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STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2020-2025

EQUITY AT THE HEART OF HEALTH

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Foreword by the Director

Merriam-Webster defines equity as "justice according to natural law or right." I like this definition, which can be linked to two concepts central to health equity: social justice and the right to the enjoyment of the highest attainable standard of health. These universal bedrock principles can help guide us in peaceful as well as turbulent times.

Our Region faces a number of political, social, and economic challenges. I choose to focus on what we have in common: our desire for freedom, for justice, for economic opportunity, and for health and well-being. I believe that we are united in our fundamental humanity, and I truly believe that in order to fully realize this humanity, we cannot and must not leave anyone behind: not the indigenous child of the Andes; not the Afro-descendant youngster on the Atlantic coast of Central America; and not the elderly grandmother on a remote island in the Caribbean. We must ensure that all of them have equitable access to health, and we must not rest until all health inequities have been eliminated.

This commitment lies at the heart of this Strategic Plan. The Plan sets out concrete health outcomes and impacts that will directly measure our progress in delivering health to our people. I further commit the Pan American Sanitary Bureau (PASB or the Bureau) to work toward health equity and to improve our capacity for measuring inequities. We are jointly accountable for progress, and the Bureau will support Member States in efforts to target interventions to the most underserved populations.

When developing this Plan, the strategic signposts had already been set: the Sustainable Development Goals, the Sustainable Health Agenda for the Americas 2018-2030, and WHO's 13th General Programme of Work. I applaud the work of PAHO's Member States and staff to develop a coherent and actionable Strategic Plan that responds to these mandates, sets a clear strategic direction, and allows us to tangibly judge our progress in health development over the next six years.

Equity at the Heart of Health means that we will strive together for health equity, for the absence of remediable differences in health outcomes among groups of people. PAHO will work together with every country and territory in the Americas to plan for success, to implement tirelessly, and to celebrate our achievements and learn from our shortcomings.

I have no doubt that in the coming six years we will advance toward health equity, social justice, and universal health. This Strategic Plan will help us get there; it is a product of our collective efforts, and we should be proud and hopeful for the future as we move forward together with clear direction and a sense of common purpose.

[Signature]
Carissa F. Etienne

Executive Summary

1. 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 specifies the public health results to be achieved during the period 2020-2025. The Plan establishes the joint commitment of PAHO Member States and the Pan American Sanitary Bureau (PASB or "the Bureau") for the next six years. PAHO Member States have clearly stated that the Strategic Plan is a principal instrument for implementation of the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) and thus for realizing the health-related Sustainable Development Goals (SDGs) in the Region of the Americas. The 11 SHAA2030 goals form the impact-level objectives of this Plan.

2. Under the theme *Equity at the Heart of Health*, this Plan seeks to catalyze efforts in Member States to reduce inequities in health within and between countries and territories in order to improve health outcomes. The Plan identifies specific actions to tackle health inequality, including those recommended by the Commission on Equity and Health Inequalities in the Americas, with guidance from the High-level Commission for Universal Health. Four cross-cutting themes (CCTs) are central to this Plan's approach to addressing the determinants of health: equity, gender, ethnicity, and human rights. In addition to highlighting an integrated multisectoral approach, this Plan applies evidence-based public health strategies, such as health promotion, the primary health care approach, and social protection in health, to address the social determinants.

3. In addition to directly addressing the regional priorities established in the SHAA2030, this Plan aligns with the World Health Organization (WHO) 13th General Programme of Work (GPW13) and with other regional and global mandates in force during the planning period. The results chain outlined in Annex A contains 28 impact indicators, 28 outcomes, and 99 outcome indicators, all extensively reviewed by Member States and PASB technical staff. Annexes B and D outline how the results chain responds to the mandates listed above. Recognizing that resources are limited, Member States have conducted prioritization consultations, and the resulting regional priorities are listed in Annex C.

4. The Region continues to face important health gaps and emerging public health issues that are described in Health in the Americas 2017 and referenced in the Health Context section of this document. This analysis of health gains, gaps, and trends serves as the basis for defining the results structure outlined in the Strategic Plan 2020-2025. Although the final evaluation of the Strategic Plan 2014-2019 (to be presented to PAHO Governing Bodies in 2020) will contain a thorough assessment of the lessons learned, preliminary analysis based on the End-of-Biennium Assessment 2016-2017 serves as a useful reference for how the Organization will carry forward the unfinished agenda of the previous plan during the next period.

5. As the regional and global context continues to evolve, the Strategic Plan 2020-2025 outlines the perspective of the Organization concerning the evolution of PAHO's role in health development. The Program Budgets that will be developed under this Plan will follow the 2019 PAHO Budget Policy and the new health needs index, known as the Sustainable Health Index Expanded Plus (SHIe+). In this regard, and in line with the principles of equity and Pan American solidarity, the Plan identifies eight key countries—Belize, Bolivia, Guatemala, Haiti, Honduras, Nicaragua, Paraguay, and Suriname—where the Organization commits to dedicate more resources for technical cooperation to ensure that health gaps are closed. PAHO will continue to foster and strengthen technical cooperation at the subregional level, build on technical cooperation agreements at national level, scale up opportunities for cooperation among countries for health development (CCHD), and strengthen the normative work of the Organization.

6. PAHO's performance in the implementation of the Strategic Plan 2020-2025 and its Program Budgets will be assessed by measuring progress toward the attainment of the health impact and outcome targets contained in the Plan. Monitoring and reporting will make use of existing PAHO health information systems (the Regional Core Health Data and Strategic Plan Monitoring System). Internal performance monitoring and assessment (PMA) for the Program Budgets will be conducted at the end of each semester, and a report will be presented to the PAHO Governing Bodies at the end of each biennium (interim reports in 2022 and 2024, with the final report in 2026).

Introduction

7. This Strategic Plan of the Pan American Health Organization 2020-2025 (SP20-25 or the "Plan") sets out the health impact and outcome results that the Pan American Health Organization (PAHO) and its Member States commit to collectively achieve by the end of 2025. It responds directly to the highest-level regional mandate in health, the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), which represents the regional response to the Sustainable Development Goals (SDGs). This Plan also aligns with the 13th General Programme of Work (GPW13) of the World Health Organization (WHO), ensuring that PAHO will meet its global obligations in carrying out its functions as the WHO Regional Office for the Americas. Finally, this Plan serves as the principal means of ensuring accountability and transparency in the achievement of health objectives mandated by the PAHO Governing Bodies.

8. PAHO adopted a Results-based Management (RBM) approach two decades ago, and this Plan builds on the experience and lessons learned from previous plans. Specifically, the unfinished agenda from the Strategic Plan 2014-2019 (SP14-19) has been taken up in the current Plan. The Programmatic Framework for Results presented below incorporates a results chain that responds categorically to the health challenges that the Region of the Americas faces, and it includes measurable indicators of achievement for all areas of health development.

9. SHAA2030 establishes a hemispheric vision for health in the Americas. This Plan directly addresses the factors that will lead to the realization of this vision.

Vision Statement

By 2030, the Region as a whole and the countries of the Americas aim to achieve the highest attainable standard of health, with equity and well-being for all people throughout the life course, with universal access to health and universal health coverage, resilient health systems, and quality health services.

10. SHAA2030 also establishes guiding values for health development in the Region, acknowledging that individual countries have "different needs and approaches to improving health."[1] This Plan reflects these values, which are listed below, both in its direction and objectives and in the measurement of its achievements. These values will guide the work of PAHO in the years to come. In line with the statements in the SHAA2030, each of these values contributes to the attainment of human rights and optimal health for all and guides the Region's pursuit of universal access to health and universal health coverage. Specifically, equity is identified as an overarching goal with respect to the need to eliminate health disparities between population groups and to protect and promote the rights of those groups living in conditions of vulnerability.

[1] The values in the SHAA2030 are consistent with the vision, mission, and values of the Organization.

11. This Plan is underpinned by the need to translate values into practice, acknowledging that equitable, gender-sensitive, and culturally sensitive approaches to health within a human rights framework are essential to achieve the Organization's objectives. Toward this end, the Plan is informed by four cross-cutting themes: equity, gender, ethnicity, and human rights. The Plan aims to mainstream these approaches throughout the Programmatic Framework for Results, with a particular focus on the specific support and coordination required in Outcome 26.

Guiding Values

- **The right to the enjoyment of the highest attainable standard of health**
- **Pan American solidarity**
- **Equity in health**
- **Universality**
- **Social inclusion**

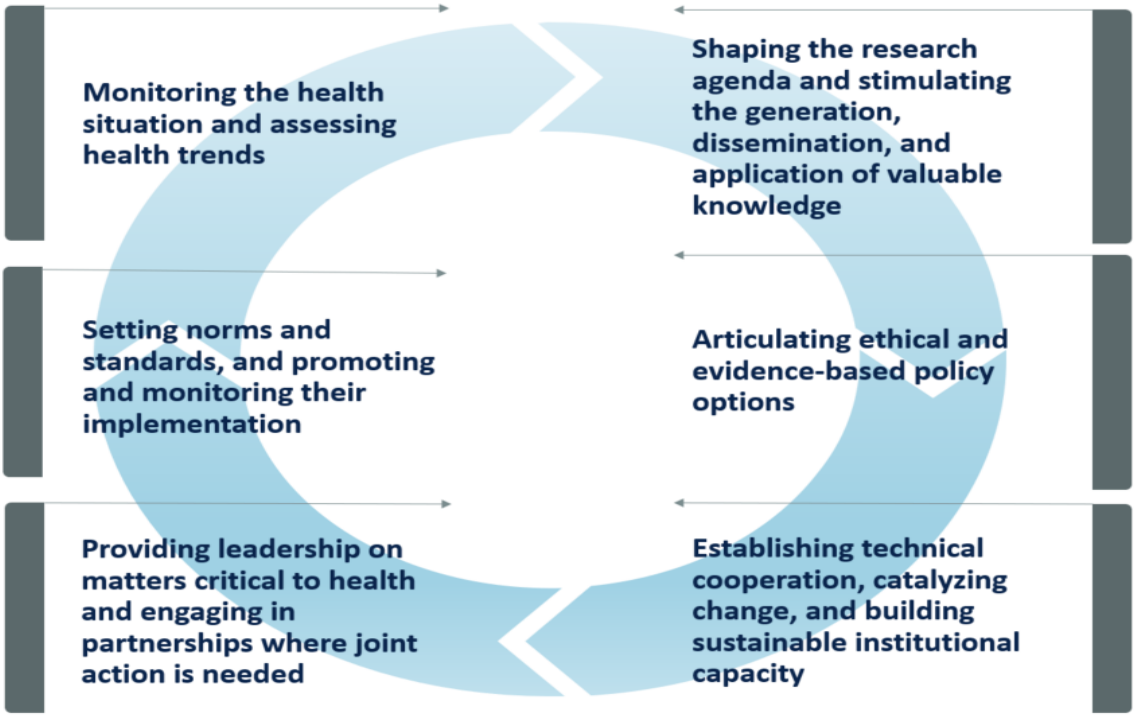
12. In addition, consistent with the principles of Results-based Management, the Organization will continue to carry out technical cooperation that utilizes its core functions, shown in Figure 1. These are areas where the Organization provides value added in the Region's efforts to reach its desired health outcomes. This approach seeks to monitor and learn from past experiences to identify and successfully implement evidence-based interventions that improve health and well-being.

Strategic Plan Development Process

13. This Plan was developed with active participation and input from PAHO Member States, as well as from staff in all parts of PASB. Plan development began with the presentation of the proposed process to the 12th session of the Subcommittee on Program, Budget, and Administration (SPBA) in March 2018. In June 2018, the 162nd Session of the Executive Committee (EC) established the Strategic Plan Advisory Group (SPAG), consisting of 21 Member States that agreed to collaborate with the Bureau to elaborate the Plan.[2] The final process document was presented to the 56th Directing Council in September 2018 (Document CD56/INF/2).

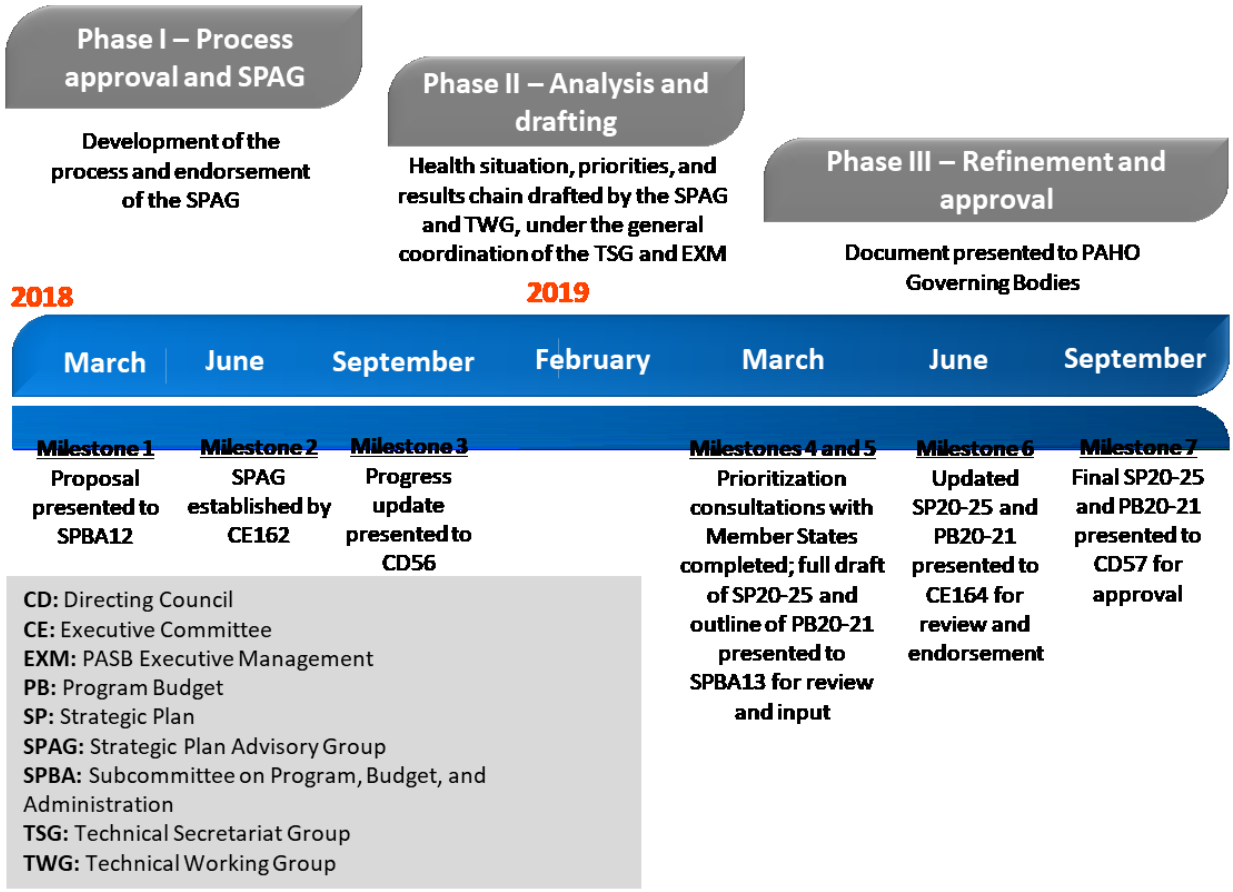
[2] The SPAG had representation from all PAHO subregions: the Caribbean (Antigua and Barbuda, Bahamas, Dominica, Guyana, Saint Lucia, and Trinidad and Tobago); Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama); North America (Canada, Mexico, and the United States of America); and South America (Argentina, Bolivia, Brazil, Ecuador, Paraguay, and Venezuela). Panama was appointed Chair, and the Bahamas, Vice Chair.

Figure 1. PAHO Core Functions



14. The Pan American Sanitary Bureau held three face-to-face meetings with the SPAG, in Panama City (6-8 August 2018) and Washington, DC (3-6 December 2018 and 1-4 April 2019). A series of virtual meetings was also held throughout the process. Meanwhile, the Bureau established a Technical Working Group (TWG), composed of technical teams, to develop the content of the results chain in close collaboration with the SPAG and under the general coordination of the Technical Secretariat Group (TSG) and the leadership of PASB Executive Management (EXM). The development process was iterative and rigorous, and the end result represents the best collective thinking about where and how the Bureau and the Member States should concentrate their efforts over the next six years. Figure 2 depicts the development process.

Figure 2. Timeline for Development of the Strategic Plan 2020-2025[3]



[3] This figure contains updates on the development process that was presented to the 56th Directing Council.

The Health Context in the Americas: Opportunities and Challenges

15. Drawing on the 2017 edition of Health in the Americas, this section provides a high-level overview of the social, economic, and environmental context in which the Strategic Plan is developed. Health in the Americas 2017 will be updated periodically based on the Region's changing health profile and health determinants, using the most recent health metrics. The vision is that it will serve as the most current health situation analysis for the Americas. This section also presents some of the main lessons learned from the past, which can serve to guide implementation moving forward. Finally, it looks to future trends and the primary reference frameworks mentioned earlier: the SDGs, SHAA2030, and GPW13.

Social and Environmental Overview from a Health Perspective

16. Over the past decade, sustained economic development in the Region, with improvements in public sanitation, housing, nutrition, and health care, has driven significant advances in health outcomes. However, significant inequities in health still persist between and within most countries, with worse health outcomes for populations living in conditions of vulnerability.[4] In all countries of the Region, noncommunicable diseases (NCDs) and injuries have overtaken communicable diseases and maternal and neonatal conditions as causes of ill health, disability, and mortality. Meanwhile, lessons learned from past public health emergencies of international concern (PHEIC), such as the 2009 influenza pandemic and the Zika epidemic, have resulted in greater preparedness for health emergencies and increased awareness of the need to strengthen surveillance.

17. Overall, the Region experienced positive trends in macroeconomic growth, a reduction in poverty and in the proportions of the indigent population, and a reduction in income inequality during 1990-2015, the period corresponding to the Millennium Development Goals (MDGs). The universal health framework has increased the momentum and commitment of Member States to further promote equitable access to and coverage of services, strengthen stewardship and inclusive governance, improve efficiency through more integrated health systems, and strengthen intersectoral coordination to address the determinants of health.[5] It also underscores the need to increase and improve investments in health, especially for strengthening the first level of care, and to move toward the creation and implementation of integrated health service networks. An increasing number of Member States have implemented plans of actions and road maps toward universal health and have developed regulatory and financial frameworks. Almost all the countries in the Region have achieved good coverage of maternal and child health interventions at the aggregate level. As a result of these successes, countries in the

[4] PAHO, Sustainable Health Agenda for the Americas 2018-2030, 29th Pan American Sanitary Conference, 69th Session of the Regional Committee of WHO for the Americas (Washington, DC: PAHO, 2017), pp. 50-51.

[5] PAHO, Strategy for universal access to health and universal health coverage (Document CD53/5, Rev. 2), 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas (Washington, DC: PAHO, 2014).

Americas have consolidated undeniable health gains and achievements for several MDGs, including childhood mortality, malaria and tuberculosis incidence, and access to safe water.

18. Despite this progress, communicable diseases still represent a significant burden in terms of morbidity and mortality, and the persistence of specific communicable diseases and preventable maternal and child illnesses in certain geographic and population settings hinders the well-being of all and constrains development and achievement of equity. The Region faces new challenges from emerging and reemerging infectious diseases, adversely affecting people, families, and communities, as well as economies and health systems and services. These challenges are related to the determinants of health—social, political, and economic factors that have resulted in, among other things, greater population movements, greater pressure on the environment, and environmental changes.

19. In addition to the endemic circulation of dengue for the past three decades, the Region has experienced the introduction of two new Aedes-borne arboviruses: chikungunya and Zika virus. The adverse outcomes associated with Zika virus infection resulted in the declaration of a PHEIC. Since the initial detection of birth defects associated with Zika virus infection in utero, 5,454 suspected cases of congenital Zika syndrome have been reported to PAHO. These events highlight the vulnerability of the Region to the introduction and spread of arboviruses.

20. Noncommunicable diseases are the leading causes of ill health, death, and disability in the Region of the Americas. NCDs disproportionately affect people living in vulnerable situations because of the complex interplay between social, economic, cultural, behavioral, biological, and environmental factors, along with the accumulation of positive and negative influences over the life course. Mortality due to NCDs tends to be higher in populations with lower income (and associated determinants, such as lower levels of education) and less social support, and in other populations that experience different and often multiple and intersecting forms of discrimination, including gender and ethnic discrimination. The forces contributing to increased prevalence of NCDs include behavioral and demographic change, epidemiological transition, economic development, and rapid and unplanned urbanization, among other factors. These dynamics have had an adverse impact on the four key risk factors that account for most preventable deaths and disabilities from NCDs: harmful use of alcohol, unhealthy diet, physical inactivity, and tobacco use.

21. One of the biggest challenges in the Region is that there are significant disparities in health outcomes across different groups. These are related to the structural inequalities in society and in institutions, including the health sector, as well as to the determinants of health. These inequalities further marginalize groups with less social and economic power, such as women and girls, people living in situations of poverty, indigenous peoples, Afro-descendant and Roma populations, people with disabilities, and refugees and migrants, among others, while increasing opportunities for groups with greater social standing and power. The challenges to overcoming health disparities in the Region are exacerbated by a lack of health service capacity in disease detection, prevention, and control, by inadequate implementation of policies designed to improve health equity

among populations, and by lack of consistent disaggregated data to track and reveal disparities.

22. Over the past 50 years, the United Nations (UN) system has addressed a range of issues related to sustainable development and its interfaces with different sectors, including health and environment. At national level, clear environmental public health governance processes have not been developed and given priority in political and economic agendas. Environmental public health programs have been more reactive than proactive, and more remedial than preventive. There has also been a chronic shortage of human, technological, and financial resources for these programs. In this context, the impact of climate change on people's health and well-being in the Americas has become an increasing concern. Populations in conditions of vulnerability, such as those living on small islands, are disproportionally at risk.[6]

23. Countries in the Region of the Americas have experienced migration flows at various moments throughout their history, as countries of origin, transit, or destination. Social and political conflict, food insecurity, adverse effects of climate change and environmental degradation, economic hardship, violence in different forms, and other structural issues are among the drivers of migration trends in the Region. In recent years, population movements of unprecedented magnitude have increased in a short time frame, along with changes in the composition of migrant flows, which now include more women and children, and a diversification of destination countries. In 2017, of the worldwide population of international migrants, 38 million were born in Latin America and the Caribbean (LAC)—the third-largest number of any world region.[7] That same year, LAC hosted 10 million international migrants. While migration within South America has intensified, migration northward by Central Americans continues as an important trend within the Americas as a whole.

24. The changing profile of migrants implies different risks to health, both along the migratory routes as well as in destination countries. In particular, health systems need strengthened capacities to address the specific health needs of migrant women, adolescents, and children in light of the gendered inequalities that are associated with particular risks (such as gender-based violence) and that compound barriers to access for those with migrant status. Managing migration, especially sudden and large population movements, has prompted profound questions about the resilience and adaptive capacity of health systems to achieve equitable health access and coverage in the Region.

[6] WHO, Climate change and health in small island developing states (Geneva: WHO, 2018).

[7] United Nations Department of Economic and Social Affairs, International migration report 2017 (New York: United Nations, 2017). Available from: http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf.

Situation Analysis: Health in the Americas 2017

25. During the past decade, the Region made important progress related to infant and maternal mortality, reproductive health, infectious diseases, and malnutrition. These successes resulted from economic development, action on environmental factors, and the improved capacity and flexibility of health systems, as well as increased coverage and access to services. However, overall progress at the regional and national levels masks not only the risk of reversing gains, but also the large gaps in health outcomes between population subgroups, such as those in the lower wealth quintiles and indigenous and Afro-descendant groups. These differentials undermine health system performance and stand in the way of equitable sustainable development.

26. During the period 2010-2015, overall life expectancy in the Region reached approximately 75 years: 78 years for women and 73 years for men. The population gained an average of 16 years of life in the past 45 years, an increase of almost two years per five-year period. Other achievements include a decrease in both the maternal mortality ratio (68.4 to 58.2 deaths per 100,000 live births, a 14.9% reduction) and the infant mortality rate (17.9 to 13.6 deaths per 1,000 live births, a 24.0% reduction). The percentage of pregnant women receiving at least four prenatal care visits increased from 79.5% in 2005 to 88.2% in 2015, although the quality of care remains a concern.

27. Important advances have been made in controlling communicable diseases. The number of malaria cases decreased 62% between 2000 and 2015 (from 1,181,095 cases to 451,242). The number of cases of neglected diseases (such as onchocerciasis, leprosy, and Chagas disease) has decreased. The Region has interrupted the endemic transmission of rubella. Although the Region was declared measles-free in 2015, two countries have lost that status. The number of annual AIDS-related deaths decreased from 73,579 to 49,564 between 2005 and 2015, a 33% reduction, although the number of new infections has been stable over the past few years. However, advances in the control of communicable diseases can be jeopardized by antimicrobial resistance, a priority intersectoral area of action in the health, agriculture, and livestock sectors.

28. Chronic noncommunicable diseases account for nearly four of five deaths annually in the Americas", and this proportion is on the rise, mostly as a result of population aging, changes in behaviors, population increase and structure, unhealthy lifestyles, urbanization, environmental hazards, and exposure to risk factors such as unhealthy foods and beverages, among others. Of the deaths caused by noncommunicable diseases in the Americas, 35% occurred prematurely in people 30-70 years of age. Of the total premature deaths in this age group, 65% were due to cancer and cardiovascular diseases. Annually, approximately 3 million people in the Americas live with cancer, which causes 1.3 million deaths per year, 45% of which are premature deaths. In Latin America and the Caribbean, prostate, lung, stomach, and colorectal cancers are the leading causes of cancer deaths in males, while breast, stomach, lung, cervical, and colorectal cancers are the leading causes in females.

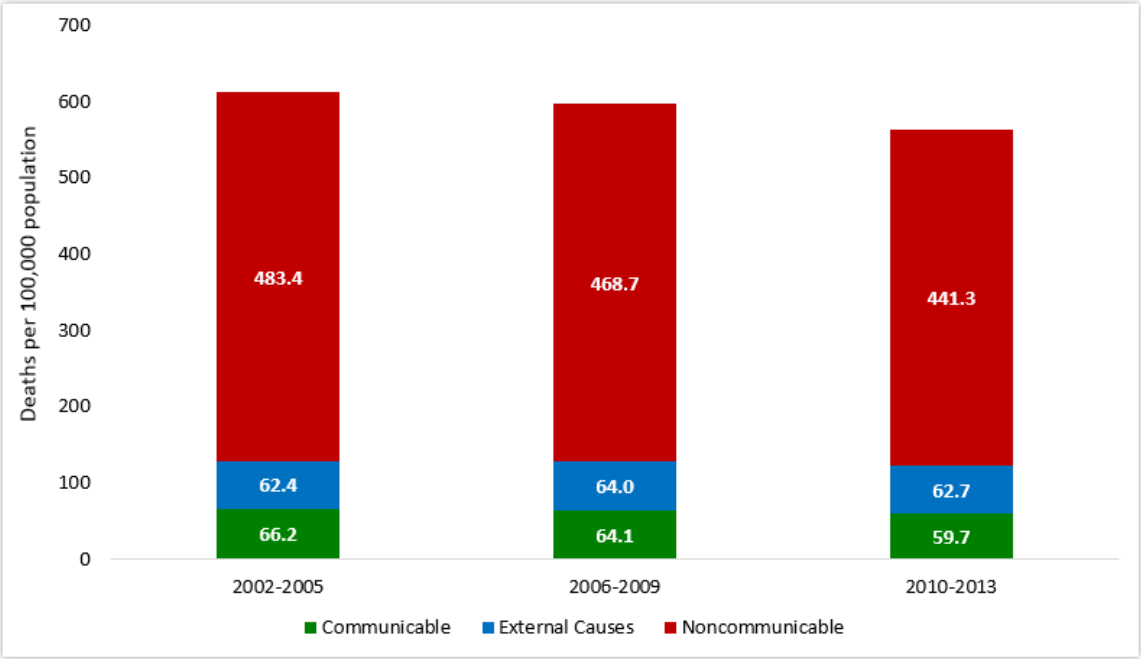
29. With obesity reaching epidemic proportions in children, adolescents, and adults, the Americas is the WHO Region with the highest prevalence of overweight and obesity. Overweight and obesity increase the likelihood of hypertension and diabetes and contribute to morbidity and mortality from cardiovascular diseases and other NCDs. They also pose greater obstetric risk for overweight and obese pregnant women. Approximately 422 million adults age 18 years and older are living with diabetes worldwide, with 62 million (15.0%) of the affected global population in the Americas; the number has tripled in this Region since 1980.

