effective Development Cooperation (2011) - WHO Reform (Document WHA66/4 [2013]) - United Nations Millennium Declaration (Document A/55/L.2 [2000]) - Triennial Comprehensive Preview of Operational activities for development of the United Nations system (Document A/62/208 [2008]) - Cooperation among countries for health development in the Americas (Document CE152/15 [2013]) - Health in the 2030 Agenda for Sustainable Development (Resolution WHA69.11 [2016])
6.2	Transparency, accountability, and risk management	- PAHO Results-Based Management Framework (Document SPB4/5, Rev. 2 [2010])
6.3	Strategic planning, resource coordination, and reporting	- Health Agenda for the Americas 2008-2017 - PAHO Budget Policy (Resolution CSP28.R10 [2012]) - WHO 12th General Programme of Work 2014-2019 (Document A66/6 [2013]) - WHO Programme Budget 2014-2015 (Document A66/7 [2013])
6.5	Strategic communications	- Strategy and Plan of Action on Knowledge Management and Communication (CSP28/12, Rev. 1 [2012])

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