30. Disability is an important consideration for the Region given aging populations, rise in chronic conditions and NCDs, and increase in non-fatal outcomes of injuries and communicable diseases. Global Burden of Disease studies have shown that years lived with disability account for an increasing proportion of Disability-Adjusted Life Years (DALYs) in Latin America and the Caribbean, from 32.7% in 2000 to 39.2% in 2017.[8] Disability prevalence is estimated to be between 12% and 15% of the population, though country estimates vary greatly depending on methods used.[9,10] There is limited specific data on health equity and access to general health services from the Region, but WHO estimates that persons with disabilities are two times more likely to find health care providers' skills and health facilities inadequate, three times more likely to be denied health care, and four times more likely to be treated poorly in the health system than persons without disabilities.[11] Finally, disability is not routinely disaggregated within health data and information systems in most countries, making accurate measurement a challenge.

31. Figure 3 shows the trends in mortality due to noncommunicable diseases, communicable diseases, and external causes (including violence and accidents) in the Region of the Americas between 2002 and 2013. The predominance of noncommunicable diseases is clear. Nonetheless, age-adjusted mortality rates for NCDs decreased steadily, from 483.4 deaths per 100,000 population in 2002-2005 to 441.3 in 2010-2013. Similarly, age-adjusted mortality rates for communicable diseases decreased from 66.2 per 100,000 population in 2002-2005 to 59.7 in 2010-2013.

[8] Data taken from GBD Results tool available at http://ghdx.healthdata.org/gbd-results-tool [cited 8 May 2019].
[9] Economic Commission for Latin America and the Caribbean (ECLAC), Panorama social de América Latina (New York: United Nations, 2012).
[10] World Health Organization/World Bank, World report on disability (Geneva: WHO, 2011).
[11] Ibid.

Figure 3. Age-Adjusted Mortality Rates in the Americas, 2002-2005, 2006-2009, and 2010-2013



Source: PAHO Regional Mortality Database.

32. External causes of mortality remained steady throughout the same period, but the underlying risk factors require more attention. The patterns and consequences of violence are different for men, women, and children across the life course. While men are more likely to experience violence perpetrated by strangers, women and children are more likely to suffer violence by individuals who are close to them. These differences have implications for programs and policies, given that blame, shame, and fear keep children, women, and the elderly from reporting violence and seeking care. For example, compared to women, men have a four times greater risk of dying due to external causes and a seven times greater risk of dying from homicide, often related to men's risk-taking behaviors and predominant forms of masculinity. However, while men experience higher levels of lethal violence than women, globally and regionally, women are more likely than men to be killed by a partner, to experience sexual violence, or to experience other forms of nonlethal violence.[12,13] WHO estimates that 38% of all women murdered in the Americas were killed by a partner, and that nearly one-third (30%) of ever-partnered women have been physically and/or sexually abused by an intimate partner at some point in life.[14]

[12] United Nations Office on Drugs and Crime (UNODC), Global study on homicide 2013: trends, context, data (Vienna: UNODC, 2014). Available from: https://www.unodc.org/gsh/.

[13] WHO, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (Geneva: WHO, 2013). Available from: www.who.int/reproductivehealth/publications/violence/9789241564625/en/.

[14] Ibid.

33. About 13% of all premature deaths in the Americas are attributed to known avoidable environmental risks, amounting to about 847,000 deaths each year.[15] The percentages vary significantly among countries, ranging from 8% of all premature deaths in St. Kitts and Nevis to 23% in Haiti. Air pollution alone is associated with almost 320,000 preventable deaths per year in the Region.[16] Approximately 106 million people still do not have adequate sanitation systems, 19 million still practice open defecation, and 34 million do not have access to improved sources of safe drinking water.[17] This results in about 30,000 preventable deaths each year. Hazardous chemical risks, such as exposure to toxic pesticides, lead, and mercury, tend to disproportionally impact children and contribute to noncommunicable diseases throughout the life course.[18] Health effects of climate change may include increased respiratory and cardiovascular diseases, injuries, and premature deaths related to extreme weather events, food insecurity, and air pollution, threats to mental health, and modified transmission patterns of infectious diseases.

Unfinished Agenda and Lessons Learned from the PAHO Strategic Plan 2014-2019

34. The SP20-25 provides an opportunity to reflect on the Region's achievements in health and on the remaining challenges. In that regard, the lessons learned from the SP14-19 are important for guiding future interventions, as the Region strives to achieve the ambitious goals and targets of the Sustainable Health Agenda for the Americas 2018-2030. The second interim assessment of the SP14-19 (Document CD56/5) noted progress in improving the health and well-being of the populations of the Region. Important reductions in health inequalities were observed in key maternal and child survival indicators, as referenced in the impact goals assessment. However, the report also called attention to areas and population groups that are lagging and require greater efforts.

35. While overall projections for the nine regional impact goals signaled improvements, including in the areas of healthy life expectancy, maternal and child mortality, elimination of communicable diseases, and reducing death, illness, and disability resulting from emergencies, four of the impact goals did not appear to be on track to meet the targets by 2019. These were Goal 4, reduce mortality due to poor quality of health care; Goal 5, improve the health of the adult population with an emphasis on NCDs and risk factors; Goal 6, reduce mortality due to communicable diseases; and Goal 7, curb mortality due to violence, suicides, and accidents among adolescents and young adults (15-24 years of age). The indicators under these goals were projected to continue to decline, but not fast enough to reach the 2019 targets. For example, the reduction of homicide and suicide rates

[15] WHO Global Health Observatory data repository: public health and environment: ambient air pollution: burden of disease. http://apps.who.int/gho/data/node.main.BODAMBIENTAIR?lang=en.

[16] WHO Global Health Observatory data repository: public health and environment: household air pollution. http://apps.who.int/gho/data/node.main.133?lang=en.

[17] WHO and UNICEF, Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines (Geneva: WHO/UNICEF, 2017). Available from: http://apps.who.int/iris/bitstream/handle/10665/258617/9789241512893-eng.pdf;jsessionid=FFCBFDC0A7521245B505A6DDA6D89D14?sequence=1.

[18] WHO Global Health Observatory data repository: public health and environment: chemicals. http://apps.who.int/gho/data/node.main.141?lang=en.

in youth 15-24 years of age continues to be a challenge for the health sector, with the homicide rate not falling sufficiently and the suicide rate on the rise. These challenges make clear that desired impact may not occur during the Strategic Plan period, and that interventions sometimes take time, along with the sustained commitment and involvement of other sectors, to show results.

36. Across the board, progress has been slow in closing health equity gaps between and within countries. This signals the need to boost the intensity of targeted interventions to meet the needs of populations living in conditions of vulnerability, as well as to change course if interventions have not been successful. The Region of the Americas continues to be one of the world's most inequitable regions with regard to health, with some of the most significant health disparities in the world, both between countries and within each country. Marginalization and social discrimination, consequences of historical and political inequalities, continue to have an impact on the Region. An example of the persistent gender, ethnic, and socioeconomic inequalities can be found in maternal mortality, often viewed as a marker: at the regional level, the maternity mortality ratio (MMR) among countries in the lowest human development quartile is 168 maternal deaths per 100,000 live births, while in countries in the highest human development quartile it is 20 maternal deaths per 100,000 live births—an eightfold difference.[19]

37. Progress in serving marginalized and underserved populations requires involving and empowering people, families, and communities to access health and strengthening partnerships with civil society organizations that are often at the forefront of service provision. It is also important to ensure that their needs, circumstances, and rights are fully addressed through differentiated services and intersectoral action on the social and environmental determinants of health, as part of an equity approach to ensure that no one is left behind. Countries need to design and implement effective policies and programs that target populations living in conditions of vulnerability. In order to increase accountability for equitable health outcomes, the Region must promote inclusive governance mechanisms based on social participation.

38. At the beginning of the sustainable development era, marked by the approval of the 2030 Agenda for Sustainable Development, eliminating equity gaps was noted to be a significant challenge in progressively realizing the right to enjoyment of the highest attainable standard of health and meeting the commitment to "leave no one behind." Indeed, one of the lessons learned from the MDG era is that having targets for national averages alone is inadequate. Rather, it is crucial to set specific targets for key affected groups (defined by place of residence [rural/urban], race, ethnicity, occupation, gender, sex, age, education, and socioeconomic status, as well as by subnational level) and to collect, analyze, and use disaggregated data to help ensure that inequities are addressed. Such a targeted approach, together with social participation, can provide greater accountability for equitable outcomes. However, gaps in information systems and in the availability of data impede the ability of Member States and PASB to make evidence-based decisions. In particular, lack of disaggregated data in many countries often makes it

[19] PAHO, Health in the Americas+: 2017 edition (Washington, DC: PAHO, 2017).

difficult to develop, monitor, and evaluate targeted interventions to address inequities in health affecting specific groups, including interventions that adopt specific approaches such as intercultural and gender-sensitive approaches.

39. High-level political dialogue and intersectoral action are critical to advancing the mission to promote equity in health, combat disease, increase lifespans, and improve the quality of life of the peoples of the Americas. The 2030 Agenda for Sustainable Development and the health-related SDGs lay out principles for tackling global health challenges through actions both within and beyond the health sector, recognizing that many social, economic, and environmental determinants of health and risk factors lie beyond the direct control of the health sector and the national health authorities. The SHAA2030 also aims to facilitate consensus within the Region on health objectives focusing on social determinants of health and health inequalities that must be addressed through intersectoral action. At the same time, it has become imperative that health systems address the impact of demographic changes (such as aging, fertility, and the dependency ratio, among others) and of other changes that also originate outside the health sector's immediate sphere of action.

40. Intersectoral action to deal with these challenges at societal and institutional levels is important for reducing structural inequalities that constitute barriers to health. Although the Organization continued to increase its engagement with other sectors, the implementation of the SP14-19 also showed that there is a continued need for high-level political dialogue and intersectoral collaboration in order to address priorities involving other sectors beyond health, especially for tackling the social and environmental determinants of health.

41. Despite the limited control that the health sector has in addressing the above-mentioned determinants and risk factors, it must nonetheless take them into account when planning. The health sector itself can be a highly significant agent of transformational change. National governments have an important role as the primary actors in health governance and in promoting partnerships with other government sectors, the private sector, civil society, and other nongovernmental partners. Health systems must have the capacity to provide health promotion, disease prevention and treatment, rehabilitation, and palliative care for the entire population, utilizing equitable, gender-sensitive, and culturally sensitive approaches that respect human rights. Financing, inclusive governance with social participation at its core, and efficient planning of human resources development are essential elements.

42. Throughout the period of the SP14-19, competing national priorities made it difficult to mobilize and allocate resources for key programs in areas such as aging, mental health, substance use disorders, violence, vision and hearing diseases, disabilities, and rehabilitation, as well as for cross-cutting areas such as gender and ethnic inequalities. At the same time, funding levels needed to strengthen health systems and achieve the goals are often insufficient. Increased demand for health services due to migration has put pressure on countries' institutions and health care systems, which struggle to adequately address the migrants' health needs and rights while continuing to serve local populations.

The health issues affecting migrants go beyond delineated borders. Therefore, the situation calls for a joint, concerted, and cross-national effort to promote and protect the health of migrants and host populations in close collaboration with all relevant sectors and actors.

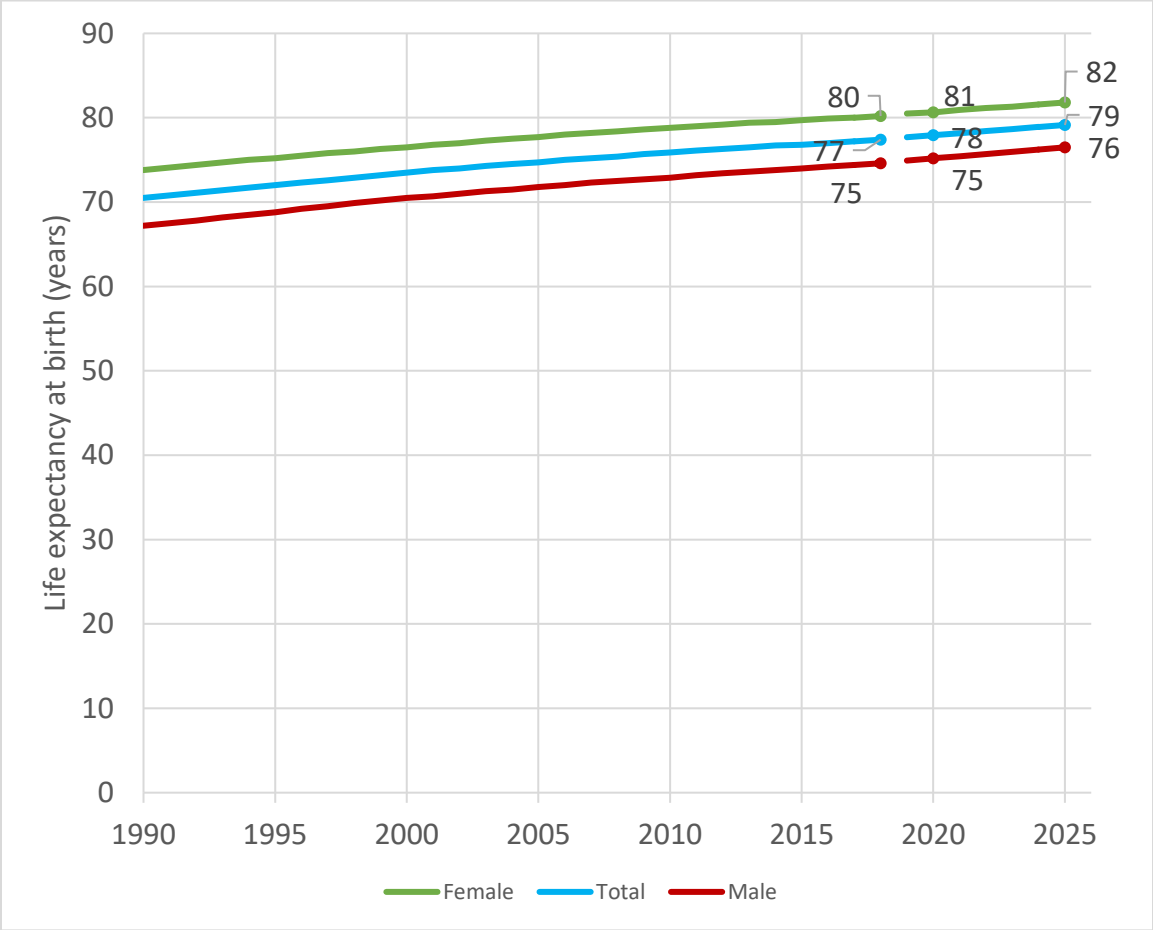
43. Great strides have been made within the Bureau toward working more inter-programmatically to address cross-cutting issues, with a focus on country impact. These efforts have promoted an integrated approach to technical cooperation. Nonetheless, the category structure of the SP 14-19 in some cases led to a tendency to operate in siloes. Subregional approaches with political commitment have proven to be effective in promoting access to medicines, strengthening regulatory capacity, sharing resources among Member States with limited capacity, and developing consensus among countries on priorities such as gender equality in health and intercultural health. Meanwhile, active collaboration between Member States and PASB has improved strategic planning at all levels, but there is an ongoing need to consolidate joint planning and monitoring and assessment gains and to work with more concerted action to implement the SHAA2030.

44. With regard to PASB's leadership, governance, and enabling functions, the Bureau has worked to ensure the efficient functioning of the Organization in support of its mandates. Administrative and enabling functions have managed to streamline processes and reduce costs. Flexible funding has been allocated to fund priority programs that are most in need, in line with the Programmatic Priorities Stratification Framework (Document CD55/2), although resource mobilization for key priorities continues to lag. Government-sponsored initiatives have become an increasingly significant modality of technical cooperation at national level in many countries, as discussed further below.

Future Prospects for Health

45. As the Organization plans for the future, it is important to invest in programs to maintain past gains in the Region's health status while working to contain emerging threats. Life expectancy at birth continues to increase for both sexes throughout the Region, although there are differences between women and men. As of 2019, it is estimated that life expectancy at birth is 80 years for women and 77 years for men. Based on current trends, the forecasted calculation for the 2020-2025 period is for life expectancy to increase to 82 years for women and 79 years for men by the year 2025 (Figure 4).

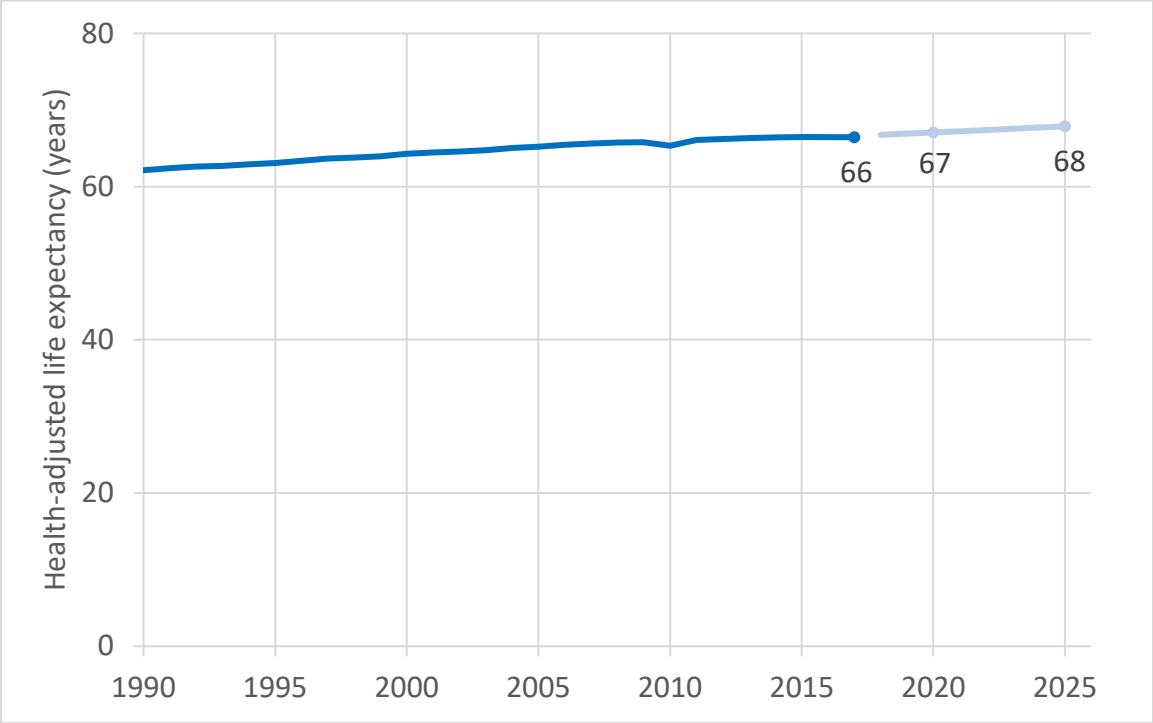
Figure 4. Life Expectancy at Birth in the Americas: Current Trends 1990-2019 and Forecast 2019-2025



Source: United Nations, Department of Economic and Social Affairs, Population Division, World population prospects: 2017 revision (New York: United Nations, 2017).

46. While the increase in life expectancy is quite an achievement for the Region, ensuring healthy lives and promoting well-being at all ages remains a challenge. Based on current trends (1990-2017) and the latest available data for health-adjusted life expectancy (HALE), which is a measure of population health that considers mortality and morbidity, healthy life expectancy increased 0.7% between 2014 and 2019, slightly below the expected regional rate of 1.0%. With renewed and consistent efforts, it is considered possible for the Region to reach a gain of 1.2% (Figure 5).

Figure 5. Health-Adjusted Life Expectancy (HALE) in the Americas: Current Trends 1990-2017 and Forecast 2018-2025



Note: 95% uncertainty interval.
Source: Institute for Health Metrics and Evaluation (IHME), Global Health Data Exchange (GHDx) [accessed 26 April 2019]. Available from: http://ghdx.healthdata.org/gbd-results-tool.

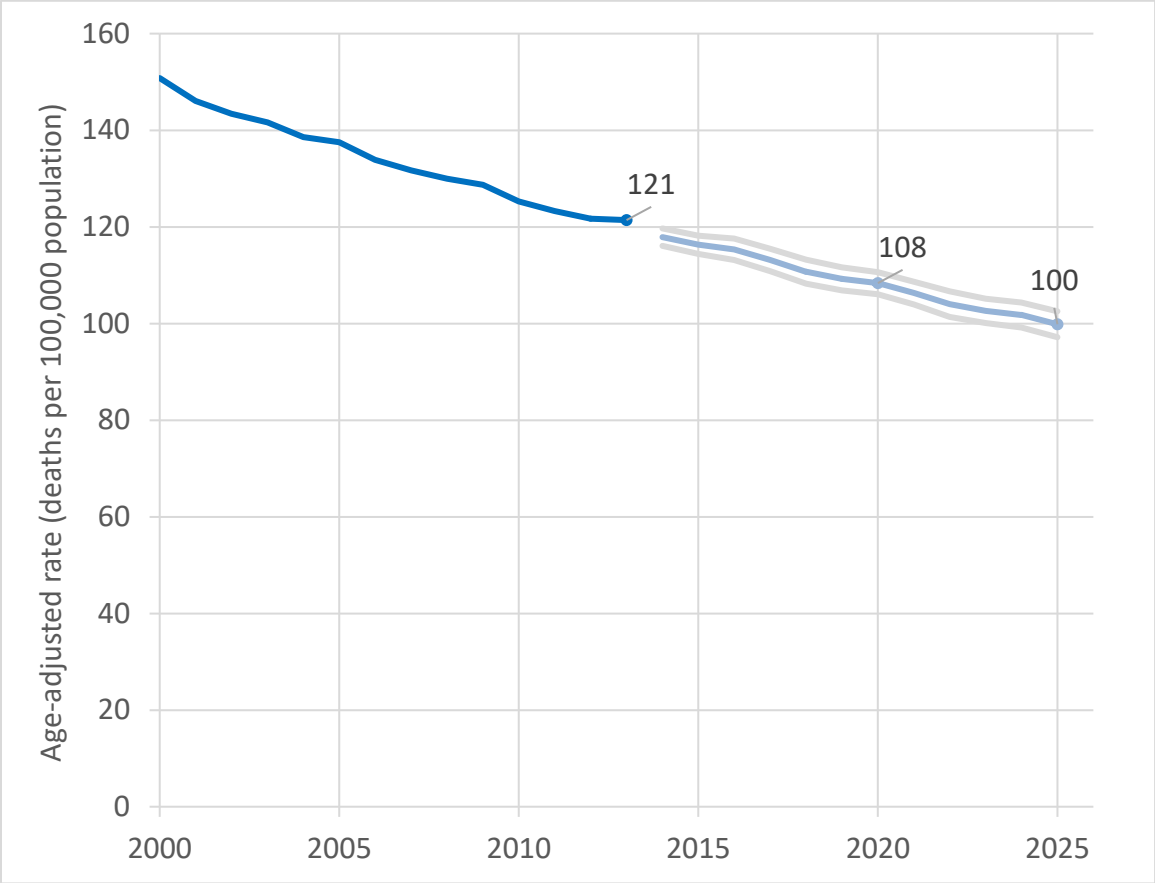
47. As health authorities in Member States become increasingly aware of the limitations of treating health problems without addressing their determinants and risk factors, they must act deliberately to maintain their stewardship by prioritizing intersectoral coordination and management of the health sphere.[20] An approach based on the social and environmental determinants of health and the resulting inequities serves as an essential mechanism for developing targeted public policies that respond to the population's needs. This approach needs to be complemented by integrated prevention, surveillance, early detection and treatment, and care for diseases.

48. The Strategy for Universal Access to Health and Universal Health Coverage, approved by Member States in 2014, calls for reducing inequities by strengthening health systems and services through universal coverage and access. Mortality amenable to health care was introduced as a proxy indicator for the quality of medical care in the Strategic Plan 2014-2019. This indicator refers to the subset of deaths that should not have occurred if health care interventions were accessible in a timely manner. In the years 2014 to 2017, the estimated mortality decreased by 7%. This figure is below the 9% reduction outlined in the SP14-19 as the regional target to be achieved by 2019. Forecasts for this indicator

[20] PAHO, Universal health in the 21st century: 40 years of Alma-Ata: report of the High-Level Commission (Washington, DC: PAHO, 2019).

show that the 2019 target will be difficult to achieve, which means that countries should intensify efforts to reach the target for 2025 (Figure 6).

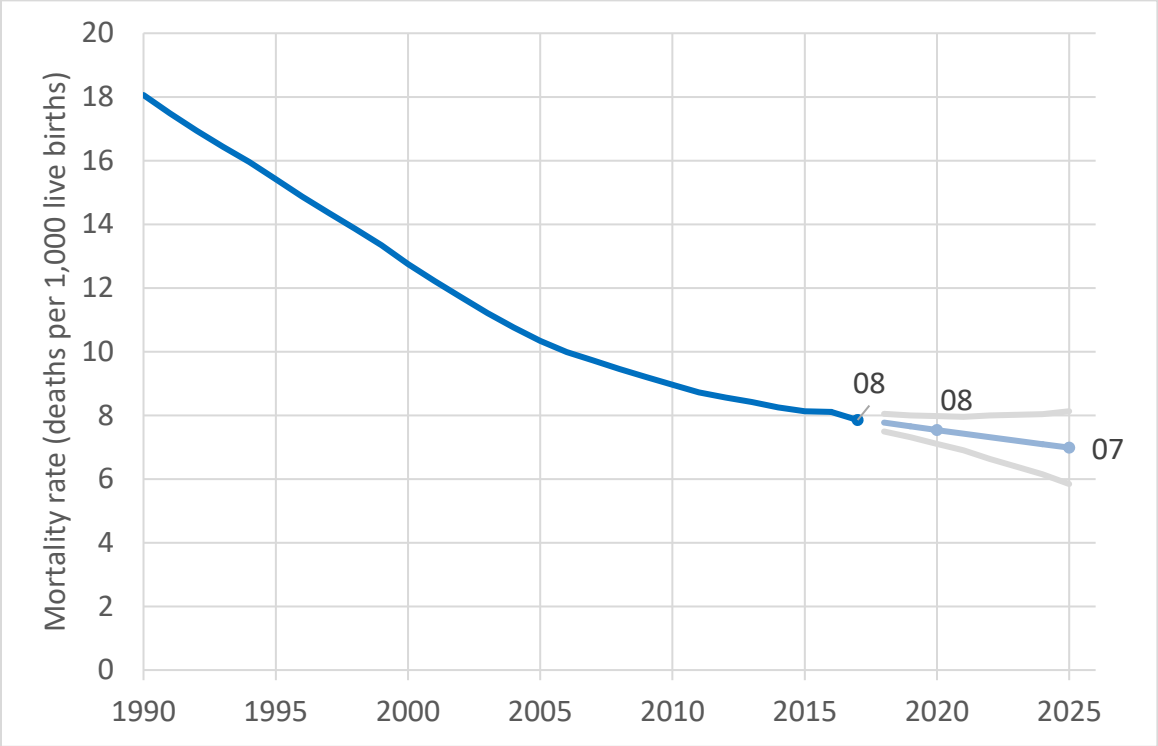
Figure 6. Age-Adjusted Rate of Mortality Amenable to Health Care in the Americas: Current Trends 2000-2013 and Forecast 2014-2025



Note: 95% uncertainty interval.
Source: PAHO Regional Mortality Database. Current trends and forecast are based on projections developed by the Health Information and Analysis unit, applying statistical modeling with exponential smoothing, as approved by PAHO Member States and PASB for the Strategic Plan 2014-2019.

49. Another important indicator of health care quality is neonatal mortality. After a commendable decrease of 54% in the neonatal mortality rate between 1999 and 2013 at the regional level, the rate between 2014 and 2019 is estimated to decrease by only 6%, with a forecasted decrease between 2020 and 2025 of 7% (Figure 7). This calls for renewed efforts to improve the quality of care for mothers and infants from the start of pregnancy through the first 28 days of life for the newborn infant. Such efforts are critical drivers for reducing neonatal mortality, and they will have a positive impact on improving the infant mortality rate for the Region.

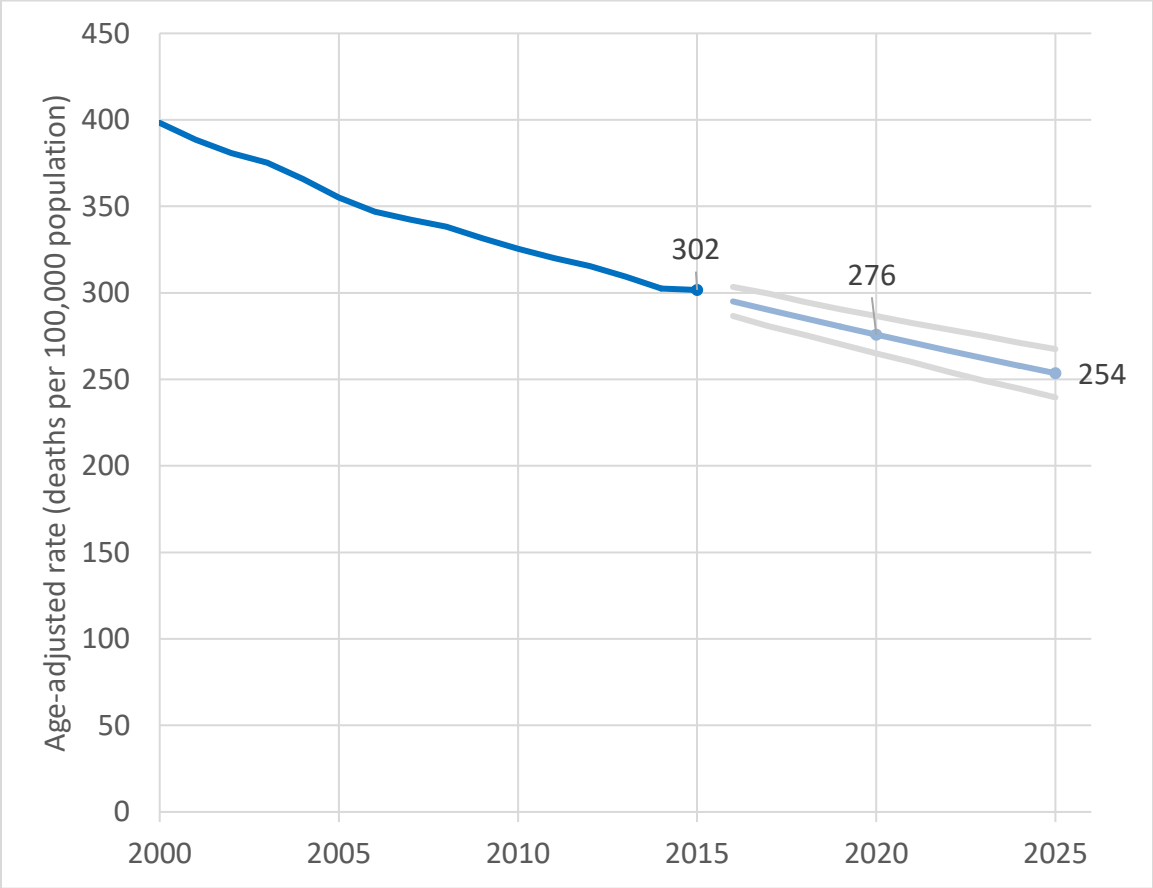
Figure 7. Neonatal Mortality Rate in the Americas: Current Trends 1990-2017 and Forecast 2018-2025



Note: 95% uncertainty interval.
Source: United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), 2018.

50. Noncommunicable diseases—primarily cardiovascular disease, diabetes mellitus, cancer, and chronic respiratory disease—are recognized as the leading causes of preventable disease, disability, and mortality. The trend in estimated annual mortality from NCDs shows a continuous decrease, with a forecasted 9% reduction by 2020 and 8% reduction by 2025 (Figure 8).

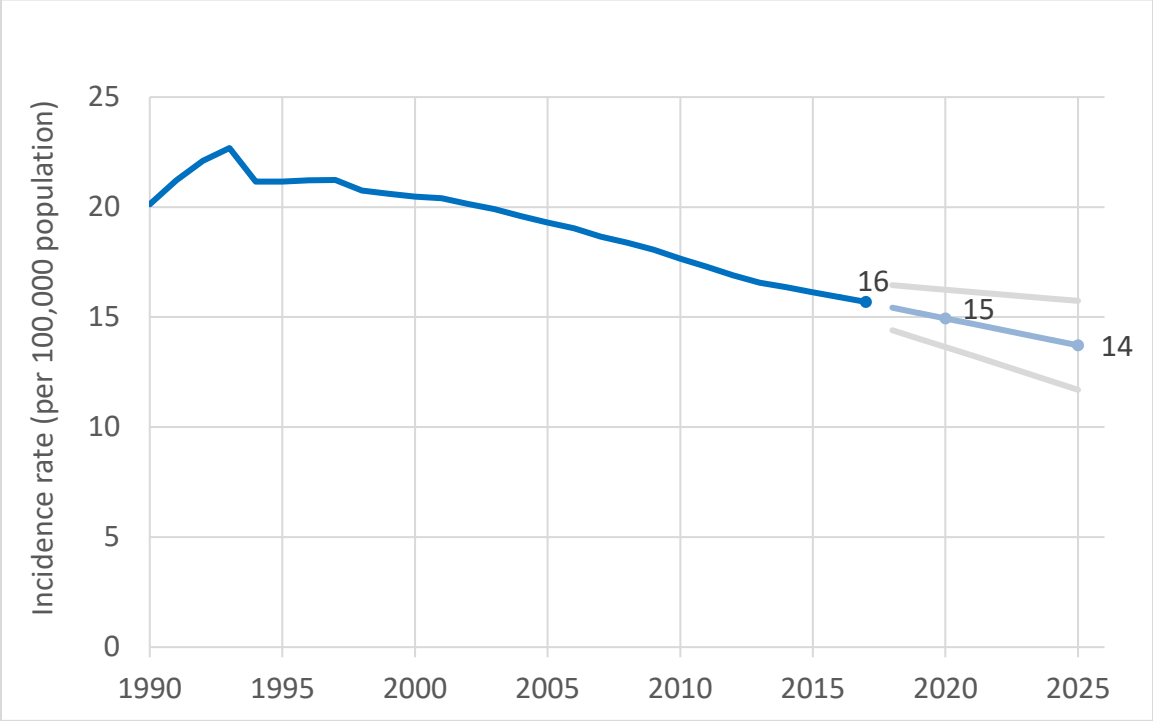
Figure 8. Age-Adjusted Mortality Rate from Noncommunicable Diseases in the Americas: Current Trends 2000-2015 and Forecast 2016-2025



Note: 95% uncertainty interval.
Source: PAHO Regional Mortality Database.

51. Communicable diseases continue to be an important threat in the Region. Member States selected the HIV incidence rate as one of the regional impact indicators to approximate an assessment of the Region's performance in the control of communicable diseases. Based on information from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the HIV incidence rate decreased 7% between 2014 and 2019. With this estimated trend, it is forecasted that there will be an 8% reduction in HIV incidence between 2020 and 2025 (Figure 9).

Figure 9. HIV Incidence Rate in the Americas: Current Trends 1990-2017 and Forecast 2018-2025



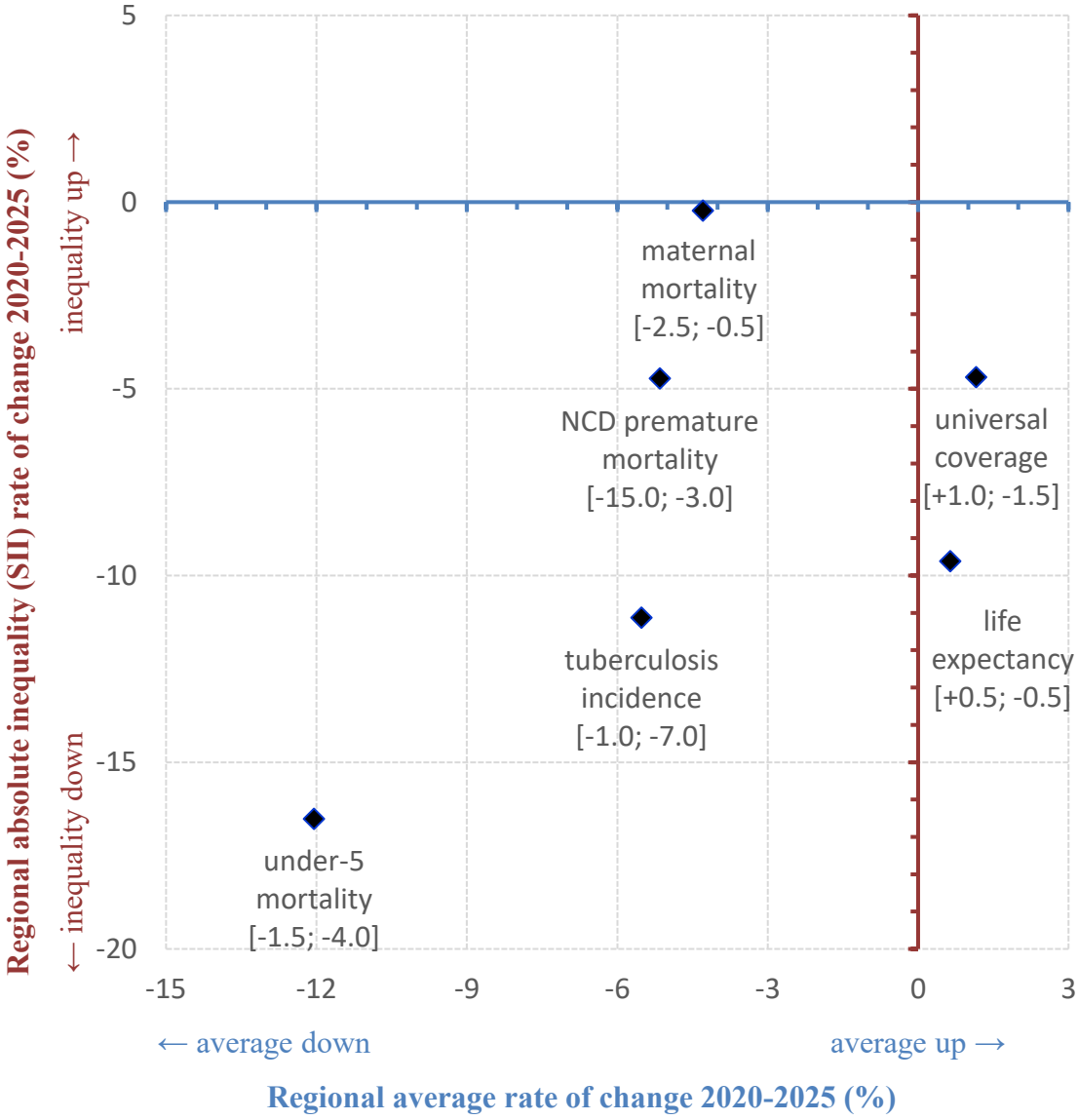
Note: 95% uncertainty interval.
Source: UNAIDS, Spectrum estimates, 2018.

52. Figure 10 depicts the results from a health equity forecasting exercise that analyzes life expectancy at birth plus five SDG 3 health indicators (maternal mortality ratio, under-5 mortality, premature mortality from noncommunicable diseases, tuberculosis incidence, and universal coverage) for the period 2020 to 2025. For each indicator, the figure presents the regional average rate of change (horizontal axis) and absolute inequality in terms of changes along the income gradient (vertical axis). There are two numbers in brackets below each health indicator: the first is the forecasted value for the indicator, and the second is the forecasted value of absolute inequality. On average, all the indicators are estimated to improve, but the forecasted trends of improved regional averages and reduced inequalities represent modest changes in magnitude.

53. For instance, the regional under-5 mortality rate is forecasted to decrease, on average, by 1.5 deaths per 1,000 live births from 2020 to 2025 (that is, from 13.1 to 11.6 deaths per 1,000 live births). Its absolute inequality is forecasted to decrease by 4 deaths per 1,000 live births in the same period (that is, from 25 to 21 deaths per 1,000 live births along the income gradient). The regional maternal mortality ratio, in turn, is forecasted to decrease by 2.5 deaths per 100,000 live births, and its inequality gap along

the income gradient is forecasted to decrease by just 0.5 deaths per 100,000 live births.[21] Such analyses are important because they highlight the fact that while the Region overall may be achieving the goal of improving a specific health outcome, it may not be performing as well when it comes to reducing health inequalities for that outcome.

Figure 10. Forecast for Regional Gains in Average Health and Equity in the Americas, 2020-2025



[21] Forecasted data were produced by the Institute for Health Metrics and Evaluation (IHME), modelling the annualized rates of change across location-years for all 65 Global Burden of Disease risk factors, income per capita, educational attainment, select intervention coverage, and total fertility rate under 25 years in the past. Health inequality analyses with these forecasted data were produced by PASB (EIH: Department of Evidence and Intelligence for Action in Health).

54. Facing these prospects, Member States require key resources to strengthen their health systems and social protection systems in order to respond to health needs. These key resources—human, technological, and financial—are indispensable for institutional transformation. They include the skills and commitment of actors in the health care and health-related fields to develop people-, family-, and community-based models of care, technological resources to address the population's health needs, and public resources to finance the development of a model of care based on conditions of equity. These key resources have two important characteristics: *a)* they are necessary conditions to meet the health needs of the population, and *b)* resource availability and appropriate allocation depend on the necessary political and institutional processes.

55. Evidence-based decision-making capacities among health authorities must be prioritized. This includes the ability to analyze health problems, identify the impact of specific social determinants on health, recognize policy options that strengthen interventions, and improve the capacity of health systems to respond to health needs. Regional- and national-level health data, including socio-demographic information and other variables, are useful to describe the health situation in a macro context. However, it is critical to obtain information at subnational levels to detect and measure problems that have previously been masked. This can improve public health surveillance, response to health emergencies and disasters, and alerts regarding population threats. Through the analysis and synthesis of such information, Member States can use evidence more strategically to guide implementation of policies and strategies for the reduction of health inequities. Knowledge translation skills should be applied with a multilingual and multicultural focus to disseminate information in a transparent manner, making full use of available technologies and social media. This area of action enhances awareness of specific issues that will guide investments to improve health in the Region.

The Sustainable Development Goals

56. The Region realized significant gains when working toward the Millennium Development Goals; the Region achieved most of the health-related MDG targets with the exception of maternal mortality, reproductive health, and universal access to treatment for HIV/AIDS. However, disparities between and within countries were less visible, and the Organization must address the health needs of populations living in conditions of vulnerability. PAHO gained substantial experience while working toward the achievement of the MDGs, and it will build on the lessons learned and apply them to achieve the SDGs with equity, in line with the 2030 Agenda's commitment to "leave no one behind." The Bureau conducted an internal analysis on how the health-related SDGs are linked to and can be addressed through different PAHO resolutions and programs.[22]

[22] PAHO, The road to achieve the Sustainable Development Goals for health: preparing the Region of the Americas for the next 15 years, preliminary version, Sustainable Development and Health Equity (SDE) internal document, 2015.

57. Health in the context of the SDGs falls primarily under SDG 3 (Good health and well-being); however, other SDGs also address health-related topics. These health-related goals and targets, sometimes collectively known as SDG 3+, are presented in Table 1. Following approval of the Strategy for Universal Access to Health and Universal Health Coverage in 2014,[23] universal health has become the cornerstone for achieving many of the SDG 3-related targets that depend on the delivery of comprehensive health services. Universal health and the achievement of health equity depend on the progressive elimination of geographic, economic, sociocultural, organizational, and gender barriers that hinder different groups from having universal access to timely, quality health services that meet their needs. Achieving these goals also depends on intersectoral action to address the social determinants of health.

Table 1. SDGs Directly Related to PAHO's Work

SDG	Name	Target(s)
1	End poverty in all its forms everywhere	1.5
2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture	2.1 and 2.2
3	Ensure healthy lives and promote well-being for all at all ages	All
4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	4.2
5	Achieve gender equality and empower all women and girls	5.1, 5.2, 5.6, and 5.C
6	Ensure availability and sustainable management of water and sanitation for all	6.1, 6.2, and 6.3
7	Ensure access to affordable, reliable, sustainable and modern energy for all	7.1
8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	8.8
10	Reduce inequality within and among countries	10.2 and 10.7
11	Make cities and human settlements inclusive, safe, resilient and sustainable	11.2, 11.5, 11.6, 11.7, and 11.B
12	Ensure sustainable consumption and production patterns	12.4
13	Take urgent action to combat climate change and its impacts	13.1, 13.2, and 13.B
16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	16.1 and 16.2
17	Strengthen the means of implementation and revitalize the global partnership for sustainable development	17.18

[23] PAHO, Strategy for universal access to health and universal health coverage (Resolution CD53.R14), 53rd Directing Council, 66th Session of the Regional Committee of WHO for the Americas.

58. Given that national contributions to SDG targets and their respective indicators are being defined by each country, PASB will work closely with Member States to establish, achieve, and monitor progress toward their specific objectives. Throughout the SP20-25 period, interventions will be planned to support Member States that need additional technical cooperation to advance toward and reach their SDG targets, in addition to supporting those states that need to sustain gains already achieved. Technical cooperation will also be provided to countries to assist them in integrating approaches to PAHO's cross-cutting themes, so that achievement of the SDG targets strongly contributes to health equity, and to gender and ethnic equality, within a human rights framework in the Region.

59. Finally, given that not all the SDG 3+ targets are under the direct responsibility of the health sector, and given the integrated and indivisible nature of the 2030 Agenda, the Organization must take a Health in All Policies approach to address the social, economic, and environmental determinants of health. Health in All Policies is defined as an "approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[24]

Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030)

60. SHAA2030 was approved by the 29th Pan American Sanitary Conference in September 2017. It represents "the health sector response to the commitments adopted by the countries in the 2030 Agenda for Sustainable Development and unfinished business from the Millennium Development Goals and the Health Agenda for the Americas 2008-2017, as well as the commitments of the WHO regional office for the Americas, other global health commitments of the Region, and future public health challenges that may arise in the Region."[25] The SHAA2030 goals are incorporated in the SP20-25 as the impact results that the Region seeks to achieve. Therefore, this Plan very much reflects both the SHAA2030 goals and the health-related SDGs.

61. The PAHO Strategic Plan 2020-2025 (and the subsequent plan for 2026-2031) will be the principal means of implementation of SHAA2030. This is reflected by the Programmatic Framework for Results, in which the SHAA2030 goals represent the impact level, and the outcome results contribute directly to their achievement (see Annex A). The goals are presented in Figure 11. Furthermore, the outcome and impact indicators in this Plan provide the means to measure achievement of the SHAA2030 targets (see Annex B). SHAA2030 also stipulates that monitoring, assessment, and reporting on SHAA targets will be coordinated through existing processes for reporting on Strategic Plan indicators. This includes the joint assessment of indicators with Member States at the end of each biennium, and it will be supplemented by information coming from other existing platforms, such as Health in the Americas.

[24] Helsinki Statement on Health in All Policies, 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013.

[25] PAHO, Sustainable Health Agenda for the Americas 2018-2030, para. 24.

Figure 11. Goals of the Sustainable Health Agenda for the Americas 2018-2030



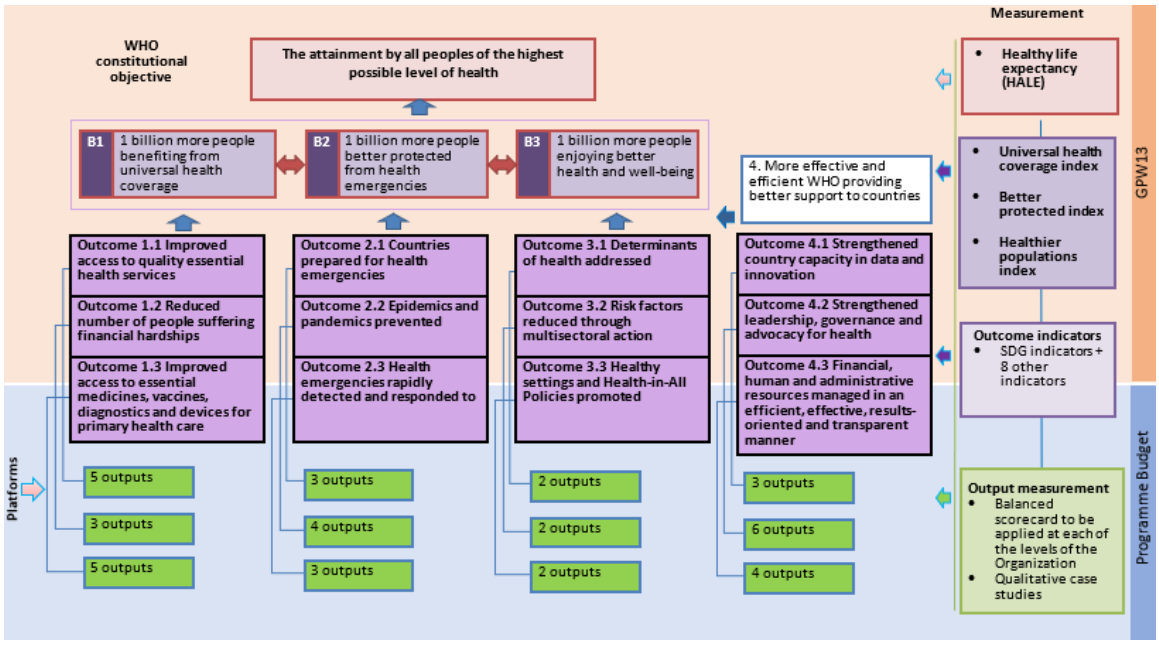
1. Expand equitable access to comprehensive, integrated, quality, people-, family-, and community-centered health services, with an emphasis on health promotion and illness prevention.
2. Strengthen stewardship and governance of the national health authority, while promoting social participation.
3. Strengthen the management and development of human resources for health (HRH) with skills that facilitate a comprehensive approach to health.
4. Achieve adequate and sustainable health financing with equity and efficiency and advance toward protection against financial risks for all persons and their families.
5. Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context.
6. Strengthen information systems for health to support the development of evidence-based policies and decision-making.
7. Develop capacity for the generation, transfer, and use of evidence and knowledge in health, promoting research, innovation, and the use of technology.
8. Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, and emergencies and disasters that affect the health of the population.
9. Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders.
10. Reduce the burden of communicable diseases and eliminate neglected diseases.
11. Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health.

WHO 13th General Programme of Work

62. The 13th General Programme of Work of WHO (GPW13) was approved by the 71st World Health Assembly in May 2018, with a set of three strategic priorities and associated goals for the five-year period: 1 billion more people benefiting from universal health coverage, 1 billion more people better protected from health emergencies, and 1 billion more people enjoying better health and well-being (known as the "triple billion" targets). The GPW13 is aligned with and articulates WHO's response to the SDGs, and it contains strategic and organizational shifts that will be carried out during its implementation.

63. Following approval of the GPW13, WHO continued to develop its associated results framework, including a set of 12 outcomes different from those contained in the GPW13 itself. Figure 12 shows the GPW13-associated results framework, including the triple billion targets, plus a fourth group that refers primarily (but not exclusively) to WHO Secretariat functions. WHO also continued to develop the GPW13 Impact Framework, which contains the targets and indicators intended to provide accountability for results.

Figure 12. GPW13 Results Framework



64. The SP20-25 provides the response of the Region of the Americas to the commitments in the GPW13 and its related documents. It details how the regional results chain is aligned with and contributes to the GPW13 Impact Framework (Annex B). Alignment between the regional and global frameworks will be critical for the implementation of this Plan and its contribution to global monitoring, assessment, and reporting processes. The GPW13 covers 2019 to 2023, including the WHO Programme Budgets for 2020-2021 and 2022-2023, with 2019 serving as a transition year.

Related Mandates, Strategies, and Plans

65. Annex D contains the regional and global plans of action that already are or will be supporting the achievement of the 2020-2025 outcome results. Regional plans and strategies that are considered by PAHO Governing Bodies between 2020 and 2025 should be developed in alignment with this Strategic Plan. PASB will also collaborate with national health authorities to promote the adoption of the SP20-25 results chain in subregional and national health plans, strategies, and policies, including measurement of and reporting on relevant indicators.

Programmatic Framework for Results

66. The core of this Plan is the new results chain and the associated indicators. This section, combined with Annexes A through E, provides the basis for PAHO's program planning, monitoring, and assessment for the next six years, in consonance with the frameworks listed in the preceding section and taking into account the changing health context, as well as the context and priorities of each country. It also outlines the methodology for setting programmatic priorities for the six years of the Strategic Plan, the transparency, accountability, and risk management approaches, and the main strategies and mechanisms for implementation, monitoring, assessment, and reporting.

Theory of Change and the New Results Chain

67. For the period 2020-2025, PAHO is adopting a new results chain. For clarity and ease of comprehension, the full programmatic results chain containing the results at impact and outcome levels has been moved to Annex A, which is an integral part of this Plan. Although the elements of the results chain are new, it uses accepted international concepts of programmatic results at impact, outcome, and output levels, described below and depicted graphically in Figure 13. The relationship between the regional and global elements of the planning framework is set out explicitly in Figure 14. The regional elements have been designed to allow for accountability and reporting to the global level (consistent with PAHO's function as the WHO Regional Office for the Americas) and to reflect regional needs and specificities in health.

a) **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. The 11 SHAA2030 goals established by Member States as the regional response to the health-related SDGs represent the impact goals for this Strategic Plan.

b) **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 national 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. Progress made toward achieving outcomes will be assessed with corresponding indicators that measure changes at national or regional level. They contribute both to the impact goals and to the global outcomes related to the WHO GPW13. While the regional outcomes are designed to align with and provide for clear aggregation to the global outcomes, the two sets of outcomes are not identical. The regional outcomes reflect a desire for more programmatic granularity at the regional level for planning and prioritization, while at the same time embracing the need to promote an integrated approach to technical cooperation.

c) **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 Program Budget and will be assessed with a defined set of output indicators that will measure PASB's ability to influence such changes.

d) **Products and Services** are deliverables against an agreed budget for which PASB is directly accountable during the biennium. Products and services are tangible and observable. They are developed by each PASB entity to operationalize the deliverables for each two-year Program Budget period. These are further subdivided into activities and tasks.

Figure 13. Theory of Change for the Strategic Plan 2020-2025

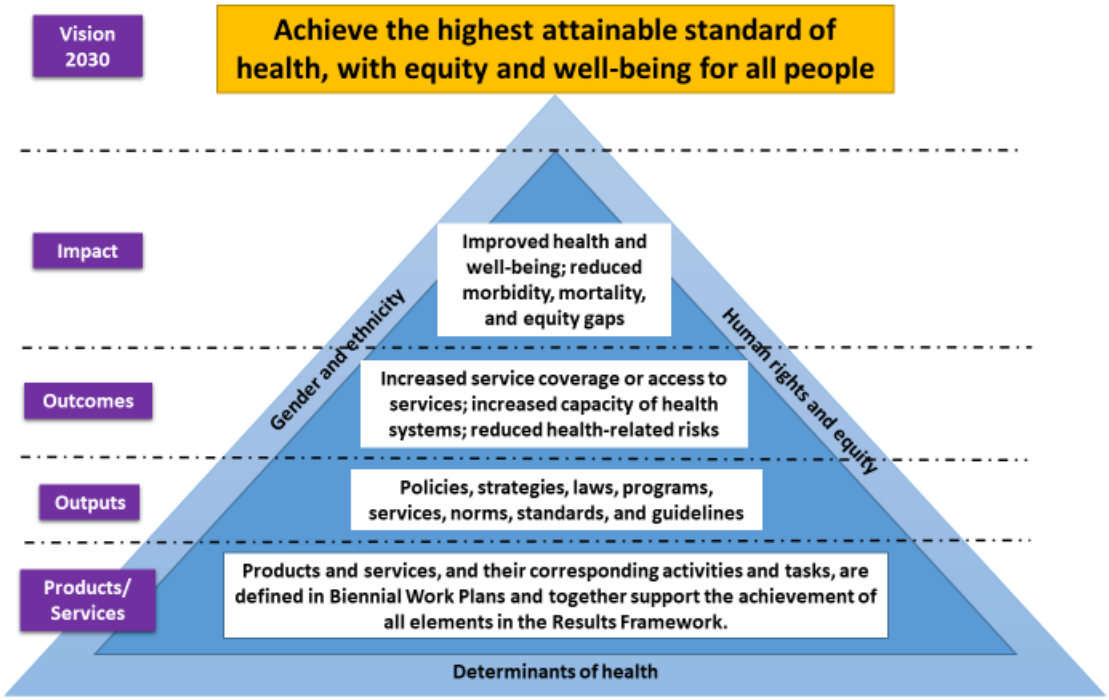
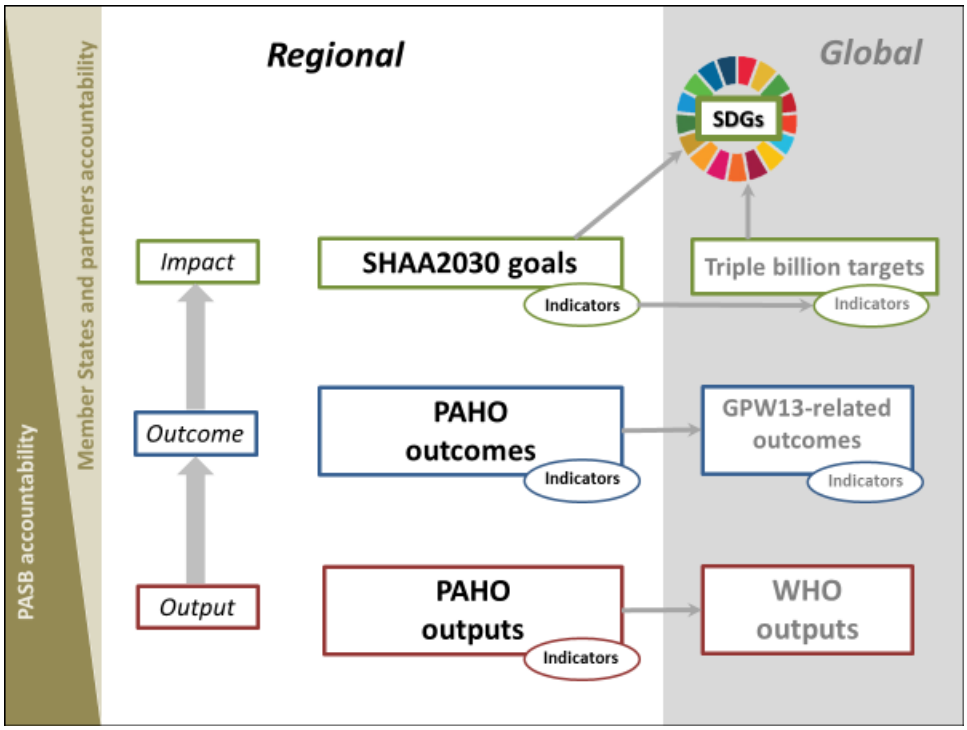


Figure 14. PAHO and WHO Results Chain



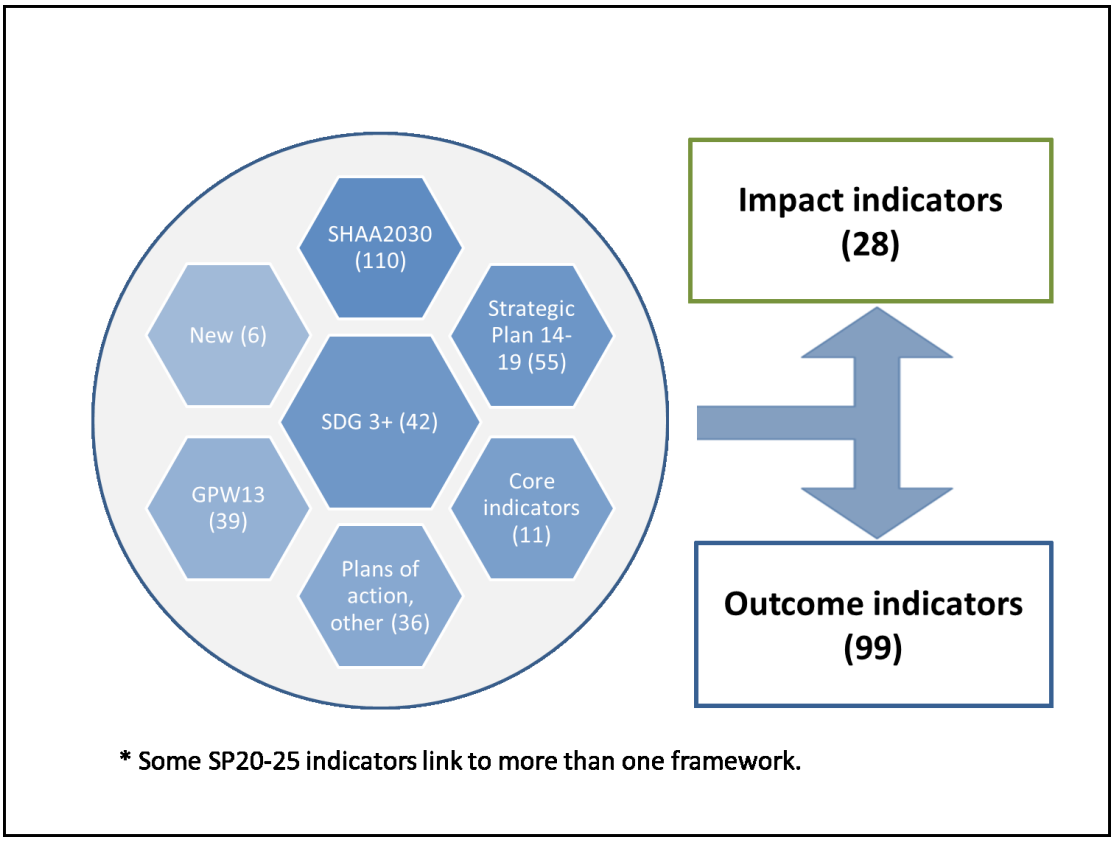
68. This Plan promotes a more integrated approach to technical cooperation, with an emphasis on comprehensive, integrated, and quality health services, with systems based on primary health care and using innovative models of care, in line with the Organization's commitment to universal health. Emphasis will also be placed on strengthening the capacity of national health authorities for stewardship, governance, and intersectoral coordination to address the determinants of health. At the same time, the Organization will continue to ensure a rapid and effective response to health emergencies and disasters, redouble efforts to maintain health gains (elimination of diseases, vaccination coverage), and coordinate the response to cross-border issues, including international disease transmission and the promotion and protection of migrant health. All of this will be done while striving for still greater advances, as expressed in the ambitious health impact and outcome targets.

69. The cross-cutting themes of equity, gender, ethnicity, and human rights will frame and weave throughout SP20-25 in recognition of underlying inequalities in the Region and the need to address them to achieve equity of health outcomes and human rights for all. This can only be accomplished by mainstreaming equitable, gender-sensitive, culturally sensitive, and human rights-based approaches across all programs. Outcome 26 ensures accountability for integration of the cross-cutting themes. The Plan aims to address the determinants of health through specific outcomes related to the health sector's role in health governance, intersectoral action, and health promotion.

70. If the execution of the Plan is consistent with the Organization's strategic direction, by 2025 PAHO will be able to show tangible improvements in the health of the population, in particular the health of groups living in conditions of vulnerability. This, by definition, should produce a reduction of health inequities by narrowing the gaps within and between countries. We will only know how successful we are in these efforts if countries are able to strengthen their information systems so that they report on health impact and outcome indicators with disaggregation.

71. Impact and outcome indicators will be the main basis for measuring success in the implementation of the PAHO Strategic Plan 2020-2025. Figure 15 depicts the pool of indicators from various sources that will be used to measure either impact or outcome results. For each level of results, indicators have been developed through a comprehensive examination of existing measures and requirements to assess progress toward the targets of the SDGs, SHAA2030, GPW13, and other relevant regional and global mandates. Consideration was also given to existing indicators from SP14-19 that have served as useful measures of progress. In addition, best practices were taken into account in the development of indicators (i.e., they should be specific, measurable, attainable, realistic, and time-bound).

Figure 15. Development of Impact and Outcome Indicators for the Strategic Plan 2020-2025



Prioritization

72. The PAHO-adapted Hanlon method[26] is recognized by Member States as a systematic, objective, and robust approach to identify the public health priorities in the Region. Therefore, the Strategic Plan Advisory Group made the following recommendations:

a) The PAHO-adapted Hanlon method will continue to be used to identify the programmatic priorities for the Strategic Plan 2020-2025, with some variations in the criteria definitions, given the inter-programmatic scope of the outcomes.

b) The outcomes will be the element to be prioritized during the national consultations.

c) National consultations will be conducted once prior to the beginning of the Strategic Plan, with no further iterations for each Program Budget as was done in the past.

73. Region-wide national consultations were conducted with all countries and territories to apply the PAHO-adapted Hanlon method for the SP20-25 outcomes. Each consultation comprises individual assessments by senior public health officials who have a broad understanding of the national public health context. The individual country results are consolidated at the regional level and inform the programmatic priorities for the Strategic Plan 2020-2025. In accordance with the PAHO Programmatic Priorities Stratification Framework, the consolidated regional prioritization results will be key to implement the SP20-25 and its Program Budgets, guide the allocation of resources, and target resource mobilization efforts. Individual country results will inform planning and implementation of the Organization's technical cooperation.

74. Annex C presents the consolidated regional results of the programmatic priorities stratification exercises in 47 countries and territories, as of the date of publication for the Directing Council. It groups 25 of the 28 outcomes to which the methodology applies into three priority tiers: high, medium, and low. Outcomes 26, 27, and 28 were excluded from the prioritization consultations because of the corporate nature of their scope. Outcome 26 calls for enabling integration of the cross-cutting themes, within PASB as well as in the countries, as corporate mandates. Outcomes 27 and 28 focus on strengthening the enabling functions of the Organization to facilitate the delivery of technical cooperation. These outcomes include functions and services that contribute to strengthening PAHO's leadership and governance, as well as transparency, accountability, and risk management. They also seek to enhance strategic planning, resource coordination, resource mobilization and reporting, management and administration, and strategic communications.

[26] The Programmatic Priorities Stratification Framework, approved by Member States in SP14-19, has served as a key instrument to guide the allocation of all resources available to PASB and to target resource mobilization efforts for implementation of the Plan. The PAHO-adapted Hanlon method (Resolution CD55.R2) was endorsed by the Member States as the instrument to implement the Framework and identify the programmatic priorities of the Plan.

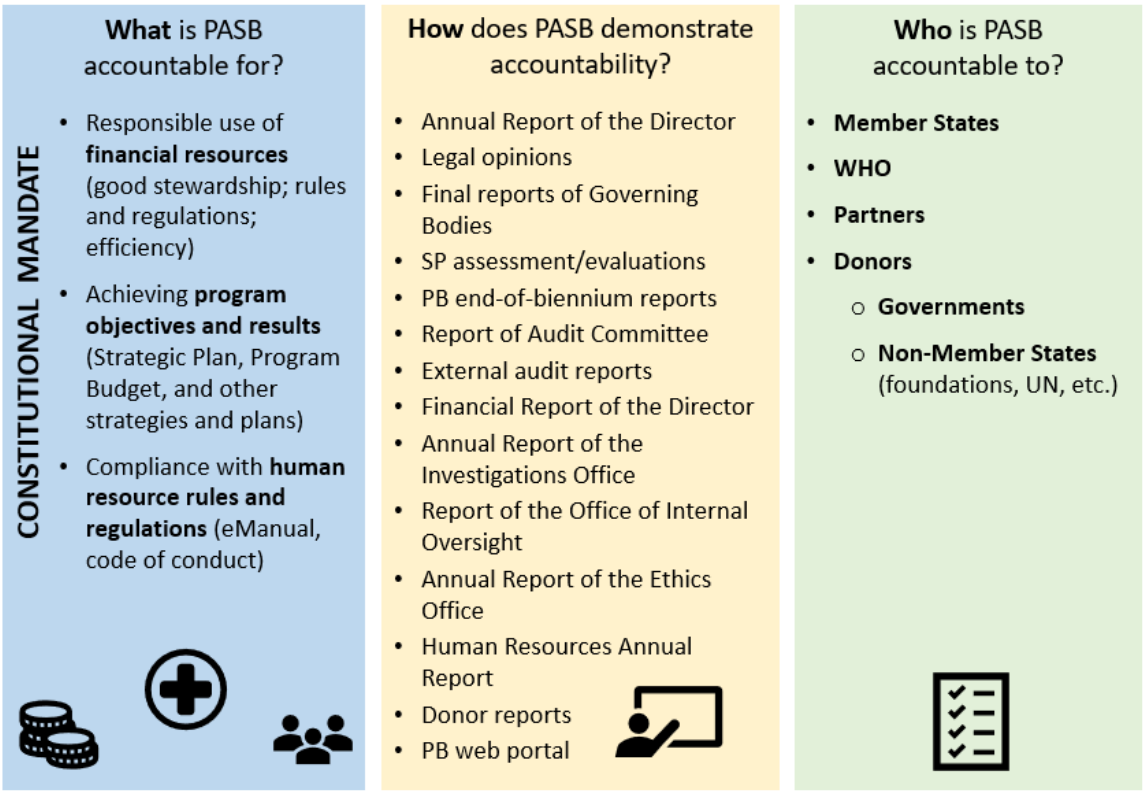
75. It is important to emphasize that all outcomes will constitute priorities for the Organization regardless of their ranking. Nonetheless, the outcomes that fall in the top two tiers (high-medium) will be recognized as the greatest challenges across the Region, on which PAHO's technical cooperation is most needed. The Organization will therefore focus most intensively on these areas.

Transparency and Accountability

76. PAHO strives for constant and systematic improvement in its mechanisms for corporate accountability and transparency. There are many processes and mechanisms that form part of this framework, and this Plan attempts to set them out in one place for the first time.

77. For the 2020-2025 period, PAHO will rely on a number of mechanisms to provide a transparent view of its operations to Member States and the public (via publicly available Governing Bodies documents, as well as technical websites, PAHO/WHO Representative Office websites, and the PAHO Program Budget web portal). This Plan presents the main mechanisms through which PASB provides accountability and transparency to its stakeholders. Figure 16 describes what PAHO is accountable for, how it demonstrates accountability and transparency, and to whom the Organization is accountable.

Figure 16. Overview of PAHO Accountability Mechanisms



78. A description of each of the mechanisms is included in Annex E. With respect to this Strategic Plan, programmatic accountability is demonstrated primarily through the instruments detailed below under "Implementation, Monitoring, Assessment, and Reporting."

Risk Management

79. The 2014-2019 Strategic Plan identified several risks with the potential to affect the accomplishment of the PASB strategic objectives for each of the six categories. Inclusion of such risks in the Plan added significant value to the monitoring of its implementation throughout the three biennial work plan cycles. Based on this first experience of identifying and assessing risks, PASB established a more formal and systematic process to enable the Organization to use the enterprise risk management approach for the identification, monitoring, and mitigation of risks.

80. Building on this experience, the SP20-25 has identified 11 key risks, including their potential adverse impact on the achievement of the Plan's outcomes, and also developed tools to mitigate them. The key risks identified for 2020-2025 are summarized as follows.

a) Insufficient resources or decline in investment in health may hinder achievement of the Strategic Plan targets and health-related SDGs.

b) Increasing scale of recurring and new humanitarian crises may affect health outcomes.

c) Uneven focus across health priorities may hinder results for some programmatic objectives. One of the most difficult and challenging situations for national authorities is to maintain a balance among competing demands and pressures. There is a risk of focusing on the most pressing demands while delaying actions needed to impact the social determinants of health and reduce inequities.

d) Insufficient understanding of the intersectoral benefits of public health programs for national strategic objectives. Compared with other sectors, the health sector often faces challenges in achieving recognition and resources commensurate with the value added of public health for the achievement of the sustainable development goals in general.

e) Allocation of resources to respond to emergencies may drain resources from long-term programmatic activities. With the growing frequency of emergencies, this risk is increasingly relevant for Member States and for PASB's operations. Sustainable preparedness requires responsive, resilient health systems and multisectoral action.

f) Information systems that produce limited disaggregated data and scarce data on the social determinants of health.[27]

[27] This risk remains relevant because it affects the capability to monitor progress and make informed decisions for progress toward agreed health outcomes. In the framework of the previous Strategic Plan, this risk was one of the top priorities, and there has been a notable shift in the willingness of countries to assign importance to this issue.

g) Governance collapse or crisis within or among Member States, PAHO, or other international organizations impacts delivery of services in the health sector.

81. The following approaches have been identified to mitigate these risks.

a) Engage in high-level political dialogue to ensure commitment of Member States and partners to invest in and finance priority health programs with a focus on health equity.

b) Implement new modalities for technical cooperation such as South-South cooperation, Cooperation among Countries for Health Development (CCHD), and triangular cooperation, to better respond to country priorities and needs at all levels of the Organization.

c) Promote regional cooperation among Member States, UN entities, and nongovernmental organizations.

d) Advocate for investment and upgrading of integrated information systems for health with capacity to generate and analyze disaggregated health data for decision making and monitoring.

e) Strengthen the capacity of countries to perform the essential public health functions**,** including increasing health systems capacity to address new demands due to migratory movements.

f) Monitor the impact of governance weaknesses on populations living in conditions of vulnerability.

g) Use existing mechanisms to leverage affordable prices for health supplies including vaccines, medicines, and equipment.

h) Monitor, anticipate, and prepare to mitigate the health consequences of emergencies and disasters, improving national preparedness, response, and resilience.

i) Advocate for a multisectoral, whole-of-government, and whole-of-society approach, foster opportunities and platforms to increase intersectoral dialogue, promote the inclusion of non-State actors, strengthen the competencies of national counterparts in negotiation, planning, and strategic dialogue, and nurture national regulatory capacities.

82. In addition to risks related to the main outcomes defined in the Strategic Plan, PASB will continue to manage risks that may affect its own capabilities, credibility, reputation, and performance. In this context, PASB has identified four key risks:

a) Cyberattacks on PASB may affect the integrity of data and availability of systems to support operations, communications, and collaboration with Member States: A detailed information security program has been developed, including industry-standard technological tools as well as training to raise staff awareness and compliance with information security procedures.

b) Staff skills are not always aligned with evolving technical cooperation needs: the Pan American Health Organization People Strategy 2015-2019 provides for regular reprofiling of existing posts, succession planning for expected retirements, and expanding talent management of existing staff through a strengthened learning and development program.

c) Potential for fraud, conflict of interest or misconduct to damage PASB's reputation: PASB has developed a new policy on prevention of fraud and misconduct and mandatory staff training to raise staff awareness.

d) Insufficient accountability may impact compliance with internal control policies: Managing this risk is necessary to provide assurance to PASB Executive Management, internal and external oversight bodies, and Member States that PASB's internal controls function effectively. To mitigate this risk, the PASB has implemented and will continue to enhance a technology-assisted compliance program.

83. Continued improvements in the PASB Management Information System (PMIS) enable transparency and accountability across all organizational levels, supporting the first line of accountability — represented by managers and personnel — and proactively enhancing the second line of accountability, represented by internal controls, risk management, and compliance, complemented by independent reviews by PASB's oversight functions.

Implementation, Monitoring, Assessment, and Reporting

84. Implementation, monitoring, assessment, and reporting are an integral part of PAHO's Results-based Management framework and reflect the Organization's commitment to continuously improving accountability and transparency. This section outlines the joint process for monitoring, assessing, and reporting on the implementation of the PAHO Strategic Plan 2020-2025 and each corresponding Program Budget. This process builds on lessons learned from the implementation of the PAHO Strategic Plan 2014-2019, the first to be jointly monitored and assessed with the Member States.

85. The Strategic Plan includes a set of impact and outcome indicators identified through a consultative process undertaken with the SPAG and with PASB technical teams. These indicators reflect the commitment of the Organization to the attainment of the targets in the SHAA2030, the health-related SDGs, the GPW13 Impact Framework, and other regional and global mandates. PAHO's performance will be monitored and assessed by measuring progress toward the attainment of the impact and outcome targets. The commitment of all countries and territories to report on the indicators will be required to effectively monitor the implementation of the Strategic Plan. PASB will work closely with the countries and territories throughout the monitoring, assessment, and reporting process.

86. Impact and outcome results will be jointly assessed based on data from Member States and reported to PASB, or from any other official source. The impact indicators will be monitored primarily through the PAHO Regional Core Health Data and Country Profiles Initiative (RCHDI) and other reference databases. Outcome indicators will be assessed mainly via the PAHO Strategic Plan Monitoring System, developed in response to the mandate of Member States for joint monitoring and assessment of the outcome and output indicators (Resolution CD52.R8 [2013]). For both levels, a compendium of indicators with standard definitions and measurement criteria has been developed to standardize monitoring, assessment, and reporting.

87. The Plan will be monitored and assessed on a biennial basis, and a report will be presented to the Governing Bodies during the cycle after the end of each biennium. The end-of-biennium assessment will provide a comprehensive appraisal of PAHO's performance, including an assessment of progress made toward achieving the outcome and impact targets and achievement of the Program Budget outputs. The end-of-biennium assessments will form the basis for reporting to Member States on progress made in the implementation of the Strategic Plan and will guide any necessary interim adjustments. A final assessment will be conducted at the end of the Strategic Plan period.

The Evolution of PAHO's Role in Health Development

88. In response to the changing regional and global health environments, PAHO is adapting and evolving its capacities to ensure that it remains "fit for purpose," able to provide the most efficient and effective support possible to its Member States as they seek to collectively and individually improve health and well-being in the Region. This section presents a new way to look at health needs and highlights some key modalities for the technical cooperation that the Bureau provides.

New Health Needs Index

89. PAHO's Health Needs Index (HNI) was last updated in 2012 (see the 2012 PAHO Budget Policy, Document CSP28/7). The HNI was developed jointly with Member States and was used for two main purposes: *a)* the determination of which countries in the Americas should be considered "key countries," that is, those most in need of PAHO's assistance, and *b)* calculation of the needs-based component of the 2012 Budget Policy formula. For the SP20-25, Member States requested the development of a new health needs index and Budget Policy based on lessons learned from the experience with previous HNIs.

90. As part of the SP20-25 development process, PASB worked with the Strategic Plan Advisory Group to develop a new needs index and Budget Policy. Several options for improving the 2012 HNI were discussed. After thorough consideration, the SPAG supported the Sustainable Health Index Expanded Plus (SHIe+), which is calculated using the following formula:

$$SHI_{e+} = \left(I_{health\ outcome} \times I_{health\ access} \times I_{inequality} \times I_{economic} \times I_{social} \times I_{environmental}\right)^{1/6}$$

91. The six index dimensions, with their proxy indicators, are defined as follows:

a) *health outcome:* health-adjusted life expectancy (HALE) at birth

b) *health access*: proportion of births attended by skilled health personnel (%) and immunization coverage with DPT3 (%)

c) *inequality:* Gini coefficient of income inequality

d) *economic*: gross national income per capita (US$)

e) *social:* years of education attained

f) *environmental*: proportion of population using improved water supplies (%)

92. The SHIe+ makes significant changes to expand the 2012 HNI's scope. It corrects the limitation of the previous arithmetic calculation by using the geometric mean instead.[28] While it maintains the two economic dimensions included in the 2012 HNI, the SHIe+ adds health-adjusted life expectancy, a measurement that is readily available and used by WHO. It also adds a proxy indicator for health access, measured by the combination of the proportion of births attended by skilled health personnel and DPT3 vaccination coverage. There are also two proxies for the social and environmental determinants of health. Overall, the SHIe+ is a more robust and comprehensive way to measure the health needs of the countries of the Americas.

93. In the context of the SP20-25, the 2019 SHIe+ will be used for the same purposes as the previous HNI: to identify key countries for technical cooperation and to calculate the needs-based component of the 2019 Budget Policy. The intention is to calculate the needs index only once every six years, at the start of each strategic planning period. The Budget Policy document presents the calculation of the 2019 SHIe+ (Document CE164/14, Annexes A and B) and indicates the basis for the designation of key countries for the 2020-2025 period. Traditionally, the eight countries at the bottom of the health needs ranking, corresponding to the lowest quintile, have been designated as key countries.

Key Countries

94. PAHO has used the designation "key country" (sometimes used synonymously with "priority country") since 2002 as a way to identify countries that receive priority in terms of the allocation of resources and the provision of technical cooperation. Based on the new Sustainable Health Index Expanded Plus, which measures economic, social, and environmental development, the following countries are proposed as key countries for the 2020-2025 period (in alphabetical order): **Belize, Bolivia, Guatemala, Haiti, Honduras, Nicaragua, Paraguay,** and **Suriname.** This list differs from that of 2014-2019 with the removal of Guyana, whose development indicators show relative strength, and the addition of Belize, whose indicators have declined in a relative sense compared to the situation in 2012.

95. The designation of "key country" implies prioritization for the following:

a) **Planning instruments:** Key countries are given priority in terms of the development of a Country Cooperation Strategy, as well as support for development of national health plans and policies.

b) **Allocation of resources:** PASB will prioritize the allocation of budget space (per the 2019 Budget Policy) and financial resources to key countries above all other entities in the Organization to ensure full operational capacity to support these countries.

[28] Geometric mean has the advantage of not allowing a high value to compensate for a low value. It is recognized as good practice and is used in the Human Development Index and other comparable indexes.

c) **Technical cooperation:** In addition to ensuring full capacity of PAHO/WHO Representative (PWR) Offices in key countries, the Organization will give these countries first priority in the delivery of technical cooperation from the regional and subregional levels, including for emergency response.

d) **Administrative support from PAHO Headquarters:** In many key countries there are issues of infrastructure, staffing, and security, and PASB prioritizes actions to ensure that all key country offices are secure and operational at all times.

Technical Cooperation Agreements at the National Level

96. As of 2018, 15 countries in the Region had technical cooperation agreements with the Bureau at the national level, with funding referred to as national voluntary contributions (NVC). These agreements involve specific deliverables for which national authorities have determined the Bureau can provide significant added value, and that are aligned with PAHO's technical cooperation priorities as defined in its Strategic Plan and Program Budgets. All PASB activities conducted with funding from national agreements form an integral part of the technical work of the Organization in response to the health needs of the respective countries. At the same time, the Bureau ensures "full cost recovery" for such activities in order to avoid subsidizing national agreements with funds from the Program Budget.

Cooperation among Countries for Health Development (South-South Cooperation)

97. Over the past decade, strong political backing from PAHO Member States has pushed South-South cooperation and triangular cooperation to the center stage of development. This is not only reflected in the Busan Partnership for Effective Development Cooperation but is also noted as an important mechanism for the new 2030 Agenda for Sustainable Development and the Sustainable Development Goals. Also, following the Second High-level United Nations Conference on South-South Cooperation (March 2019), Member States renewed their commitment to the diverse modalities and principles of South-South and triangular cooperation. In collaboration with the United Nations Office for South-South Cooperation and other agencies, funds, and programs, PAHO will work on the development of the forthcoming UN System-wide Strategy on South-South Cooperation with the aim of demonstrating the contribution of this modality to the achievement of national, regional, and global health targets.

98. PAHO will continue to promote cooperation among countries by linking a country's challenges in dealing with new and reemerging public health problems to existing capacities and proven solutions in other Member States. This will maximize the added value of technical cooperation not only by leveraging expertise within the Bureau, but more importantly, by identifying and mobilizing financial resources and technical expertise within countries themselves.

Subregional Technical Cooperation

99. PAHO's subregional work complements country and regional technical cooperation, focusing on the provision of technical cooperation in health to the subregional integration mechanisms in the Caribbean, Central America, and South America. Subregional programs play an important role in ensuring health policy convergence among and within subregional geographic areas. PAHO facilitates discussions among and within subregional integration mechanisms on relevant health issues that are amenable to subregional action, facilitates cooperation between countries and integration mechanisms, and promotes South-South technical cooperation among subregions.

100. PAHO has formal relationships with a number of major subregional integration mechanisms, including CARICOM (Caribbean Community), SICA (Central American Integration System), COMISCA (Council of Ministers of Health of Central America and the Dominican Republic), Mesoamerican Integration and Development Project, ORAS-CONHU (Andean Health Agency-Hipólito Unanue Agreement), ACTO (Amazon Cooperation Treaty Organization), MERCOSUR (Common Market of the South), and UNASUR (Union of South American Nations).

101. Subregional integration mechanisms have an important comparative advantage, namely their convening power. The added value of the subregional program is to support the integration mechanism with evidence on important and emerging health issues that can be addressed in various subregional forums. Subregional technical cooperation has enabled high-level decisions in key areas including NCDs, HIV, gender equality in health, intercultural health, and climate change, among others.

Regional and Global Goods

102. To streamline end-to-end processes for the delivery of technical cooperation and strengthen the normative work of the Organization, and in line with the WHO concept of Global Goods in the GPW13,[29] PAHO will identify Regional Goods, as appropriate, that contribute to WHO's Global Goods. These goods will carry a direct relationship with PAHO's Core Functions. In developing Regional Goods for the Americas, PAHO will adopt and adapt Global Goods to the regional level, as applicable. This will allow for a high degree of regional, subregional, and country-level specificity while at the same time facilitating reporting to the global level.

[29] WHO Global Goods are the norms, standards, conventions, data, research, innovations, multilateral goods, and WHO Secretariat functions or deliverables that are produced by the Organization in order to ensure access to authoritative and strategic information in ways that can be shown to improve health outcomes and well-being.

Strategic Budgeting and Financing

103. This section provides an overview of high-level trends in PAHO's financial situation and shows the way forward for the next six years in terms of budget policy, targeted resource mobilization, and resource management.

Regional Budget Policy

104. This section of the SP20-25 provides a high-level summary of the 2019 PAHO Budget Policy (Document CD57/5). The Budget Policy responds to the recommendation made by PAHO Member States during the 56th Directing Council (September 2018) to replace the previous Regional Program Budget Policy (RPBP) approved in 2012. The RPBP became largely irrelevant when the "integrated budget" approach was introduced for the 2016-2017 biennium, since the RPBP applied exclusively to the PAHO "Regular Budget" (assessed contributions plus miscellaneous income), which was no longer the basis for budgeting.

105. The intention of the new Budget Policy is to provide an evidence-based, empirical foundation for assigning budget envelopes across PAHO Member States, while allowing sufficient flexibility for PASB to respond to evolving political and technical considerations. The Policy is designed to "guide, not bind" budget allocations during the period covered. It incorporates lessons learned from the regional level (previous PAHO budget policies, and assessments and evaluations thereof) and the global level (the 2015 Strategic Budget Space Allocation exercise).

106. The 2019 Budget Policy is based on the calculation of a formula, but it also allows for transparent and justified adjustments to the formula to ensure that it stays relevant and useful throughout the planning period. The proposal is to progressively apply the formula, plus any manual adjustments, over the six-year period of the SP20-25. Reporting on Budget Policy implementation is to be incorporated into PAHO's end-of-biennium reports for the respective Program Budgets (2020-2021, 2022-2023, and 2024-2025) under this Strategic Plan.

PAHO's Funding Modalities

Assessed Contributions

107. The assessed contributions (AC) of PAHO Member States have remained flat for the past three biennia. Prior to that, there were biennial increases of between 3% and 4% for the biennia 2008-2009 through 2012-2013.

108. The level of PAHO AC as a proportion of the total budget has stayed at around one-third for the past decade, with some variation as the budget has decreased and increased. Zero AC growth represents an effective decrease, since the costs covered by AC (mainly staff and administrative costs) continue to increase steadily. For the biennia covered under this SP20-25, a holistic view of how to fund the Organization's work is needed.

Voluntary Contributions (and Other Sources)

109. While the past decade has witnessed a series of economic crises, starting with the global financial crisis of 2008-2009, these challenges have diminished in recent years as the world economy has strengthened. Despite these improvements, analyses suggest that further setbacks or negligible growth in per capita gross domestic product (GDP) are anticipated in Latin America and the Caribbean.[30] It is against this backdrop, and in light of ongoing challenges to development assistance funding for the Americas, that the Organization endeavors to mobilize voluntary contributions to support health in the Americas. The year 2016 was an important inflection point for the Organization, when a five-year decline in funding through voluntary contributions was reversed. The durability of this change is still to be determined; however, it is a positive development given the challenging earlier trend. Regional mobilization of resources has been most affected by the decision of many traditional partners to focus their voluntary resources in countries outside the Americas, given the level of socioeconomic development attained by many of our Member States.

110. The Organization has made significant progress in mobilizing resources from new partners, with approximately 20% of partners in 2016-2017 being new or reengaged supporters. Furthermore, the Organization is making substantial efforts to look beyond traditional partnerships, resulting in emerging collaborations with new government partners, interest from foundations, and opportunities with the private sector.

National Voluntary Contributions

111. Recognizing that PAHO Member States include 11 high-income countries and 23 middle-income countries (as well as one low-income country),[31] since 2005 the Organization has undertaken substantial development of national technical cooperation agreements funded through national voluntary contributions. This has created an important mechanism through which the Organization implements its technical cooperation. Currently, 15 countries are working with the Organization to implement national cooperation agreements. These Member States are finding new ways to invest in health and responding to calls for middle-income countries to increase health sector contributions. In response to Member States' needs, and to reinforce its traditional technical cooperation,

[30] United Nations, World economic situation and prospects 2018 (New York: United Nations, 2018).
[31] World Bank Data Help Desk, Country and lending groups. Available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups [cited 12 February 2019].

PAHO will continue to expand this mechanism in full harmony with its programmatic objectives and the mandates established by the Governing Bodies.

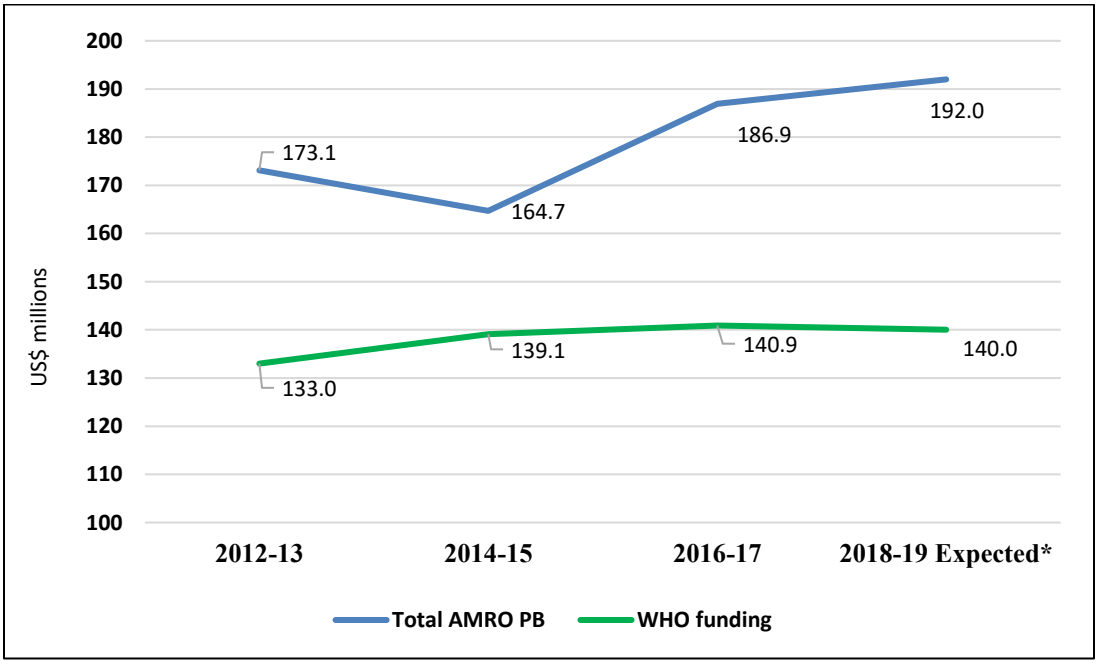
WHO Funding for AMRO

112. Flexible funding from WHO is an important source of funding for the Region, totaling around US$ 100 million[32] during recent biennia. However, these resources have not increased commensurate with WHO's global increased funding, nor with the increased budget allocations for the Region (see Figure 17).

113. WHO voluntary contributions continue to be a funding source for the Region, with $37.3 million received during the 2016-2017 biennium. However, compared to other WHO regions, funding levels for the WHO Regional Office for the Americas (AMRO) have proportionately decreased, even as AMRO's portion of the WHO budget has increased. Recognizing WHO's renewed efforts to mobilize voluntary contributions to support the 13th General Programme of Work, AMRO will advocate an increase in the level of resources made available for this Region.

114. Figure 17 illustrates the level of actual funding received from WHO against the budget ceiling allocated to the Region during recent biennia.

Figure 17. Total WHO Budget and Funding Allocations for the Americas, 2012-2013 through (Expected) 2018-2019



* Expected amounts are based on historical levels received in the last two biennia.

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

Collective Purchasing Funds

115. PAHO's collective purchasing activities are an integral part of its technical cooperation. The procurement mechanisms include: the Revolving Fund for vaccine procurement (Revolving Fund); the Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund) for medicines and public health supplies; and the Reimbursable Procurement (RP) mechanism on behalf of Member States. The Revolving Fund was established in 1977 pursuant to Directing Council Resolution CD25.R27 to facilitate the timely availability of quality vaccines at the lowest prices. The Strategic Fund was established in 1999 for the procurement of essential medicines and strategic public health supplies to combat HIV/AIDS, tuberculosis, malaria, neglected diseases, hepatitis C, and noncommunicable diseases. Created by PAHO at the request of Member States, the Strategic Fund has worked with countries to improve access to medicines and other health technologies by strengthening demand planning and the organization of national supply management systems while facilitating access to affordable strategic public health supplies through a pooled procurement mechanism. The RP mechanism supports the procurement of health program items that are unobtainable or difficult to procure in Member States.

116. For the 2016-2017 biennium, the total cost of goods procured through the three procurement mechanisms was approximately $1.363 billion. The Funds' operations include an assessed charge of 4.25% on the procurement of all public health supplies: 3% is deposited into a capitalization account that serves as a line of credit for Member States to purchase vaccines, syringes, and related supplies, and the remaining 1.25% is assigned to the Special Fund for Program Support to finance related staff and operating costs, as outlined in Resolution CD52.R12 of the Directing Council in 2013.

117. During the period 2017-2018, an assessment of the Revolving Fund was conducted to ensure the continued improvement of services to Member States. This independent review assessed the current operating model of the Revolving Fund, mapped drivers of change in the operation, outlined governance considerations, and provided short-term and long-term recommendations to preserve the relevance and growth of the Fund. Specifically, in the coming years the Revolving Fund will:

a) Transform to a digital platform, with operational performance metrics and dashboards, improving visibility for Member States;

b) Reinvigorate the Revolving Fund's growth path (fuller alignment with country needs);

c) Optimize use of credit line to support Member States;

d) Leverage the Revolving Fund's position as a market-maker to position new services to Member States.

Organizational Strategies: Taking PASB to 2025

118. The successful implementation of this Plan in an evolving global and regional context will require PASB to make changes in the way it operates and collaborates with its Member States and stakeholders, while at the same time leveraging its already existing capabilities. Through implementation of the strategies below, PASB will endeavor to contribute to the implementation of the "strategic and organizational shifts" envisaged in GPW13, and will provide improved cooperation to its Member States.

Embracing Multisectoral Work Modalities

119. One of the principal purposes of the SDGs is to foster a multisectoral approach to development across social and economic sectors. This is not an entirely new approach for the Bureau, which has implemented Health in All Policies and similar initiatives in the past. Nonetheless, the SDGs present a fertile landscape for collaboration, making it easier to address health determinants and risk factors, as well as cross-cutting themes such as equity, gender, ethnicity, and human rights, across sectors. At the same time, they offer an opportunity to learn what related sectors need from the health sector, and vice versa, and how cross-sectoral collaboration can be of joint benefit.

120. The Organization strives to build partnerships and strengthen cross-sectoral collaboration among various stakeholders to nurture trust and foster commitment toward the attainment of mutually beneficial goals. Strategic partnerships are based on increased and ongoing engagement of the private sector, civil society, and communities, which complements more traditional government decision-making processes for health-related actions. Given the often-limited health budgets in many countries, strong collaboration with other sectors and partners presents an important opportunity to mobilize resources and implement collective efforts to address multifaceted health issues.

Managing Human Resources Effectively in the Virtual Age

121. It is a truism in a knowledge-based organization like PAHO that "our people are our greatest asset." But in an age of global outsourcing, high worker mobility, and virtual workplaces, new approaches to human resources (HR) management are required. PAHO faces a variety of challenges related to HR. It is becoming increasingly difficult to attract high-quality candidates to PAHO vacancies. Staff who have served in PAHO for many years can lose their cutting-edge knowledge and struggle to adapt to changing environments. The combination of these factors, along with the need to constantly renew and improve PAHO's human resources, means the Organization must rapidly modernize its HR practices, strengthen competencies in line with today's needs, and seek ways to reduce costs without compromising the quality of its services to Member States.

Ensuring Efficient Administration and Use of Resources

122. Implementation of the Workday enterprise resource planning (ERP) system in PAHO in 2016 signaled a new era of information technology in the Organization. Since then, PASB has sought to benefit from the system's capabilities and to adopt innovative ways of working. Nonetheless, there remains a great deal of opportunity for leveraging technology to improve business processes and realize efficiencies. Some key areas for action in the next six years are:

a) Use of information technology (IT) platforms for technical program management.

b) Optimization of business processes to benefit from Workday.

c) Review of enabling functions to realize cost-savings through solutions such as outsourcing and offshoring.

d) Expand and improve opportunities for virtual collaboration, with corresponding reduced need for travel.

Responding to United Nations Reform

123. PAHO was established in 1902 as the specialized health agency of the Organization of American States (OAS) within the inter-American system. In 1949, through an agreement with WHO, PAHO agreed to serve as WHO's Regional Office for the Americas, known as AMRO. In its capacity as AMRO, PAHO will continue to participate in the United Nations Development System (UNDS) and in the framework of the United Nations Resident Coordinator (RC) system to contribute to the health components of Member States' national goals and objectives. While collaborating with the UNDS and the RC, PAHO will continue to preserve and uphold the Organization's constitutional status and specific mandate, as dictated by its Governing Bodies.

124. PAHO's position within UNCTs at the national level can present challenges, particularly with regard to the new mandate of the United Nations Resident Coordinators in the context of United Nations reform. It is important that PAHO Member States be conscious of the nature of the Organization and its status vis-à-vis the UN system, and that this status be clear in multilateral forums at the national, regional, and global levels.

Annexes

Annex A. Health Impact and Outcome Results for 2025

Impact Results

1. The Pan American Health Organization (PAHO) has endorsed the 11 goals in the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) as the impact results for the Strategic Plan 2020-2025. Altogether, the impact indicators in Table A.1 and corresponding targets set forth below represent what the Organization will measure at the impact level to report on its contribution to the collective achievement of the SHAA2030 goals. At the same time, many of the impact indicators in the Strategic Plan will contribute to fulfilling the obligations of the Region to report on the indicators in the World Health Organization (WHO) 13th General Programme of Work (GPW13) and health-related indicators in the Sustainable Development Goals (SDGs), among other mandates.

Table A.1. Impact Indicators

Impact Indicator	Baseline (2019)	Target (2025)
1. Reduction of within-country health inequalities	N/A	17
2. Health-adjusted life expectancy (HALE)	66.91 years (2019)	67.58 years
3. Neonatal mortality rate	7.9 deaths per 1,000 live births (2017)	6.9 deaths per 1,000 live births[1]
4. Under-5 mortality rate	14 deaths per 1,000 live births (2017)	11.5 deaths per 1,000 live births[2]
5. Proportion of children under 5 who are developmentally on track in health, learning, and psychosocial well-being	84.5% (surveys in 15 countries from 2010-2016)	90%
6. Maternal mortality ratio (MMR) (deaths per 100,000 live births)	52 deaths per 100,000 live births (2015)	35 deaths per 100,000 live births[3]

[1] This target was established based on an Average Annual Percent Change of -2.1% considering the estimates from UN IGME 2017. The 2018 estimates will be published in September 2019. Baseline and targets may change once the new estimates are published.

[2] Target will be revised once the 2018 data is published in 2019.

[3] Target is consistent with SHAA2030 Target 1.2.

Impact Indicator	Baseline (2019)	Target (2025)
7. Rate of mortality amenable to health care (MAHR) (deaths per 100,000 population)	110.7 deaths per 100,000 population[4] (2018)	94.7 deaths per 100,000 population
8. Proportion of adults 65+ who are care-dependent	~8.0% (2010)	6.5%
9. Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	15.1% (2016)	11.9%
10. Mortality rate due to cervical cancer	4.9 deaths per 100,000 women (2018)	4.0 deaths per 100,000 women
11. Mortality rate due to homicide among youths 15-24 years of age	35.6 deaths per 100,000 youth 15 to 24 years of age (2015)	33.5 deaths per 100,000 youth 15 to 24 years of age
12. Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months	TBD[5] (2019)	No increase
13. Number of deaths due to road traffic injuries	154,000 deaths (2016)	123,000 deaths
14. Mortality rate due to suicide	7.8 deaths per 100,000 population (2014)	7.0 deaths per 100,000 population[6]
15. Incidence rate of measles	0.9412 per 1,000,000 population (2018)	0 per 1,000,000 population

[4] Data currently under validation by PASB. The baseline and target will need to be adjusted upon completion of the data validation.

[5] Comparable estimates are available for 24 countries in the Region. However, the methodology for the estimate for the regional baseline is currently under review. It is expected that it will be available after September 2019.

[6] Target is for a 10% reduction relative to 2014.

Impact Indicator	Baseline (2019)	Target (2025)
16. Incidence rate of HIV infections	0.19 per 1,000 population[7] (2017)	0.09 per 1,000 population
17. Rate of mother-to-child transmission of HIV	12% of births to women living with HIV (2017)	2% of births to women living with HIV
18. Incidence rate of congenital syphilis (including stillbirths)	2.1 per 1,000 live births (2017)	0.5 per 1,000 live births
19. Mortality rate due to chronic viral hepatitis	11.4 per 100,000 population (2017)	6.3 per 100,000 population
20. Incidence rate of tuberculosis	28 per 100,000 population (2015)	14 per 100,000 population[8]
21. Incidence rate of malaria	0.78 per 1,000 population (2015)	0.20 per 1,000 population[9]
22. Number of endemic countries in 2015 that maintain or achieve elimination of malaria	3 out of 21 countries and territories that were endemic in 2015 (2018)	6 out of 21 countries and territories that were endemic in 2015
23. Case-fatality rate due to dengue	0.056% (2012-2018)	0.050%
24. Elimination of neglected infectious diseases in countries and territories	-	-
a. Trachoma	1 out of 5 (2019)	3 out of 5

[7] Target is a 50% reduction by 2025, which is aligned with WHO's 2030 target for Latin America and the Caribbean (that is a 90% reduction compared to 2010, or 0.02 HIV infections per 1,000 population).
[8] Target is consistent with the 2025 global target for a 50% reduction from the 2015 level.
[9] Target is for a 75% reduction, consistent with 2025 milestone in the WHO Global Technical Strategy for Malaria 2016-2030.

Impact Indicator	Baseline (2019)	Target (2025)
b. Chagas disease	17 out of 21 (2019)	21 out of 21
c. Dog-mediated human rabies	32 out of 35 (2019)	35 out of 35
d. Leprosy	17 out of 23 (2019)	23 out of 23
e. Human taeniasis/cysticercosis	0 out of 16 (2019)	3 out of 16
f. Lymphatic filariasis	3 out of 7 (2019)	5 out of 7
g. Onchocerciasis	4 out of 6 (2019)	6 out of 6
h. Schistosomiasis	3 out of 10 (2019)	5 out of 10
25. Number of bloodstream infections per 1,000 patients per year caused by carbapenem-resistant organisms	TBD[10]	At least a 10% reduction from the baseline
26. Mortality rate attributed to household and ambient air pollution	13.05 deaths per 100,000 population (2019)	12.40 deaths per 100,000 population[11]
27. Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene	1.65 deaths per 100,000 population[12] (2016)	1.32 deaths per 100,000 population
28. Mortality rate due to disasters per 100,000 population	TBD[13]	At least a 10% reduction from the baseline

[10] The 2019 baseline will be available by June 2020. Data will correspond to 2019 and countries will report during the first trimester of 2020. The target will be based on that baseline (at least a 10% reduction).
[11] Target is for a 5% reduction compared to 2019.
[12] This rate is calculated using data from 29 countries.
[13] Baseline data will be made available within the first quarter of 2020.

2. Unless otherwise indicated, all impact indicators contain regional baseline and target figures, and progress toward the targets will be reported biannually to PAHO Governing Bodies.[14] The regional estimates will depend on data reported by individual countries and territories, collected primarily via the PAHO Regional Core Health Data and Country Profiles Initiative (RCHDI) and other reference databases.

Outcome Results

3. In keeping with the results-based approach, outcomes will contribute to the achievement of impact targets and the SHAA2030 goals. Outcomes, including those related to the Pan American Sanitary Bureau (PASB) enabling functions, may contribute toward the achievement of several impact indicators. There is not a one-to-one relationship between individual outcome and impact indicators. The extent of the technical cooperation required for each outcome is described in the corresponding scope, and outcome indicators are provided for measuring progress.

Outcome 1. Access to comprehensive and quality health services Increased response capacity[15] of integrated health services networks (IHSNs), with emphasis on the first level of care, to improve access to comprehensive, quality health services[16] that are equitable, gender- and culturally sensitive, rights-based, and people-, family-, and community-centered, toward universal health		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
1.a Number of countries and territories that show a reduction of at least 10% in hospitalizations for ambulatory care sensitive conditions	8 (2019)	20
1.b Number of countries and territories that have implemented strategies to strengthen the response capacity of the first level of care	N/A* (2019)	20

***** N/A is used to indicate that information is not available or does not apply to a particular situation.

4. **Scope:** Work toward this outcome aims to strengthen and transform the organization and management of health services at both the individual and public health

[14] In addition to the baselines that remain to be determined at the time of publication of this Plan, should any baselines need to be updated based on the latest information available for the indicators, PASB will publish revisions via the end-of-biennium assessment reports, or amendments to the SP20-25 if necessary. Targets may also be adjusted accordingly to take into account updated baselines. Such changes to the targets will remain consistent in magnitude with the original target, unless otherwise warranted. This applies for all impact and outcome indicators.

[15] Response capacity, in this context, is defined as the ability of health services to provide health care responses adapted to people's needs and demands, in line with current scientific and technical knowledge, resulting in improved health.

[16] Comprehensive, appropriate, timely, quality health services are actions, directed at populations and/or individuals, that are culturally, ethnically, and linguistically appropriate, with a gender approach, and that take into account differentiated needs in order to promote health, prevent diseases, provide care for disease (diagnosis, treatment, palliative care, and rehabilitation), and offer the necessary short-, medium-, and long-term care.

levels, with a primary health care (PHC) approach to universal health. Emphasis will be given to ensuring quality and capacity to respond to the diverse needs of all groups and populations, with due attention to groups in conditions of vulnerability.[17] People-, family-, and community-centered health services require an innovative model of care[18] and the development of integrated health services networks to meet the needs and demands of the entire population. Special attention will be given to improving capacity for effective governance of the networks and innovative approaches to improve management, ensuring coordination, communication, and continuity of care.

5. This outcome must take into consideration the actions needed to overcome access barriers to services, particularly those posed by policies and legislation that need to be adapted to international human rights standards. Attention will be paid to the response capacity of all levels of care, including hospitals, ambulatory specialized services, and emergency services, as well as supporting diagnostic services. Investments to improve response capacity at the first level of care will be a strategic priority, including the use of communication and information technology and a systemic primary health care approach. Additionally, actions will be strengthened to facilitate the empowerment of people and communities so that they are more knowledgeable about their health situation and their rights and responsibilities, which can help them make informed decisions. This includes actions to strengthen the capacity of national authorities to develop mechanisms for social participation, transparency, and accountability, at the territorial level, to fulfill the obligation of the state to protect the health of the population.

6. The participation and engagement of communities and people will be promoted through training, self-care, and access to information for community members, to enable them to take an active role in actions to address social determinants of health and in health promotion and protection to maintain their health. Emphasis will be placed on strengthening the capacity of health services networks to implement essential public health functions, particularly at the first level of care.

Outcome 2. Health throughout the life course Healthier lives promoted through universal access to comprehensive, quality health services for all women, men, children, and adolescents in the Americas, focusing on groups in conditions of vulnerability		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
2.a Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods	60% (2019)	68%

[17] Groups in conditions of vulnerability include the poor, women, children and adolescents, older persons, indigenous groups, Afro-descendants, migrants, LGBT individuals, and persons with disabilities, among others.

[18] By innovative models we refer to those systems that provide solutions or respond to a need by developing and delivering new or superior options that improve health, focused on families, communities, and people. The options can be political, or related to health systems, products, or technologies, or to delivery, organization, or financing of services.

Outcome 2. Health throughout the life course Healthier lives promoted through universal access to comprehensive, quality health services for all women, men, children, and adolescents in the Americas, focusing on groups in conditions of vulnerability		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
2.b Fertility rate in women 10-19 years of age (disaggregated by 10-14 and 15-19 years) in Latin America and the Caribbean	66.5 births per 1,000 adolescent girls (2010-2015)	59.9 births per 1,000 adolescent girls[19]
2.c Proportion of births attended at health facilities	93.7% (2016)	95.6%
2.d Proportion of births attended by skilled health personnel	96.4% (2016)	98.3%
2.e Number of countries and territories with capacity to implement and monitor national policies or strategies to improve the health and development of young children that are informed by the WHO/UNICEF framework Nurturing Care for Early Childhood Development	19 (2019)	23
2.f Number of countries and territories developing, implementing, and monitoring policies or strategies with an integrated approach to address men's health	5 (2019)	16

7. **Scope:** Work toward this outcome aims to protect achievements, accelerate progress, and reduce inequalities by increasing and improving universal access to comprehensive, quality health services focused on people, families, and communities. This is essential for the achievement of universal health and consistent with the aspirations of the 2030 Agenda for Sustainable Development. This outcome recognizes the interdependence of individual, social, environmental, temporal, and intergenerational factors, and the differential effects of these interactions in several sensitive periods in the life course. It seeks to improve national capacity to create a sound normative environment that promotes equitable access to quality health services focused on people, families, and communities. Central to these efforts is the promotion of effective multidisciplinary teams, intersectoral work, and social participation in the coproduction of health and well-being, looking beyond survival to generate the ability of people and populations to thrive and transform. This outcome includes all age groups (newborns, children, adolescents, adult women and men), with a special focus on groups in conditions of vulnerability.[20]

[19] Target is for a 10% reduction.
[20] See footnote 17 in Outcome 1.

Outcome 3. Quality care for older people Increased health system response capacity to provide quality, comprehensive, and integrated care for older people, in order to overcome access barriers, prevent care dependence, and respond to current and future demands		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
3.a Number of countries and territories with capacity to prevent care dependence	6 (2019)	20

8. **Scope:** Population and individual aging is an important modulator of health and social needs throughout the life course. Over the next decade, the Americas will age much faster than the rest of the world. This will require changes in the response capacity of health systems and increased interdependence between the health sector and other sectors involved in the dynamics of health and social care. Steps must be taken to overcome the physical, geographic, cultural, and financial barriers to access that older persons face when attempting to receive and make effective use of comprehensive integrated health services. It will be necessary to:

a) Expand equitable access to comprehensive, quality health services with a strengthened first level of care, coordinated and organized in integrated health networks. These networks should include social and community services that guarantee continuity of care and respond to older people's need to maintain their functional capacity and their optimal ability to live in and interact with their communities.

b) Strengthen the leadership and governance of health systems, the active social participation and empowerment of communities and individuals as drivers of their own health, and intersectoral coordination to address the social determinants of health and aging.

c) Achieve effective integration of social and health care that helps ensure the sustainability of coverage and universal access to health for older persons, including long-term care for those who need it.

d) Establish financing mechanisms that prevent direct payment from becoming an access barrier to services or leading to the impoverishment of older persons and their families.

Outcome 4. Response capacity for communicable diseases Increased response capacity of integrated health services networks (IHSNs) for prevention, surveillance, early detection and treatment, and care of communicable diseases, including vaccine-preventable diseases		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
4.a Percentage of people with HIV who have been diagnosed	82% (2017)	90%
4.b Antiretroviral treatment (ART) coverage among persons living with HIV	66% (2017)	90%
4.c Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women	20 (2017)	29
4.d Tuberculosis treatment coverage	81% (2017)	90%
4.e Number of endemic countries and territories with >70% of malaria cases diagnosed and treated within 72 hours of the start of symptoms	3 out of 19 countries (2017)	9 out of 19 countries
4.f Number of countries and territories with capacity to conduct integrated surveillance of arbovirus cases	0 (2019)	20
4.g Number of countries and territories reporting at least 95% coverage at the national level of the second dose of measles and rubella-containing vaccine (MRCV)	6 (2017)	15
4.h Number of countries and territories reporting at least 95% coverage of 3 doses of diphtheria, pertussis, and tetanus-containing vaccine (DPT3) in 80% of municipalities	6 (2017)	20
4.i Number of countries and territories reporting at least 95% coverage of 3 doses of pneumococcus-containing vaccine at national level	3 (2017)	20
4.j Number of countries and territories that have incorporated HPV vaccines in their national vaccination program	29 (2017)	45

9. **Scope:** Work toward this outcome aims to increase the capacity of health services networks to prevent and reduce morbidity, disability, and mortality related to communicable diseases, by ensuring access to interventions throughout the life course and by giving particular attention to the specific needs of groups in conditions of vulnerability.[21] The response capacity of the first level of integrated health services networks will be prioritized, and interventions will also address the social and environmental determinants and inequities that surround these diseases. Emphasis will be on:

[21] See footnote 17 in Outcome 1.

a) Increased access to comprehensive, quality health services and interventions throughout the life course, within a PHC/universal health approach.

b) Increased synergies between communicable disease-specific interventions and established service platforms for maternal and child health and immunization campaigns, among others.

c) Increased access to interventions for sexually transmitted infections, HIV/AIDS, viral hepatitis, and tuberculosis, and for zoonotic, foodborne, waterborne, neglected, and vector-borne diseases.

d) Increased vaccination coverage, especially for hard-to-reach populations and communities.

e) Strengthening of the systems, services, and methods for communicable disease surveillance.

Outcome 5. Access to services for NCDs and mental health conditions Expanded equitable access to comprehensive, quality health services for the prevention, surveillance, early detection, treatment, rehabilitation, and palliative care of noncommunicable diseases (NCDs)[22] and mental health conditions[23]		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
5.a Number of countries and territories that achieve the 2025 global NCD target to halt the rise in diabetes assessed by age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years	0 (2019)	10
5.b Number of countries and territories that reach a target of 35% prevalence of controlled hypertension at population level (<140/90 mmHg) among persons with hypertension 18+ years of age	4 (2019)	12
5.c Number of countries and territories with cervical cancer screening programs that achieve at least 70% coverage of screening in women aged 30-49 years, or for the age group defined by the national policy	7 (2019)	11
5.d Number of countries and territories that increase access to palliative care, assessed by increase in morphine equivalent consumption of opioid analgesics (excluding methadone)	0 (2019)	7
5.e Number of countries and territories whose surveillance systems have the capacity to report on key indicators of the Global Monitoring Framework on Noncommunicable Diseases	23 (2017)	35

[22] The four main types of NCDs are cardiovascular diseases, cancer, diabetes, and chronic respiratory disease.
[23] Mental health conditions include mental, neurological, and substance use disorders.

Outcome 5. Access to services for NCDs and mental health conditions Expanded equitable access to comprehensive, quality health services for the prevention, surveillance, early detection, treatment, rehabilitation, and palliative care of noncommunicable diseases (NCDs)[22] and mental health conditions[23]		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
5.f Number of countries and territories that have tertiary care centers that provide rehabilitation services with multi-disciplinary teams for complex injuries	6 (2019)	15
5.g Number of countries and territories that have increased capacity to manage mental health disorders at the first level of care	0 (2019)	20
5.h Number of countries and territories that have increased the rate of persons admitted with mental disorders to general hospitals	10 (2019)	25
5.i Number of countries and territories that have increased the rate of persons receiving treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders in the health service network	6 (2019)	12

10. **Scope:** Work toward this outcome aims to reduce premature mortality due to noncommunicable diseases by strengthening health systems for improved prevention and management of NCDs; promote mental health and reduce the treatment gap for mental health conditions; and reduce gaps in care for persons with disabilities. The foundation of this work is to integrate prevention and response activities related to NCDs, mental health, and disability as part of overall efforts toward universal health coverage and access, with a focus on primary care, using an approach that is gender-focused and rights-based, throughout the life course.

11. The scope of technical work will include capacity building, development of evidence-based guidelines and normative guidance, and actions to improve quality of care for persons affected by NCDs, mental health conditions, and disability.

12. The specific approaches are set out in the relevant PAHO and WHO mandates on these public health matters, and include the following:

a) Improve the quality of health services for screening and early detection, diagnosis, treatment, and palliative care of the four main types of NCDs.

b) Improve the availability, access, and quality of habilitation and rehabilitation services, and of assistive devices, for all people.

c) Improve health equity for people living with disabilities.

d) Strengthen the health services response with emphasis on primary care for mental health conditions, including dementia, epilepsy, and alcohol- and drug-related disorders.

e) Strengthen noncommunicable disease surveillance systems.

Outcome 6. Response capacity for violence and injuries Improved response capacity for comprehensive, quality health services for violence and injuries		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
6.a Number of countries and territories that minimize the time interval between road traffic crashes and the provision of first professional emergency care	N/A (2019)	10
6.b Number of countries and territories that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines[24]	13 (2019)	18

13. **Scope:** Work toward this outcome aims to reduce the burden of violence and injuries, including death and disabilities, through a strengthened health system response, with a focus on violence in all its forms and on road safety, using a life course approach.[25] The scope of the technical work in this area will include the development and application of guidelines and capacity building of health workers on evidence-based strategies and interventions to prevent violence; respond to the health needs of victims of violence, particularly persons in conditions of vulnerability, to mitigate consequences (such as death and disability); reduce reoccurrence of violence; and respond to the health needs of victims of road traffic crashes and other injuries. The intersectoral work required to address these public health matters is covered under Outcome 15.

Outcome 7. Health workforce Adequate availability and distribution of a competent health workforce		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
7.a Number of countries and territories that have reduced the density gap with respect to physicians, nurses, and midwives, achieving at least 25 health workers per 10,000 population in underserved areas, keeping in mind the global target of 44.5 by 2030	7 (2019)	16
7.b Number of countries and territories that have an interprofessional health team at the first level of care, consistent with their model of care	12 (2019)	21

[24] Post-rape care will be used as a proxy indicator, though countries and territories should strive to strengthen the health system response to violence in all its forms.

[25] Violence includes gender-based violence, intimate partner violence, sexual abuse, violence against children, gun violence, and elder abuse, among others.

14. **Scope:** Attainment of this outcome requires:

a) Strengthening and consolidating governance and leadership in human resources for health (HRH), including decentralized management and a transdisciplinary vision of teamwork.

b) Developing conditions and capacities[26] in HRH to expand access to health and health coverage, with equity and quality, by developing instruments for monitoring and evaluation of health workforce performance, exploring strategies to enhance health workers' motivation and engagement, and fostering the development of a well-trained workforce.

c) Partnering with the education sector to respond to the qualitative and quantitative needs of health systems in transformation toward universal access to health and universal health coverage.

15. Key components include actions to foment high-level coordination and collaboration mechanisms with education, labor, and other sectors to strengthen HRH planning and regulation and better address health system requirements and population needs; strengthen strategic planning capacity and HRH information systems to better inform planning and decision making; develop national HRH policies aimed at enhancing recruitment, training, retention, and distribution of health personnel, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel; increase public investment and financial efficiency in HRH; prioritize interprofessional teams at the first level of care, including community health workers and caregivers; develop strategies to maximize, upgrade, and regulate the competencies of the health team to ensure their optimal utilization; enhance dialogue, partnerships, and agreements to address the challenges of health worker mobility and migration; promote high-level agreements between education and health sectors to shift the educational paradigm and align HRH training with universal health; develop evaluation and accreditation mechanisms to promote improvements in the quality of professional health education; encourage transformation in the education of health professionals toward the principles of social accountability and culturally inclusive selection/admission criteria; and develop regulatory mechanisms and training plans for priority specialties that stipulate health system requirements; and increase training in family and community health.

[26] Capacities will be defined based on the country context.

Outcome 8. Access to health technologies Increased equitable access to essential medicines, vaccines, and other health technologies that are safe, affordable, clinically effective, cost-effective, and quality-assured, and rational use of medicines, with strengthened regulatory systems that contribute to achieving universal access to health and universal health coverage		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
8.a Number of countries and territories that ensure that products listed on the essential medicines list are available without out-of-pocket expenditure at the point of care	5 (2019)	11
8.b Number of countries and territories with regulatory systems that reach level 3 under the WHO Global Benchmarking Tool (GBT)	8 (2019)	16
8.c Number of countries and territories that increase the number of units of blood available for transfusion per thousand inhabitants (UBAT) by at least 5% per year to reach the target of 30 UBAT	7 (2019)	16
8.d Number of countries and territories that have regulations and oversight that ensure access to quality and safe radiological services	0 (2019)	11
8.e Number of countries and territories that have regulations and oversight that ensure availability of quality pharmaceutical services	3 (2019)	8
8.f Number of countries and territories that have implemented institutional frameworks, strategies, and/or legal frameworks for the assessment, selection, and rational use of medicines and other health technologies including antibiotics	3 (2019)	9

16. **Scope:** Increased equitable access to medicines and other health technologies is one of the requirements for universal access to health and universal health coverage. The availability, accessibility, acceptability, and affordability of these medical products and their rational use should be pursued according to the national context and within the context of comprehensive integrated health services, with recognition of the right to the enjoyment of the highest attainable standard of health for all. The following measures should be considered:

a) Promote and update policies, norms, and strategies that improve timely access to and rational use of safe, affordable, quality-assured, clinically effective, and cost-effective health technologies, including medicines and vaccines, and that improve the sustainable capacity of health systems to prevent, diagnose, treat, eliminate, and palliate diseases and other medical conditions.

b) Advocate for the adoption of an explicit essential medicines list,[27] essential in-vitro diagnostics lists, and a priority health technologies list—one based on health technologies assessment and other evidence-based approaches—that are evaluated, reviewed, and monitored periodically and are coherent with health benefit plans and coverage decisions.

c) Promote adequate financing and financial protection mechanisms to foster the progressive elimination of out-of-pocket expenditures and improve access to the essential medical products included in the national lists, according to national public health priorities and the context of each health system.

d) With a view to containing costs within health systems, adopt comprehensive strategies that improve affordability and foster competition, such as multisource and generic strategies; mechanisms to encourage the use of effective lower-cost medical products in lieu of more costly ones of little or no added value; and actions that promote, among other innovative mechanisms, when possible, the delinkage of the cost of research and development from the final price of medicines, in particular where existing market mechanisms fail to provide incentives for research and development.

e) Improve access to quality radiological, pharmaceutical, diagnostic, transplant, and blood services within a comprehensive and integrated network of health services.

f) Promote the development and strengthening of national and subregional regulatory systems that can ensure the quality, safety, and effectiveness of health technologies, including medicines and vaccines, throughout their entire life cycle.

g) Promote sustainable, efficient, and transparent public procurement mechanisms, as well as national, subregional, and regional pooled procurement mechanisms such as the PAHO revolving funds, which limit fragmentation, improve availability, and take advantage of economies of scale to improve equitable access to essential and strategic medical products.

h) Improve capacities to manage and oversee national medical product supply chains, including planning, forecasting, quality assurance, availability, and use, to ensure that the population has timely access to these products at the point of service.

i) Taking into account public health perspectives, strengthen the capacity to implement intellectual property policies and health policies that promote research and development of medicines, vaccines, and other health technologies for communicable and noncommunicable diseases that primarily affect developing countries; and promote increased access to affordable, safe, effective, and quality medicines and diagnostics and other technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights

[27] Essential medicines are those that satisfy the priority health care needs of the population and that should be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford. The WHO Model List of Essential Medicines (EML) is a model reference list containing products that are affordable and cost-effective for most health systems and that can significantly contribute to positive health outcomes (Document CD55/10, Rev. 1).

(TRIPS Agreement), as amended, and also reaffirming the 2001 Doha Declaration on the TRIPS Agreement and Public Health, which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and notes the need for appropriate incentives in the development of new health products.

j) Advance strategies and interventions to ensure appropriate use of antimicrobials to decrease the risk of intractable resistant infections, improving quality of care.

k) Promote the use of existing regional platforms for sharing knowledge and experiences, taking into account developmental differences among Member States.

Outcome 9. Strengthened stewardship and governance Strengthened stewardship and governance by national health authorities, enabling them to lead health systems transformation and implement the essential public health functions for universal health		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
9.a Number of countries and territories that have achieved, by 2025, a reduction of at least 10 percentage points in the population reporting access barriers to health services, as compared to 2020	N/A (2019)	15
9.b Number of countries and territories that have reached at least 60% of their capacity to implement the essential public health functions	N/A (2019)	20

17. **Scope:** Achievement of this outcome requires strengthening the capacities of health authorities to lead collective action and processes to change the norms that regulate actors and critical resources affecting universal access to health and universal health coverage, equity, and respect for human rights. The scope of this outcome also includes improving and prioritizing implementation of the essential public health functions, which are understood as the capacities of health authorities, at all institutional levels, together with civil society, to strengthen health systems and guarantee the health of the population, acting on the social determinants and other factors that affect population health. The following are key for the achievement of this outcome:

a) Leadership by the national health authority in the formulation, monitoring, and evaluation of policies, plans, and programs to strengthen health systems, with mechanisms that facilitate social participation and accountability.

b) Formulation, oversight, and implementation of legislation, policies, and regulatory frameworks, according to the national context and consistent with the commitment to universal access to health and universal health coverage, equity, and human rights.

c) Enhancement of competencies and capacities for the regulation of actors, mechanisms, and critical resources that influence health access and outcomes, including risk factors for NCDs and other conditions.

d) Establishment or adjustment of the mechanisms for coordination with other sectors (public, social security, private, nongovernmental) and geographic units (subnational, state, provincial, municipal).

e) Comprehensive management of international cooperation to ensure alignment with national subregional and regional health priorities.

f) Strengthened capacities for the implementation of essential public health functions related to monitoring and evaluation of health and well-being, equity, social determinants of health, and health system performance; promotion of social participation and mobilization; inclusion of strategic actors and transparency; improvement of access to public health services and interventions with a PHC approach; and management and promotion of interventions on the social determinants of health.

Outcome 10. Increased public financing for health Increased and improved sustainable public financing for health, with equity and efficiency		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
10.a Number of countries and territories that have increased public expenditure on health to at least 6% of GDP	6 (2019)	12
10.b Number of countries and territories that have allocated at least 30% of the public expenditure in health to the first level of care[28]	N/A (2019)	12

18. **Scope:** Work toward this outcome aims to secure increased and improved public financing for health, with equity and efficiency, as a necessary condition to advance toward universal health, according to national context. To achieve this outcome, it is necessary to:

a) Improve and/or increase public expenditure on health, prioritizing investments in promotion, prevention, and the first level of care (infrastructure, medicines and other health technologies, and human resources for health) within integrated health services delivery networks with a people-, family-, and community-centered approach, with due attention to public health interventions/programs to respond to the health needs of the population, including health promotion, and actions to address the social determinants of health.

b) Increase investment to build national health authorities' capacity to fulfill the essential public health functions.

[28] The methodology to calculate the 30% value may vary according to the national context, given the structure of the first level of care in each country.

c) Develop coordinated initiatives to mobilize complementary national and international resources, including with the private sector and other sectors.

d) Establish solidarity-based pooling arrangements for efficient and equitable use of diverse sources of public financing.

e) Develop systems for procurement and payment to suppliers that promote efficiency and equity in the allocation of strategic resources.

f) Develop and validate instruments for monitoring and evaluating the performance of financing.

g) Develop mechanisms for equitable allocation of funds and decentralization of resources, according to public health priorities and the response capacity of health facilities in the context of integrated health services networks.

Outcome 11. Strengthened financial protection Strengthened protection against health-related financial risks and hardships for all persons		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
11.a Number of countries and territories that have decreased by 20% the percentage of population in households experiencing out-of-pocket catastrophic health spending	0 (2019)	17
11.b Number of countries and territories that have decreased by 10% the percentage of people in households experiencing impoverishment due to out-of-pocket health expenditure	0 (2019)	17

19. **Scope:** Work toward this outcome aims to eliminate direct payment for health services, as a necessary condition to advance toward universal health. The following should be undertaken in coordination and collaboration with financial authorities, according to the national context:

a) Eliminate direct payments that constitute a barrier to access at the point of service.

b) Protect against financial risks due to health events that cause impoverishing or catastrophic expenditure.[29]

c) Advance toward solidarity-based pooling mechanisms[30] to replace direct payment as a financing mechanism, combat segmentation, and increase the efficiency of the health system.

[29] Catastrophic expenditure refers to out-of-pocket health expenditure that represents a substantial proportion of a household's income or ability to pay, defined as more than 25% of total household expenditure. Impoverishing expenditure refers to out-of-pocket health expenditure that pushes a household below the poverty line, meaning that they live on less than $1.90 per capita per day. The practical distinction is that indicator 11.1 measures the proportion of households that suffer serious financial difficulties due to out-of-pocket spending on health, regardless of whether they are poor or not, while indicator 11.2 measures the proportion of households that are poor because of out-of-pocket health expenditures.

[30] Pooling resources means combining all sources of financing (social security, government budget, individual contributions, and other funds) in a single, pooled fund, so that all contribute according to their

Outcome 12. Risk factors for communicable diseases Risk factors for communicable diseases reduced by addressing the determinants of health through intersectoral action		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
12.a Number of countries and territories reporting data on discrimination in health services experienced by men who have sex with men (MSM) in the past 12 months	6 (2019)	12
12.b Number of countries and territories where the entire endemic (by vector transmission) 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 (2019)	21
12.c Number of countries and territories with increased antimicrobial resistance (AMR) surveillance capacity to guide the public health interventions for decreasing the risk and preventing the spread of multidrug-resistant infections through intersectoral action	5 (2019)	20
12.d Number of countries and territories that have adequate mechanisms in place to prevent or mitigate risks to food safety	5 (2019)	10

20. **Scope:** Work toward this outcome aims to increase capacity to prevent and reduce morbidity, disability, and mortality caused by communicable diseases, while fostering access to interventions throughout the life course that address equity and human rights. Interventions are directed not only at health threats, but also at their social and environmental determinants. Emphasis will be on:

a) Strengthening health promotion and personal and family self-care, with a focus on rights and duties in the prevention of communicable diseases, in accordance with national law.

b) Coordination with actors involved in addressing risk factors and the determinants of health, including for surveillance of disease trends and impact on public health.

c) Developing stakeholder capacity to address risk factors and the determinants of health, including for surveillance.

d) Increasing access to interventions for waterborne, neglected, and vector-borne diseases, considering social and environmental determinants of health.

e) Increasing implementation of policies, strategies, and interventions to reduce risk and improve access as a means to tackle sexually transmitted infections, blood-transmitted infections, HIV/AIDS, viral hepatitis, and tuberculosis.

means and receive services according to their needs. In such a scheme, the public budget covers contributions for those individuals who do not have the means to contribute (poor and homeless people).

f) Increasing access to comprehensive, quality health services and interventions to prevent, diagnose, and treat infectious diseases throughout the life course, with a primary health care and universal health approach.

g) Increasing access to public health interventions to prevent infections caused by resistant pathogens acquired in the community or in health services.

h) Increasing vaccination coverage, especially for hard-to-reach populations and communities, and continuation of activities to control, eradicate, and eliminate vaccine-preventable diseases.

i) Increasing access to interventions for food safety along the food supply chain to prevent food-borne illnesses, including infections produced by resistant pathogens.

j) Increasing access to interventions against zoonotic diseases, especially to prevent transmission from infected animals to people, with a One Health approach.

k) Implementing effective mechanisms focused on the rational use of antibiotics to reduce the impact of antimicrobial resistance on public health.

Outcome 13. Risk factors for NCDs Risk factors for noncommunicable diseases reduced by addressing the determinants of health through intersectoral action		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
13.a Age-standardized prevalence of current tobacco use among persons aged 15 years and older	16.9%[31] (2016)	13%[32]
13.b Total (recorded and unrecorded) alcohol per capita (APC) consumption among persons 15+ years of age within a calendar year in liters of pure alcohol, adjusted for tourist consumption	8.0 L[33] (2016)	8.0 L[34]
13.c Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years	3.6 g/day (Canada/USA) 3.2 g/day (Latin America/	<2.0 g/day

[31] WHO, Global Health Observatory, Americas, age-standardized prevalence of current tobacco smoking among persons aged 15 years and older, 2016, both sexes (2018).
[32] WHO, Global report on trends in prevalence of tobacco smoking, 2000-2025, second edition (Geneva: WHO, 2018).
[33] WHO, Global Information System on Alcohol and Health (GISAH), Regional alcohol per capita (15+) consumption by WHO region, 2018.
[34] WHO projection for 2025 is for an increase if nothing is done.

Outcome 13. Risk factors for NCDs Risk factors for noncommunicable diseases reduced by addressing the determinants of health through intersectoral action		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
	Caribbean) (2019)	
13.d Number of countries and territories that have eliminated industrially produced trans fatty acids	6 (2019)	35
13.e Age-standardized prevalence of insufficiently physically active persons aged 18+ years	39.3% (2016)	35%

21. **Scope:** Work toward this outcome aims to *a)* address the underlying social, economic, and environmental determinants of noncommunicable diseases and the impact of economic, commercial, and market factors, and *b)* reduce the most common risk factors for the leading NCDs, namely cardiovascular diseases, cancer, diabetes, and chronic respiratory disease. These risk factors include harmful use of alcohol, tobacco use, unhealthy diet, insufficient physical activity, and air pollution.

22. Many social and environmental determinants and risk factors for NCDs, and the solutions to these risk factors, lie beyond the health sector. Therefore, there is a need for coordinated intersectoral action with a whole-of-government approach, led by the Ministry of Health, and a whole-of-society approach including civil society and the private sector, taking into account real or perceived conflicts of interest.

23. Activities will include surveillance of NCD risk factors and strengthening of health promotion throughout the life course. This requires steps to promote healthy environments, mass media campaigns, school and workplace programs, and policy options such as those described in the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020, including regulatory measures as appropriate. This will involve using economic studies to support fiscal policies, building cases for investment to address NCDs, and determining return on investment for the main risk factors. It is essential to support implementation of the WHO Framework Convention on Tobacco Control and, for those countries that are Parties, the new Protocol to Eliminate Illicit Trade in Tobacco Products.

Outcome 14. Malnutrition Malnutrition in all its forms reduced		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
14.a Prevalence of stunting in children under 5 years of age	6.5% (2018)	3.9%[35]
14.b Prevalence of wasting in children under 5 years of age	0.8%	0.8%

[35] Target is for a 40% reduction.

Outcome 14. Malnutrition Malnutrition in all its forms reduced		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
	(2018)	
14.c Prevalence of childhood overweight (under 5 years of age)	7.2% (2019)	7.2%
14.d Prevalence of childhood and adolescent obesity (5-19 years of age)	33.6% (2016)	33.6%
14.e Prevalence of overweight and obesity in persons 18+ years of age	62.5% for overweight, 28.6% for obesity (2016)	62.5% for overweight, 28.6% for obesity
14.f Percentage of infants under 6 months of age who are exclusively breastfed	27.8% (2019)	50%

24. **Scope:** The multiple expressions of malnutrition include overweight and obesity, stunting and wasting, and micronutrient deficiencies, and can contribute to the occurrence of diet-related noncommunicable diseases such as specific cancers, cardiovascular disease, and diabetes. These forms of malnutrition can result from exposure to products, practices, environments, and systems that do not promote healthy eating practices adequately. There is a need for a systematic approach to actions to address malnutrition, according to national context, that include but are not limited to:

a) Promotion, support, and protection of motherhood and of early and exclusive breastfeeding for the first six months, and the continuation of breastfeeding up to 2 years of age or beyond, together with timely and appropriate complementary feeding.

b) Interventions to improve diets tailored specifically to women; encourage and facilitate mothers to breastfeed through maternity leave policies and legislation, workplace lactation locations, counseling, and support, and establish "baby-friendly" hospitals, workplaces, and other settings, and similar initiatives.

c) Interventions to implement and/or strengthen national mechanisms for effective implementation of measures aimed at giving effect to the International Code of Marketing of Breast-milk Substitutes as well as other WHO evidence-based recommendations, keeping in mind the special needs of children and women who cannot breastfeed.

d) Support for timely and adequate complementary feeding, in accordance with the guiding principles for complementary feeding of the breastfed child as well as the guiding principles for feeding of the non-breastfed child, 6-24 months of age; support to continue taking all necessary measures in the interest of public health to implement recommendations to end inappropriate promotion of foods for infants

and young children; as well as education to facilitate the adoption of health practices that do not displace breastfeeding or give inappropriate foods to infants.

e) Implementation of policies on food production, supply, safety, and access that are coherent with a healthy diet; establishment of supportive environments, including supporting the role of the family in healthy food shopping, preparation, and consumption.

f) Implementation of policies to create and support the development of healthy eating patterns among children and adolescents by reducing consumption of energy-dense nutrient-poor products, including sugar-sweetened beverages, in alignment with national dietary guidelines and recommendations.

g) Enactment of regulations and policies to protect children and adolescents from the impact of marketing of energy-dense nutrient-poor products, including sugar-sweetened beverages, while implementing education policies and messaging campaigns to improve understanding of healthy eating patterns.

h) Development and implementation of norms for front-of-package labeling with nutrient content information that promotes healthy choices, including allowing for quick and easy identification of energy-dense nutrient-poor products, in alignment with national dietary guidelines and recommendations.

i) Development and implementation of norms and policies to encourage that consumers are provided accurate information regarding the nutrient content of non-packaged foods.

Outcome 15. Intersectoral response to violence and injuries Improved intersectoral action to contribute to the reduction of violence and injuries		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
15.a Number of countries and territories with an operational advisory committee or lead agency on road safety that supports the development and/or implementation of a national road safety strategy	29 (2019)	32
15.b Number of countries and territories that have a national or multisectoral plan addressing violence that includes the health system	20 (2019)	25

25. **Scope:** This area of work covers multiple forms of violence throughout the life course, road traffic injuries, and other injuries. Addressing violence and injuries requires comprehensive intersectoral action across relevant government, civil society, and private sectors, including health, transportation, education, justice, and safety, among others. Nonetheless, the health sector has an essential role to play, given its mandate to address all major causes of morbidity and mortality. Health systems are also adversely affected by the resulting burden of the direct costs of injuries and violence. Therefore, the scope of technical work will include:

a) Strengthening health leadership and governance, through collaboration with other sectors, to raise awareness and create an enabling legal and policy environment to address violence and injuries, with a focus on reducing risk factors for violence (including alcohol) and addressing gender-based violence.

b) Establishing or strengthening violence surveillance systems to improve the production, dissemination, and use of data on the magnitude and consequences of violence and injuries, the characteristics of the most affected groups, and evidence on what works to prevent and respond to violence and injuries.

c) Promoting and strengthening policies and programs for prevention of violence and injuries, and implementing relevant population-level prevention and health promotion activities.

d) Establishing or strengthening national agencies for road safety with the authority and responsibility to make decisions, administer resources, and coordinate actions across relevant government sectors.

e) Promoting intersectoral collaboration for the creation of mass transit systems to help diminish the individual use of motor vehicles and encourage the use of safer, cleaner modes of transportation in order to reduce exposure to the risk of road traffic injuries, reduce diseases caused by motor vehicle emissions, and increase physical activity.

f) Promoting the development of infrastructure conducive to safe transit for all users of roads and highways, particularly pedestrians, cyclists, and motorcyclists, who are the most vulnerable road users.

Outcome 16. Intersectoral action on mental health Increased promotion of mental health, reduction of substance use disorders, prevention of mental health conditions[36] and suicide, and diminished stigmatization, through intersectoral action		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
16.a Number of countries and territories with ongoing collaboration between government mental health services and other departments, services, and sectors	15 (2019)	30

26. **Scope:** Mental, neurological, and substance use disorders are a leading cause of morbidity, mortality, and disability in the Americas, and are influenced by complex interaction of genetic and environmental factors. Substance use is strongly linked to premature mortality, as well as to numerous adverse social and health consequences. Likewise, suicide, for which mental disorders and substance abuse are key risk factors, is a significant and growing public health concern in the Region, representing the third leading cause of death in young adults aged 20 to 24. Half of all mental illnesses begin by the age of 14 and three-quarters by the mid-20s, creating the need for joint early action that promotes positive mental health and prevents the development of mental disorders.

[36] Mental health conditions include mental, neurological, and substance use disorders.

27. The scope of technical work for this outcome will include development of intersectoral policies, and plans, as well as legislation, aimed at maximizing the psychological and overall well-being of individuals and populations. Additional actions will focus on strengthening the capacity of the health system and other sectors for the prevention, surveillance, early detection, treatment, and health promotion activities related to mental health and substance use disorders and their respective risk factors throughout the life course. Education, in the form of mental health literacy, coping skills, and life skills development, will help to reduce stigma, promote positive mental health, and minimize risk for mental disorders, alcohol and substance use disorders, and suicide. Priority psychosocial interventions will target youth and adolescents as well as groups in conditions of vulnerability.

28. Work toward this outcome will promote collaboration and action across diverse entities (government agencies and ministries, nonprofits, academic organizations, civil society, private sector, and so on, as appropriate) throughout the planning and implementation processes. The participation and inclusion of people who have lived experiences of mental health issues will be emphasized.

Outcome 17. Elimination of communicable diseases Health systems strengthened to achieve or maintain the elimination of transmission of targeted diseases		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
17.a Number of countries and territories that achieve 90% of viral suppression (viral load <1,000 copies/ml) in persons on antiretroviral therapy (ART)	2 (2017)	15
17.b Number of countries and territories with >80% of malaria cases investigated and classified in areas targeted for elimination or prevention of reestablishment	22 out of 34 (2019)	28 out of 34 countries
17.c.(a-g) Interruption of transmission of neglected infectious diseases (NID) in countries, following WHO criteria and guidelines	-	-
a. Trachoma	1 out of 4 (2019)	3 out of 4
b. Chagas disease	17 out of 21 (2019)	21 out of 21
c. Dog-mediated human rabies	28 out of 35 (2019)	35 out of 35
d. Human taeniasis/cysticercosis	0 out of 16 (2019)	5 out of 16
e. Lymphatic filariasis	3 out of 7 (2019)	6 out of 7

Outcome 17. Elimination of communicable diseases Health systems strengthened to achieve or maintain the elimination of transmission of targeted diseases		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
f. Onchocerciasis	4 out of 6 (2019)	6 out of 6
g. Schistosomiasis	3 out of 10 (2019)	5 out of 10
17.d Number of countries and territories with established capacity and effective processes to eliminate human rabies transmitted by dogs	30 (2019)	35
17.e Number of countries and territories in which endemic transmission of measles or rubella virus has been reestablished	1 (2018)	0
17.f Regional average coverage of newborns with hepatitis B vaccine during the first 24 hours of life	76% (2017)	95%
17.g Number of countries and territories reporting cases of paralysis due to wild poliovirus or the circulation of vaccine-derived poliovirus (cVDPV) in the past year	0 (2017)	0

29. **Scope:** This outcome addresses the elimination of targeted diseases, including selected neglected diseases and zoonoses. Efforts will concentrate on eliminating diseases as public health problems and on eliminating transmission and/or maintaining the elimination status of selected diseases of public health importance. Interventions for elimination will address social and environmental determinants as well as equity and human rights as barriers to access. Emphasis will be on:

a) Increasing access to interventions that target the elimination of neglected diseases as public health problems, as defined in Document CD55/15 (2016).

b) Increasing access to interventions that target the elimination of mother-to-child transmission of HIV and congenital syphilis.

c) Increasing access to interventions that target the elimination of local malaria transmission within and between Member States and the prevention of the spread, reintroduction, and reestablishment of the disease, as defined in Document CD55/13 (2016).

d) Increasing access to interventions to eliminate, prevent, rapidly detect, and respond to the reintroduction and reestablishment of foot-and-mouth disease.

e) Maintaining the elimination of selected vaccine-preventable diseases.

Outcome 18. Social and environmental determinants Increased capacity of health actors to address social and environmental determinants of health with an intersectoral focus, prioritizing groups in conditions of vulnerability		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
18.a Number of countries and territories with capacity to implement and monitor policies to address social determinants of health	6 (2019)	9
18.b Number of countries and territories with capacity to prevent key occupational diseases	3 (2019)	7
18.c Proportion of population using safely managed drinking water services	57.5% in eight countries and territories (2019)	75%
18.d Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water	38% in 11 countries and territories (2019)	50%
18.e Proportion of population with primary reliance on clean fuels and technology	87% in 23 countries (2019)	89%
18.f Number of cities with population ≥500,000 inhabitants (or at least the major city of the country) in each country and territory that are within or making progress toward meeting the WHO Air Quality Guidelines for the annual mean of fine particulate matter (PM2.5)	TBD based on a calculation for 44 cities (2019)	Target cities reduce levels of PM2.5 by 20%, in at least 35 of the 44 cities, as compared to 2019
18.g Number of countries and territories with capacity to address health in chemical safety (including human health exposure to metals and/or pesticides)	7 (2019)	22
18.h Number of countries and territories with capacity to address the health-related effects of climate change	13 (2017)	25

30. **Scope:** Consistent with the 2030 Agenda for Sustainable Development and the Sustainable Health Agenda for the Americas 2018-2030, work toward this outcome seeks to reduce the adverse health effects attributable to social and environmental determinants of health and to increase health equity. The following are essential in this regard:

a) Scaling up action on the social and environmental determinants of health in the area of primary prevention, in accordance with the 2030 Agenda for Sustainable Development and based on a risk management approach.

b) Promoting intersectoral action to address the social and environmental determinants of health in policies in all sectors.

c) Strengthening the health sector's capacity to implement the essential public health functions, particularly in the areas of surveillance, capacity building for service provision, and control and analysis of determinants of health and their impacts on public health.

d) Building mechanisms for governance and political and social support.

e) Producing and providing new evidence on risks and solutions, and efficient communication to stakeholders to guide choices and investments.

f) Monitoring progress to guide actions toward the achievement of the Sustainable Development Goals.

g) Ensuring special consideration for small island states and other isolated islands with respect to environmental impact on health.

Outcome 19. Health promotion and intersectoral action Health promotion strengthened and inequities reduced, using the Health in All Policies approach, health diplomacy, and intersectoral action		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
19.a Number of countries and territories that implement the Health in All Policies framework to improve health equity as well as health and well-being	6 (2019)	16
19.b Number of countries and territories that have integrated health promotion into health services based on the principles of primary health care	7 (2019)	14
19.c Number of countries and territories that are implementing policies or strategies based on regional guidance for healthy schools	8 (2019)	13

31. **Scope:** Health is largely created through actions outside the health sector. Work toward this outcome seeks to ensure a renewed focus on health promotion and on use of the Health in All Policies (HiAP) approach to create health and well-being and reduce health inequities. It focuses on developing and strengthening public health policies and on advocacy for the development of public policies across sectors, with systematic and holistic consideration of the health implications of decisions and actions in other sectors. Key elements of health promotion and HiAP strategies involve action at all levels of government, with a strong focus on engaging with local governments, and the creation of healthy settings in schools, homes, and workplaces. The empowerment and participation of people, families, and communities is essential to this approach, as is engagement with

civil society, the private sector, and academia. This outcome aims to strengthen the advocacy, health diplomacy, and stewardship role of the health sector, which is critical for the success of this whole-of-government and whole-of-society strategy, while strengthening health systems and services through health promotion.

Outcome 20. Integrated information systems for health Integrated information systems for health developed and implemented with strengthened capacities in Member States and the Pan American Sanitary Bureau		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
20.a Number of countries and territories that implement integrated interoperable information systems for health that include subnational disaggregation	7 (2019)	18

32. **Scope:** Work toward this outcome focuses on the development and implementation of integrated, interoperable information systems for health in countries and territories, with ethically used data from various sources, using effective information and communication technologies (ICTs) to generate disaggregated strategic information for the benefit of public health. Capacity building within countries and PASB is an integral part of this effort, including the sustained registration and availability of data. This outcome supports country efforts to implement information systems that ensure universal and timely open access to data and strategic information, using the most cost-effective tools to improve policy making and decision making, measurement and monitoring of health inequalities, measurement of progress toward achieving universal health, and public health surveillance.

Outcome 21. Data, information, knowledge, and evidence Increased capacity of Member States and the Pan American Sanitary Bureau to generate, analyze, and disseminate health evidence and translate knowledge for decision making at national and subnational levels		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
21.a Number of countries and territories with functional governance for generating and using evidence integrated into health systems	7 (2019)	15
21.b Number of countries and territories that generate, analyze, and use data and information according to health priorities, disaggregated by geopolitical and demographic strata, as appropriate to the national context	8 (2019)	51
21.c Number of countries and territories with established mechanisms on knowledge management, multilingualism, open access, and publishing	11 (2019)	26

33. **Scope:** Work toward this outcome seeks to strengthen capacity for knowledge management and knowledge translation[37] in health. This includes generating, capturing, disseminating, and sharing multilingual scientific and technical information, adopting best practices and lessons learned, and increasing the capacity to access and use this information. The emphasis is on strengthening knowledge networks, providing equitable access, and reaching a broader audience by adopting an approach based on multilingualism,[38] among other strategies.

34. This outcome also ensures the capacity to establish and implement data analytics and evidence to impact as key drivers for equitable, effective, and people-centered policies, systems, and practices. The aim is to develop innovative approaches for Member States to use data and evidence for decision making and policy making.

Outcome 22. Research, ethics, and innovation for health Strengthened research and innovation to generate solutions and evidence to improve health and reduce health inequalities		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
22.a Number of countries and territories implementing a funded policy, strategy and/or agenda on research and innovation for health	7 (2019)	17
22.b Number of countries and territories that have ethical standards for conducting research with human subjects	15 (2019)	23

35. **Scope:** Work toward this outcome seeks to ensure capacity to conduct and use relevant and appropriate ethical research for health. This includes supporting country efforts to exercise functional research governance (policies, agendas, and priorities for health research, monitoring, evaluation, and accountability); establishing and applying research norms, standards, and good practices; ensuring adequate human and financial resources in health research; facilitating intersectoral coordination; and ensuring uptake, evaluation, publication, and dissemination of research. It also focuses on promoting and enabling innovative solutions to health problems (new analytical methods, digital health, social media, and communication technologies, among others) based on collaboration, transparency, and sustainability.

[37] In the context of WHO, the term "knowledge translation" refers to "the synthesis, exchange, and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health" (see https://www.who.int/ageing/projects/knowledge_translation/en/).

[38] In WHO, the term "multilingualism" is used in the context of promoting "respect for the diversity of cultures and the plurality of international languages for improving health policies in the world, especially in the developing countries, and for giving all Member States access to information and to scientific and technical cooperation" (Resolution WHA71.15 [2018]).

Outcome 23. Health emergencies preparedness and risk reduction Strengthened country capacity for all-hazards health emergency and disaster risk management for a disaster-resilient health sector		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
23.a Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies	26 (2019)	40
23.b Number of States Parties[39] meeting and sustaining International Health Regulations (IHR) requirements for core capacities	N/A[40]	35

36. **Scope:** Work toward this outcome seeks to ensure that all countries and territories in the Region are prepared and ready to manage the health impact of emergencies and disasters caused by any type of hazard. PASB will work with countries, territories, and partners to increase their capacities in all phases of emergency management through implementation of the International Health Regulations (IHR) and the Sendai Framework for Disaster Risk Reduction (SFDRR).

37. PASB will work collaboratively to progressively strengthen the capacity of national and subnational levels and local communities to reduce and manage health emergencies using an all-hazards approach and by building strong people-centered and public health-oriented health systems, institutions, and networks. Support will focus on increasing the sustainability of the essential public health functions, the corresponding IHR core capacities, and the SFDRR priorities for action. Interventions will target institutional planning, organization, financing, and coordination mechanisms to enhance the development and streamlining of a national suite of legal instruments, policies, plans, and standard operating procedures encompassing all hazards in an interoperable manner. They will also target development of action-oriented frameworks that governments and relevant stakeholders can implement in a supportive and complementary manner and that facilitate identification of risks to be managed, with corresponding investments to build resilience. PASB will promote compliance with IHR provisions related to reporting to the World

[39] Thirty-five Member States of PAHO are States Parties to the International Health Regulations.

[40] To be achieved, as per Decision WHA71(15) and also taking into account Resolution WHA68.5 endorsing Document A68/22 Add.1, States Parties must have improved the scores, or maintained them (where the latter is higher than 0%), for at least 10 out of the 13 core capacities. The core capacities scores for States Parties failing to submit their State Party Annual Report to the WHA in any given year will be regarded as 0%. The core capacities scores of the subsequent submission will be assessed against the most recent prior submission. As a result of a formal global consultative process held in 2018, a revised version of the proposed tool for submitting the State Party Annual Report to the WHA was introduced in 2019, and includes 13 revised capacities encompassing 24 indicators (http://www.who.int/iris/bitstream/10665/272432/1/WHO-WHE-CPI-2018.16-eng.pdf?ua=1 [accessed on 29 April 2019]). Therefore, no "Baseline 2019" is available.

Health Assembly,[41] and the adoption and monitoring of benchmarks for health emergencies and disaster preparedness. Emphasis will also be placed on increasing the operational readiness of countries and territories in high-risk conditions; increasing PASB's preparedness; implementing new and existing initiatives and plans of action, including Safe and Smart Hospitals initiatives; identifying and implementing inclusive strategies, particularly for groups in conditions of vulnerability; and ensuring the fundamental role and participation of both women and men.

38. PASB's work to build country preparedness relies on inter-programmatic work within the Bureau, involving the areas of universal health, health systems strengthening, antimicrobial resistance, maternal and child health, nutrition, and noncommunicable diseases, as well as disease-specific programs (such as those dealing with polio and arbovirus diseases), among others.

39. Achievement of this outcome will result in the protection and promotion of the physical, mental, and social well-being of populations, including the most vulnerable ones. It will also increase the resilience of the health systems, allowing for continuous operation and rapid recovery from health emergencies and disasters. The establishment of strategic alliances with political and administrative authorities, public and private entities, nongovernmental organizations, civil society, and all other sectors is key to achieving this outcome. Also important is the development of a regional culture of prevention, preparedness, and mitigation of health emergencies and disasters that incorporates the rights and contributions of individuals, families, and communities.

[41] The IHR Monitoring and Evaluation Framework (IHR MEF) includes one mandatory component, namely the State Party Annual Report, and three voluntary ones: After-Action Review of Public Health Events, Simulation Exercises, and Voluntary External Evaluations, including Joint External Evaluations.

Outcome 24. Epidemic and pandemic prevention and control Countries' capacities strengthened to prevent and control epidemics and pandemics caused by high-impact and/or high-consequence pathogens		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
24.a Number of countries and territories with capacity to effectively respond to major epidemics and pandemics	N/A[42]	35
24.b Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine	0 (2019)	5

40. **Scope:** This area of work supports countries in surveillance, prevention, preparedness, and control of pandemic and epidemic-prone diseases (including influenza, Middle East respiratory syndrome (MERS), dengue, Zika virus, chikungunya, hemorrhagic fevers, hantavirus, yellow fever, emerging arboviruses, plague, cholera, epidemic-prone diarrheal diseases, leptospirosis, and meningococcal disease, among others). Capacity building will focus on forecasting, characterization of diseases and infectious risks, and development of evidence-based strategies to predict, prevent, detect, and respond to infectious hazards in the context of universal access to health. This includes developing and supporting prevention and control strategies, tools, and capacities for high-impact, high-consequence pathogens (including extremely resistant pathogens), and establishing and maintaining expert networks to leverage international expertise to detect, understand, and manage new and emerging pathogens. In the context of epidemics, people and communities should, without any kind of discrimination, have access to comprehensive, appropriate, timely, quality health services and technologies determined at the national level according to needs, as well as access to safe, effective, and affordable quality medicines, vaccines, and health supplies.

41. Work related to this outcome targets improved sharing of available knowledge and information on emerging and reemerging high-impact and/or high-consequence pathogens, enhancing surveillance and response to epidemic diseases with a strong focus on addressing groups in conditions of vulnerability, and working through networks to contribute to global mechanisms and processes. It also includes management of regional mechanisms to tackle the international dimension of epidemic diseases, with special emphasis on the Pandemic Influenza Preparedness Framework.

[42] To be achieved, as per Decision WHA71(15) and also taking into account Resolution WHA68.5 endorsing Document A68/22 Add.1, States Parties must have improved the scores, or maintained them (where the latter is higher than 0%), for at least 8 out of the 11 core capacities, considered critical for epidemic/pandemic prevention and control. The core capacities scores for States Parties failing to submit their State Party Annual Report to the WHA in any given year will be regarded as 0%. The core capacities scores of the subsequent submission will be assessed against the most recent prior submission. As a result of a formal global consultative process held in 2018, a revised version of the proposed tool for submitting the State Party Annual Report to the WHA was introduced in 2019, and includes 13 revised capacities encompassing 24 indicators (http://www.who.int/iris/bitstream/10665/272432/1/WHO-WHE-CPI-2018.16-eng.pdf?ua=1 [accessed on 29 April 2019]). Therefore, no "Baseline 2019" is available.

Outcome 25. Health emergencies detection and response Rapid detection, assessment, and response to health emergencies		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
25.a Percentage of acute public health events for which a risk assessment is completed within 72 hours	75% (2019)	100%
25.b Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies	75% (2019)	85%

42. **Scope:** To achieve this outcome, PASB will work with countries, territories, and partners to ensure early detection of potential emergencies and the provision of essential life-saving health services to emergency- and disaster-affected populations. Early detection, risk assessment, information sharing, and rapid response are essential to reduce illness, injury, death, and large-scale economic loss. To achieve this outcome, it is essential that PASB provide authoritative information for public health decision making in emergencies and disasters, including through actions such as identifying acute public health events, assessing risks to public health, conducting epidemiological surveillance and field investigations, monitoring public health interventions and operational capacities of health care services and facilities, and communicating public health information to technical partners.

43. A major focus in this area is working with countries, territories, and partners to implement response and early recovery operations. This includes providing essential health services and technologies to address new health issues associated with emergencies and disasters, as well as with preexisting health needs, focusing on groups in conditions of vulnerability. Key actions include coordination of the PAHO response team, emergency medical teams, the regional Global Outbreak Alert and Response Network (GOARN) network, and other partners; development of strategic response plans and joint operational planning; operational support and logistics; emergency crisis and risk communication; and activation of emergency response mechanisms in accordance with the PAHO/WHO Policy and Key Procedures on the Institutional Response to Emergencies and Disasters, underpinned by full support to the Incident Management System, consistent with the International Health Regulations (2005).

Outcome 26. Cross-cutting themes: equity, gender, ethnicity, and human rights Strengthened country leadership and capacity to advance health equity and gender and ethnic equality in health, within a human rights framework		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
26.a Number of countries and territories with institutional responses and accountability mechanisms that are advancing health equity, gender and ethnic equality in health, and human rights	N/A (2019)	18

44. **Scope:** This outcome is consistent with the commitment of the 2030 Agenda for Sustainable Development to "leave no one behind," and with efforts to accelerate advances toward universal health. It aims to ensure that all health sector policies, programs, and plans, including intersectoral action, address the persistent inequities in health that affect the enjoyment of the highest attainable standard of health by all people and population groups in the Region. Within action toward health equity, priority attention is given to ensuring that all actions are based on human rights; to addressing the gender and ethnic inequalities that often drive health inequities; and to addressing the situation of members of other groups in conditions of vulnerability, according to context.[43]

45. The scope of technical work includes support for health sector leadership for health equity, with priority setting at the highest level of health sector decision making; decision making and/or advocacy for normative and policy frameworks that promote health equity and equality, with respect for human rights; institutionalization of inclusive governance structures; creation of enabling environments for broad intersectoral collaboration; and adequate and sustainable human and financial resource allocation for health equity. It also involves strengthening capacity at all levels to identify and address health inequities and inequalities, and their drivers, in the planning and implementation of all health sector actions to advance equitable, gender- and culturally sensitive approaches to health within a human rights framework; to engage in intersectoral action with an equity and rights focus; to promote inclusive governance by ensuring strong and effective social participation of all relevant groups at all levels; and to implement evidence-based monitoring and evaluation that are equity-focused, gender- and culturally sensitive, and based on respect for human rights.

Outcome 27. Leadership and governance Strengthened PASB leadership, governance, and advocacy for health		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
27.a Proportion of countries and territories where the national health authority reports satisfaction with PAHO/WHO's leading role on global and regional health issues	No data (2019)	100%
27.b Number of countries and territories for which there is alignment between the national health policy, strategy, or plan and the outcomes defined in the PAHO Strategic Plan 2020-2025	20 (2019)	51
27.c Proportion of corporate risks with an approved mitigation plan implemented	50% (2019)	100%
27.d Percentage of approved PAHO (not AMRO) budget funded for each biennial Program Budget	TBD[44]	100%

[43] See footnote 17 in Outcome 1.
[44] Baseline for 2019 will be determined during the first quarter of 2020.

Outcome 27. Leadership and governance Strengthened PASB leadership, governance, and advocacy for health		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
27.e Percentage of PAHO Strategic Plan 2020-2025 outcome indicator targets achieved	To be determined based on final assessment of the SP14-19	90%

46. **Scope:** This outcome incorporates strategic leadership, governance, and advocacy functions to strengthen PAHO's leading role in health development in the Region. It includes reinforcing Member States' ability to take charge of their people's health and advancing toward regional priorities in health and health equity, as detailed in this Strategic Plan and in the Sustainable Health Agenda for the Americas 2018-2030. Work toward this outcome includes championing and advocating for health in support of Member States through the effective development and implementation of technical cooperation agendas; strengthening country presence to efficiently and effectively address national health needs; coordinating and convening relevant stakeholders, including other UN agencies and programs and relevant non-State actors, among others; further strengthening PAHO's governance mechanisms to ensure continuous engagement and oversight of Member States; strengthening managerial transparency, accountability, and risk management; maintaining a respectful workplace and underscoring the importance of ethical behavior at all levels of the Organization; strengthening policy development, strategic and operational planning, budget management, performance, monitoring and assessment, and reporting at all levels; ensuring effective, equitable, and efficient financing and management of resources to respond to the priorities in the Strategic Plan; providing the public with timely and accurate health information, including during emergencies; and better communicating the work of the Organization and its impact on progress in health throughout the Region.

Outcome 28. Management and administration Increasingly transparent and efficient use of funds, through improved PASB management of financial, human, and administrative resources		
Outcome Indicator	**Baseline (2019)**	**Target (2025)**
28.a Proportion of total human resource costs expended on management and administrative functions	TBD	10% reduction

47. **Scope:** This outcome covers the various enabling functions related to finance, human resources, information technology, procurement, and general services. The ultimate goal of these functions is to support PASB efforts to advance the regional health priorities detailed in this Strategic Plan and in the Sustainable Health Agenda for the Americas 2018-2030. A continuing commitment to accountability and transparency is important not only for measuring impact, but also as a foundation of the operational model.

48. PASB will continue expanding, consolidating, and strengthening the PASB Management Information System (PMIS) to increase the transparency and efficiency of its use of resources, focusing on improving performance and sustainability to support the implementation of strategic priorities at all levels of the Organization and at the country, subregional, and regional levels. Emphasis will be on strengthening corporate functions at normative and compliance levels and updating policies and procedures to respond to evolving needs, provide flexibility, and increase efficiencies. PASB is committed to attracting and retaining high-level performers in the various areas of public health (reflecting the high-level commitments to diversity and gender stated in the SDGs) and to offering staff development paths to better serve global, regional, and subregional initiatives.

49. PASB is committed to responding to the various emerging needs associated with public health emergencies. Business processes across the Organization will be coordinated, business continuity plans will be updated, and adequate training will be provided.

Annex B. Contribution to Health-Related SDG and GPW13 Impact Framework Indicators and to SHAA2030 Targets

This annex provides a comprehensive mapping of the Strategic Plan 2020-2025 (SP20-25) impact and outcome indicators (presented in Annex A) to three key reference frameworks: *a)* the targets and indicators associated with the United Nations Sustainable Development Goals (SDGs); *b)* the targets and indicators in the Impact Framework associated with the World Health Organization (WHO) 13th General Programme of Work 2019-2023; and *c)* the targets in the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030).

The mapping reflects the most direct relationship between the SP20-25 indicators and the indicators/targets in the frameworks mentioned above. Nevertheless, the SP20-25 indicators were developed to allow for regional specificity in order to respond to the priorities of Member States in the Region. Therefore, the mapping in Tables B.1 and B.2 may reflect an indirect contribution in some cases.

Table B.1. Contribution to the Health-Related Sustainable Development Goals and GPW13 Impact Framework

Note: Per WHO Document A72/5, the GPW13 Impact Framework comprises all indicators under SDG 3, plus SDG indicators 1.5.1, 1.8.2, 2.2.1, 2.2.2, 4.2.1, 5.2.1, 5.6.1, 6.1.1, 6.2.1,7.1.2, 11.6.2, and 16.2.1. In addition, the table also includes eight WHO-specific indicators that respond to other mandates or priorities of WHO Member States. PAHO will update the mapping as required, should there be any changes to the GPW13 impact framework.

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
3. Ensure healthy lives and promote well-being for all at all ages	**3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	**3.1.1** Maternal mortality ratio	**Impact Indicator 6** Maternal mortality ratio (MMR) (deaths per 100,000 live births)
		3.1.2 Proportion of births attended by skilled health personnel	**Outcome Indicator 2.c** Proportion of births attended at health facilities

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
			Outcome Indicator 2.d Proportion of births attended by skilled health personnel
	3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	**3.2.1** Under-five mortality rate	**Impact Indicator 4** Under-5 mortality rate
		3.2.2 Neonatal mortality rate	**Impact Indicator 3** Neonatal mortality rate
	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	**3.3.1** Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	**Impact Indicator 16** Incidence rate of HIV infections
		3.3.2 Tuberculosis incidence per 1,000 population	**Impact Indicator 20** Incidence rate of tuberculosis
		3.3.3 Malaria incidence per 1,000 population	**Impact Indicator 21** Incidence rate of malaria
		3.3.4 Hepatitis B incidence per 100,000 population	**Impact Indicator 19** Mortality rate due to chronic viral hepatitis
		3.3.5 Number of people requiring interventions against neglected tropical diseases	**Impact Indicator 24** Elimination of neglected infectious diseases in countries

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
	3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	**3.4.1** Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	**Impact Indicator 9** Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases
		3.4.2 Suicide mortality rate	**Impact Indicator 14** Mortality rate due to suicide
	3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	**3.5.1** Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	**Outcome Indicator 5.i** Number of countries and territories that have increased the rate of persons receiving treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders in the health service network
		3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	**Outcome Indicator 13.b** Total (recorded and unrecorded) alcohol per capita (APC) consumption among persons 15+ years of age within a calendar year in liters of pure alcohol, adjusted for tourist consumption
	3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	**3.6.1** Death rate due to road traffic injuries	**Impact Indicator 13** Number of deaths due to road traffic injuries

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	**3.7.1** Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	**Outcome Indicator 2.a** Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods
		3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	**Outcome Indicator 2.b** Fertility rate in women 10-19 years of age (disaggregated by 10-14 and 15-19 years) in Latin America and the Caribbean
	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	**3.8.1** Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	**Outcome Indicator 9.a** Number of countries and territories that have achieved, by 2025, a reduction of at least 10 percentage points in the population reporting access barriers to health services, as compared to 2020

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
		3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income	**Outcome Indicator 11.a** Number of countries and territories that have decreased by 20% the percentage of population in households experiencing out-of-pocket catastrophic health spending **Outcome Indicator 11.b** Number of countries and territories that have decreased by 10% the percentage of people in households experiencing impoverishment due to out-of-pocket health expenditure
	3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	**3.9.1** Mortality rate attributed to household and ambient air pollution	**Impact Indicator 26** Mortality rate attributed to household and ambient air pollution
		3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	**Impact Indicator 27** Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene
		3.9.3 Mortality rate attributed to unintentional poisoning	*The Region of the Americas will contribute through other reporting mechanisms: PAHO mortality database (includes accidental poisoning under leading cause of death), which can be combined with national data from poisoning control centers, as available*

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
	3.A Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	**3.A.1** Age-standardized prevalence of current tobacco use among persons aged 15 years and older	**Outcome Indicator 13.a** Age-standardized prevalence of current tobacco use among persons aged 15 years and older
	3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	**3.B.1** Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	**Outcome Indicator 8.a** Number of countries and territories that ensure that products listed on the essential medicines list are available without out-of-pocket expenditure at the point of care
		3.B.2 Total net official development assistance to medical research and basic health sectors	Ministry of Finance/Foreign Affairs report to Organisation for Economic Co-operation and Development (OECD)
	3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	**3.C.1** Health worker density and distribution	**Outcome Indicator 7.a** Number of countries and territories that have reduced the density gap with respect to physicians, nurses, and midwives, achieving at least 25 health workers per 10,000 population in underserved areas, keeping in mind the global target of 44.5 by 2030

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
	3.D Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	**3.D.1** International Health Regulations (IHR) capacity and health emergency preparedness	**Outcome Indicator 23.b** Number of States Parties meeting and sustaining International Health Regulations (IHR) requirements for core capacities
1. End poverty in all its forms everywhere	**1.5** By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters	**1.5.1** Number of deaths, missing persons and persons affected by disaster per 100,000 people	**Impact Indicator 28** Mortality rate due to disasters per 100,000 population
2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture	**2.2** By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	**2.2.1** Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	**Outcome Indicator 14.a** Prevalence of stunting in children under 5 years of age
		2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)	**Outcome Indicator 14.b** Prevalence of wasting in children under 5 years of age **Outcome Indicator 14.c** Prevalence of childhood overweight (under 5 years of age)

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	**4.2** By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	**4.2.1** Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	**Impact Indicator 5** Proportion of children under 5 who are developmentally on track in health, learning, and psychosocial well-being
5. Achieve gender equality and empower all women and girls	**5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	**5.2.1** Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	**Impact Indicator 12** Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months
	5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	**5.6.1** Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	*The Region does not currently have a reliable source for this indicator*
6. Ensure availability and sustainable management of	**6.1** By 2030, achieve universal and equitable access to safe and affordable drinking water for all	**6.1.1** Proportion of population using safely managed drinking water services	**Outcome Indicator 18.c** Proportion of population using safely managed drinking water services

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
water and sanitation for all	**6.2** By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	**6.2.1** Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water	**Outcome Indicator 18.d** Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water
7. Ensure access to affordable, reliable, sustainable and modern energy for all	**7.1** By 2030, ensure universal access to affordable, reliable and modern energy services	**7.1.2** Proportion of population with primary reliance on clean fuels and technology	**Outcome Indicator 18.e** Proportion of population with primary reliance on clean fuels and technology
8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	**8.8** Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment	**8.8.1** Frequency rates of fatal and non-fatal occupational injuries, by sex and migrant status	*SDG indicator not measured by PAHO*
9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation	**9.5** Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, by 2030, encouraging innovation and substantially increasing the number of research and development workers per 1 million people and public and private research and development spending	**9.5.1** Research and development expenditure as a proportion of GDP	**Outcome Indicator 22.a** Number of countries and territories implementing a funded policy, strategy and/or agenda on research and innovation for health

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
10. Reduce inequality within and among countries	**10.7** Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies	**10.7.2** Number of countries that have implemented well-managed migration policies	*This can be addressed through output indicators in the Program Budgets*
11. Make cities and human settlements inclusive, safe, resilient and sustainable	**11.5** By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations	**11.5.1** Number of deaths, missing persons and persons affected by disaster per 100,000 people	**Impact Indicator 28** Mortality rate due to disasters per 100,000 population
	11.6 By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management	**11.6.2** Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)	**Outcome Indicator 18.f** Number of cities with population ≥500,000 inhabitants (or at least the major city of the country) in each country and territory that are within or making progress toward meeting the WHO Air Quality Guidelines for the annual mean of fine particulate matter (PM2.5)

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
12. Ensure sustainable consumption and production patterns	**12.4** By 2020, achieve the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment	**12.4.1** Number of parties to international multilateral environmental agreements on hazardous waste, and other chemicals that meet their commitments and obligations in transmitting information as required by each relevant agreement	*This can be addressed through output indicators in the Program Budgets*
13. Take urgent action to combat climate change and its impacts	**13.1** Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries	**13.1.1** Number of deaths, missing persons and persons affected by disaster per 100,000 people	**Impact Indicator 28** Mortality rate due to disasters per 100,000 population
	13.2 Integrate climate change measures into national policies, strategies and planning	**13.2.1** Number of countries that have communicated the establishment or operationalization of an integrated policy/strategy/plan which increases their ability to adapt to the adverse impacts of climate change, and foster climate resilience and low greenhouse gas emissions development in a manner that does not threaten food production (including a national adaptation plan, nationally determined contribution, national communication, biennial update report or other)	**Outcome Indicator 18.h** Number of countries and territories with capacity to address the health-related effects of climate change

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
	13.3 Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning	**13.3.2** Number of countries that have communicated the strengthening of institutional, systemic and individual capacity-building to implement adaptation, mitigation and technology transfer, and development actions	**Outcome Indicator 18.h** Number of countries and territories with capacity to address the health-related effects of climate change
16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	**16.1** Significantly reduce all forms of violence and related death rates everywhere	**16.1.1** Number of victims of intentional homicide per 100,000 population, by sex and age	**Impact Indicator 11** Mortality rate due to homicide among youths 15-24 years of age
	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children	**16.2.1** Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	*The Region of the Americas will contribute through other reporting mechanisms*
17. Strengthen the means of implementation and revitalize the global partnership for sustainable development	**17.18** By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts	**17.18.1** Proportion of sustainable development indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics	**Outcome Indicator 20.a** Number of countries and territories that implement integrated interoperable information systems for health that include subnational disaggregation **Outcome Indicator 21.b** Number of countries and territories that generate, analyze, and use data and information according to health priorities, disaggregated by geopolitical and demographic strata, as appropriate to the national context

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
Health Emergencies	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases	**Outcome Indicator 24.b** Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine
Health Emergencies	Increase the number of vulnerable people in fragile settings provided with essential health services to at least 80%	Proportion of vulnerable people in fragile settings provided with essential health services	**Outcome Indicator 25.b** Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies
WHA68.3	Eradicate poliomyelitis to zero cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus	Number of cases of poliomyelitis caused by wild poliovirus (WPV)	**Outcome Indicator 17.g** Number of countries and territories reporting cases of paralysis due to wild poliovirus or the circulation of vaccine-derived poliovirus (cVDPV) in the past year
WHA68.7	ACCESS group antibiotics at ≥60% of overall antibiotic consumption	Patterns of antibiotic consumption at national level	**Outcome Indicator 8.f** Number of countries and territories that have implemented institutional frameworks, strategies, and/or legal frameworks for the assessment, selection, and rational use of medicines and other health technologies including antibiotics
WHA67.25, WHA68.7	Reduce the percentage of bloodstream infections due to selected antimicrobial resistant organisms by 10%	Percentage of bloodstream infections due to antimicrobial resistant organisms	**Impact Indicator 25** Number of bloodstream infections per 1,000 patients per year caused by carbapenem-resistant organisms

SDG	SDG Target	SDG Indicator	SP20-25 Indicator that Contributes to the SDG Indicator
WHA66.10	20% relative reduction in the prevalence of raised blood pressure	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	**Outcome Indicator 5.b** Number of countries and territories that reach a target of 35% prevalence of controlled hypertension at population level (<140/90 mmHg) among persons with hypertension 18+ years of age
WHA66.10	Eliminate industrially produced trans-fats (increase the percentage of people protected by effective regulation)	Percentage of people protected by effective regulation on trans-fats	**Outcome Indicator 13.d** Number of countries and territories that have eliminated industrially produced trans fatty acids
WHA66.10	Halt and begin to reverse the rise in obesity	Prevalence of obesity	**Outcome Indicator 14.c** Prevalence of childhood overweight (under 5 years of age) **Outcome Indicator 14.d** Prevalence of childhood and adolescent obesity (5-19 years of age)

Table B.2. Contribution to the Sustainable Health Agenda for the Americas 2018-2030

Note: Health-adjusted life expectancy (HALE) is considered a broad indicator that reflects all SHAA2030 goals and targets.

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
1. Expand equitable access to comprehensive, integrated, quality, people-, family-, and community-centered health services, with an emphasis on health promotion and illness prevention	**1.1** Reduce by at least 50% the regional mortality amenable to health care rate (MAHR)	**Impact indicator 7** Rate of mortality amenable to health care (MAHR) (deaths per 100,000 population)
	1.2 Reduce the regional maternal mortality ratio (MMR) to less than 30 per 100,000 live births in all population groups, including those at greatest risk of maternal death (i.e. adolescents, women of over 35 years of age, and indigenous, Afro-descendent, Roma, and rural women, among others, as applicable in each country)	**Impact indicator 6** Maternal mortality ratio (MMR) (deaths per 100,000 live births)
	1.3 Reduce the neonatal mortality rate to less than 9 per 1,000 live births in all population groups, including those most at risk (indigenous, Afro-descendent, Roma, and rural population, among others, as applicable in each country), and under-5 mortality to less than 14 per 1,000 live births	**Impact indicator 3** Neonatal mortality rate **Impact indicator 4** Under-5 mortality rate **Outcome Indicator 2.c** Proportion of births attended at health facilities **Outcome Indicator 2.d** Proportion of births attended by skilled health personnel
	1.4 Ensure universal access to sexual and reproductive health care services, including for family planning, information, and education, and the integration of reproductive health into national strategies and programs	**Outcome Indicator 2.a** Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 2.b Fertility rate in women 10-19 years of age (disaggregated by 10-14 and 15-19 years) in Latin America and the Caribbean
	1.5 Increase resolution capacity of the first level of care as measured by a 15% reduction in hospitalization that can be prevented with quality ambulatory care	**Outcome Indicator 1.a** Number of countries and territories that show a reduction of at least 10% in hospitalizations for ambulatory care sensitive conditions
	1.6 Organize health services into integrated health service delivery networks with high resolution capacity at the first level of care	**Outcome Indicator 1.b** Number of countries and territories that have implemented strategies to strengthen the response capacity of the first level of care
2. Strengthen stewardship and governance of the national health authority, while promoting social participation	**2.1** Achieve universal access to health and universal health coverage, according to the national context	**Outcome Indicator 9.a** Number of countries and territories that have achieved, by 2025, a reduction of at least 10 percentage points in the population reporting access barriers to health services, as compared to 2020
	2.2 Perform the essential public health functions according to established standards	**Outcome Indicator 9.b** Number of countries and territories that have reached at least 60% of their capacity to implement the Essential Public Health Functions
	2.3 Strengthen stewardship, governance, and transparency, including policies, plans, rules, and processes for health system organization and mechanisms for monitoring and evaluation	*This can be addressed through output indicators in the Program Budgets*
	2.4 Develop and strengthen mechanisms, as applicable, for the regulation of health service delivery in order to expand access and improve quality	*This can be addressed through output indicators in the Program Budgets*

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	2.5 Increase the participation of all stakeholders, including civil society and communities, in the policy-making and evaluation process relating to Health in All Policies to reduce health inequities	**Outcome Indicator 19.a** Number of countries and territories that implement the Health in All Policies framework to improve health equity as well as health and well-being **Outcome Indicator 19.c** Number of countries and territories that are implementing policies or strategies based on regional guidance for healthy schools
3. Strengthen the management and development of human resources for health (HRH) with skills that facilitate a comprehensive approach to health	**3.1** Ensure adequate availability of a health workforce (44.5 health workers per 10,000 population) that is qualified, culturally and linguistically appropriate, and well distributed	**Outcome Indicator 7.a** Number of countries and territories that have reduced the density gap with respect to physicians, nurses, and midwives, achieving at least 25 health workers per 10,000 population in underserved areas, keeping in mind the global target of 44.5 by 2030
	3.2 Develop HRH policies and intersectoral coordination and collaboration mechanisms between health and education, as well as other social actors, to address the requirements of the health system and the health needs of the population	*This can be addressed through output indicators in the Program Budgets*
	3.3 Strengthen the quality of professional health education in collaboration with the education sector, through evaluation systems and the accreditation of training institutions and degree programs	*This can be addressed through output indicators in the Program Budgets*
	3.4 Develop working conditions that foster the attraction and retention of health personnel, as well as their participation in and commitment to health management, including through collaboration with organizations representing health workers (unions and syndicates) and other social actors	*This can be addressed through output indicators in the Program Budgets*

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
4. Achieve adequate and sustainable health financing with equity and efficiency, and advance toward protection against financial risks for all persons and their families	**4.1** Achieve a level of public expenditure in health of at least 6% of GDP	**Outcome Indicator 10.a** Number of countries and territories that have increased public expenditure on health to at least 6% of GDP **Outcome Indicator 10.b** Number of countries and territories that have allocated at least 30% of the public expenditure in health to the first level of care
	4.2 Reduce out-of-pocket expenditure on health in collaboration with the financing authorities	**Outcome Indicator 11.a** Number of countries and territories that have decreased by 20% the percentage of population in households experiencing out-of-pocket catastrophic health spending **Outcome Indicator 11.b** Number of countries and territories that have decreased by 10% the percentage of people in households experiencing impoverishment due to out-of-pocket health expenditure
	4.3 Develop and strengthen policies and strategies to reduce the segmentation of health system financing	*This can be addressed through output indicators in the Program Budgets*
	4.4 Implement policies and/or strategies to develop systems of purchase and payment to providers, which promote efficiency and equity in the allocation of strategic resources	*This can be addressed through output indicators in the Program Budgets*
	4.5 Develop and strengthen strategies to reduce segmentation and improve the mechanisms for health financing, in collaboration with relevant decision-makers and actors, that promote efficiency and equity in the allocation of resources	*This can be addressed through output indicators in the Program Budgets*

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
5. Ensure access to essential medicines and vaccines, and to other priority health technologies, according to available scientific evidence and the national context	**5.1** Ensure timely access to medicines on the national essential medicines list, and to priority health technologies, without any payment at the point of care, service, or dispensing of the medicine, according to the national context	**Outcome Indicator 8.a** Number of countries and territories that ensure that products listed on the essential medicines list are available without out-of-pocket expenditure at the point of care
	5.2 Reach 95% vaccination coverage in children under 5 years of age, through national vaccination programs	**Outcome Indicator 4.h** Number of countries and territories reporting at least 95% coverage of 3 doses of diphtheria, pertussis, and tetanus-containing vaccine (DPT3) in 80% of municipalities
	5.3 Have in place a national regulatory authority for medicines rated at level-3 capacity based on the WHO global benchmarking tool	**Outcome Indicator 8.b** Number of countries and territories with regulatory systems that reach level 3 under the WHO Global Benchmarking Tool (GBT)
	5.4 Implement health technology assessment methodologies in the decision-making processes for incorporation in health systems	**Outcome Indicator 8.f** Number of countries and territories that have implemented institutional frameworks, strategies, and/or legal frameworks for the assessment, selection, and rational use of medicines and other health technologies including antibiotics
	5.5 Implement the requirements of the international Basic Safety Standards in diagnostic and therapeutic services that use radiation health technologies	**Outcome Indicator 8.d** Number of countries and territories that have regulations and oversight that ensure access to quality and safe radiological services

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	5.6 Promote only and exclusively non-remunerated, repeated, voluntary blood donations, and discourage remunerated and family/replacement donations except where protected by the national regulatory system	**Outcome Indicator 8.c** Number of countries and territories that increase the number of units of blood available for transfusion per thousand inhabitants (UBAT) by at least 5% per year to reach the target of 30 UBAT
	5.7 Strengthen national, subregional and regional mechanisms for negotiation and purchasing to improve the capacity of countries to obtain more affordable and equitable prices for medicines, vaccines, and other health technologies	*This can be addressed through output indicators in the Program Budgets*
	5.8 Taking into account public health perspectives, strengthen the capacity to implement intellectual property policies and health policies that promote research and development of medicines, vaccines and other health technologies for communicable and noncommunicable diseases that primarily affect developing countries and that promote access to affordable medicines, vaccines, and other health technologies	*This can be addressed through output indicators in the Program Budgets*
6. Strengthen information systems for health to support the development of evidence-based policies and decision-making	**6.1** Develop a national policy for interoperable information systems for health to generate, identify, collect, process, analyze, store, and make quality data and strategic information free and publicly available for better policy- and decision-making in public health and health planning	**Outcome Indicator 20.a** Number of countries and territories that implement integrated interoperable information systems for health that include subnational disaggregation
	6.2 Strengthen information systems for health to support the assessment of the national health system performance, as well as the monitoring and reporting on progress toward achievement of national, regional, and global health objectives, including the health-related SDGs, and SHAA2030 targets, among others	**Outcome Indicator 20.a** Number of countries and territories that implement integrated interoperable information systems for health that include subnational disaggregation

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 21.b Number of countries and territories that generate, analyze, and use data and information according to health priorities, disaggregated by geopolitical and demographic strata, as appropriate to the national context
	6.3 Strengthen capacity for analysis and the use of information for decision-making at the national and subnational levels	**Outcome Indicator 21.a** Number of countries and territories with functional governance for generating and using evidence integrated into health systems **Outcome Indicator 21.b** Number of countries and territories that generate, analyze, and use data and information according to health priorities, disaggregated by geopolitical and demographic strata, as appropriate to the national context
7. Develop capacity for the generation, transfer, and use of evidence and knowledge in health, promoting research, innovation, and the use of technology	**7.1** Develop health research policies that lead to funding of at least 2% of the health budget for public health research	**Outcome Indicator 22.a** Number of countries and territories implementing a funded policy, strategy and/or agenda on research and innovation for health
	7.2 Develop institutional capacities, infrastructure, technology, and qualified human resources for public health research and its dissemination, in accordance with national health policy	**Outcome Indicator 22.b** Number of countries and territories that have ethical standards for conducting research with human subjects

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	7.3 Develop and strengthen strategies and plans on digital health (eHealth)	**Outcome Indicator 20.a** Number of countries and territories that implement integrated interoperable information systems for health that include subnational disaggregation
8. Strengthen national and regional capacities to prepare for, prevent, detect, monitor, and respond to disease outbreaks, and emergencies and disasters that affect the health of the population	**8.1** Reduce the number of cases of death, disability, and illness, with emphasis on protection of the poor and vulnerable populations affected by emergencies and disasters	**Impact Indicator 28** Mortality rate due to disasters per 100,000 population
	8.2 Bolster essential public health functions in order to strengthen resilience and adaptability to climate and other hazards in the health sector	**Outcome Indicator 23.a** Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies **Outcome Indicator 23.b** Number of States Parties meeting and sustaining International Health Regulations (IHR) requirements for core capacities **Outcome Indicator 24.a** Number of countries and territories with capacity to effectively respond to major epidemics and pandemics **Outcome Indicator 24.b** Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine **Outcome Indicator 25.a** Percentage of acute public health events for which a risk assessment is completed within 72 hours

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 25.b Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies
	8.3 Meet and sustain the critical capacities for health emergencies, including the IHR core capacities	**Outcome Indicator 23.a** Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies **Outcome Indicator 23.b** Number of States Parties meeting and sustaining International Health Regulations (IHR) requirements for core capacities **Outcome Indicator 24.a** Number of countries and territories with capacity to effectively respond to major epidemics and pandemics **Outcome Indicator 24.b** Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine **Outcome Indicator 25.a** Percentage of acute public health events for which a risk assessment is completed within 72 hours **Outcome Indicator 25.b** Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	8.4 Have critical capacity in place to respond to any type of emergency or disaster (early warning systems, emergency operation centers, risk communication, and safe hospitals)	**Outcome Indicator 23.a** Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies **Outcome Indicator 23.b** Number of States Parties meeting and sustaining International Health Regulations (IHR) requirements for core capacities **Outcome Indicator 24.a** Number of countries and territories with capacity to effectively respond to major epidemics and pandemics **Outcome Indicator 24.b** Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine **Outcome Indicator 25.a** Percentage of acute public health events for which a risk assessment is completed within 72 hours **Outcome Indicator 25.b** Percentage of countries and territories providing an essential package of life-saving health services in all graded emergencies
9. Reduce morbidity, disabilities, and mortality from noncommunicable diseases, injuries, violence, and mental health disorders	**9.1** Reduce premature mortality from noncommunicable diseases by one-third through prevention and treatment, and promote mental health and well-being	**Impact Indicator 9** Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Impact Indicator 10 Mortality rate due to cervical cancer **Outcome Indicator 5.a** Number of countries and territories that achieve the 2025 global NCD target to halt the rise in diabetes assessed by age-standardized prevalence of raised blood glucose/diabetes among adults aged 18+ years **Outcome Indicator 5.b** Number of countries and territories that reach a target of 35% prevalence of controlled hypertension at population level (<140/90 mmHg) among persons with hypertension 18+ years of age **Outcome Indicator 5.c** Number of countries and territories with cervical cancer screening programs that achieve at least 70% coverage of screening in women aged 30-49 years, or for the age group defined by the national policy **Outcome Indicator 13.b** Total (recorded and unrecorded) alcohol per capita (APC) consumption among persons 15+ years of age within a calendar year in liters of pure alcohol, adjusted for tourist consumption **Outcome Indicator 13.c** Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 13.d Number of countries and territories that have eliminated industrially produced trans fatty acids **Outcome Indicator 13.e** Age-standardized prevalence of insufficiently physically active persons aged 18+ years
	9.2 Apply the WHO Framework Convention on Tobacco Control (FCTC) according to the national context	**Outcome Indicator 13.a** Age-standardized prevalence of current tobacco use among persons aged 15 years and older
	9.3 Ensure access to comprehensive habilitation/rehabilitation services, including access to assistive technologies and support services for all those in need, and promote implementation of the community-based rehabilitation strategy, among others	**Outcome Indicator 5.f** Number of countries and territories that have tertiary care centers that provide rehabilitation services with multi-disciplinary teams for complex injuries
	9.4 Contribute to the significant reduction of violence and its impact on health, in collaboration with other government and nongovernmental actors	**Impact Indicator 11** Mortality rate due to homicide among youths 15-24 years of age **Impact Indicator 12** Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months **Outcome Indicator 6.b** Number of countries and territories that provide comprehensive post-rape care services in a medical facility in every territorial and/or administrative unit, consistent with WHO guidelines for emergency health services

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 15.b Number of countries and territories that are implementing a national or multisectoral plan addressing violence that includes the health system
	9.5 Reduce by half the number of deaths and injuries caused by road traffic accidents	**Impact Indicator 13** Number of deaths due to road traffic injuries **Outcome Indicator 6.a** Number of countries and territories that minimize the time interval between road traffic crashes and the provision of first professional emergency care **Outcome Indicator 15.a** Number of countries and territories with an operational advisory committee or lead agency on road safety that supports the development and/or implementation of a national road safety strategy
	9.6 Increase universal access to mental health services, including the promotion of emotional well-being and its favorable conditions, prevention of psychosocial problems and mental disorders, and mental recovery in all stages of life, with a gender, intercultural, and community approach, through the integration of mental health care into primary care	**Impact Indicator 14** Mortality rate due to suicide **Outcome Indicator 5.g** Number of countries and territories that have increased capacity to manage mental health disorders at the first level of care **Outcome Indicator 5.h** Number of countries and territories that have increased the rate of persons admitted with mental disorders to general hospitals

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 16.a Number of countries and territories with ongoing collaboration between government mental health services and other departments, services, and sectors
	9.7 Contribute to ending all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and addressing the nutritional needs of adolescent girls, pregnant and lactating women, and older persons	**Outcome Indicator 14.a** Prevalence of stunting in children under 5 years of age **Outcome Indicator 14.b** Prevalence of wasting in children under 5 years of age **Outcome Indicator 14.c** Prevalence of childhood overweight (under 5 years of age) **Outcome Indicator 14.d** Prevalence of childhood and adolescent obesity (5-19 years of age) **Outcome Indicator 14.e** Prevalence of overweight and obesity in persons 18+ years of age **Outcome Indicator 14.f** Percentage of infants under 6 months of age who are exclusively breastfed
10. Reduce the burden of communicable diseases and eliminate neglected diseases	**10.1** End the AIDS epidemic	**Impact Indicator 16** Incidence rate of HIV infections **Outcome Indicator 4.a** Percentage of people with HIV who have been diagnosed

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 4.b Antiretroviral treatment (ART) coverage among persons living with HIV **Outcome Indicator 17.a** Number of countries and territories that achieve 90% of viral suppression (viral load <1000 copies/ml) in persons on Antiretroviral Therapy (ART)
	10.2 End the tuberculosis epidemic	**Impact Indicator 20** Incidence rate of tuberculosis **Outcome Indicator 4.d** Tuberculosis treatment coverage
	10.3 Eliminate mother-to-child transmission of HIV and congenital syphilis	**Impact Indicator 17** Rate of mother-to-child transmission of HIV **Impact Indicator 18** Incidence rate of congenital syphilis (including stillbirths) **Outcome Indicator 4.c** Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women
	10.4 Combat waterborne diseases and other communicable diseases	**Impact Indicator 15** Incidence rate of measles **Outcome Indicator 4.g** Number of countries and territories reporting at least 95% coverage at the national level of the second dose of measles and rubella-containing vaccine (MRCV)

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 4.i Number of countries and territories reporting at least 95% coverage of 3 doses of pneumococcus-containing vaccine at national level **Outcome Indicator 4.j** Number of countries and territories that have incorporated HPV vaccines in their national vaccination program **Outcome Indicator 17.d** Number of countries and territories with established capacity and effective processes to eliminate human rabies transmitted by dogs **Outcome Indicator 17.e** Number of countries and territories in which endemic transmission of measles or rubella virus has been reestablished **Outcome Indicator 17.g** Number of countries and territories reporting cases of paralysis due to wild poliovirus or the circulation of vaccine-derived poliovirus (cVDPV) in the past year
	10.5 Halt the transmission of viral hepatitis and accelerate the reduction of chronic infections and deaths from hepatitis to eliminate viral hepatitis as a major public health threat in the Region of the Americas	**Impact Indicator 19** Mortality rate due to chronic viral hepatitis **Outcome Indicator 17.f** Regional average coverage of newborns with hepatitis B vaccine during the first 24 hours of life

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	10.6 Eliminate local malaria transmission between Member States and prevent possible reestablishment of the disease	**Impact Indicator 21** Incidence rate of malaria **Impact Indicator 22** Number of endemic countries in 2015 that maintain or achieve elimination of malaria **Outcome Indicator 4.e** Number of endemic countries and territories with >70% of malaria cases diagnosed and treated within 72 hours of the start of symptoms **Outcome Indicator 17.b** Number of countries and territories with >80% of malaria cases investigated and classified in areas targeted for elimination or prevention of reestablishment
	10.7 Eliminate neglected infectious diseases as public health problems	**Impact Indicator 24** Elimination of neglected infectious diseases in countries **Outcome Indicator 12.b** Number of countries and territories where the entire endemic (by vector transmission) 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% **Outcome Indicator 17.c** Interruption of transmission of neglected infectious diseases (NID) in countries, following WHO criteria and guidelines

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
	10.8 Treat and prevent infectious diseases, including the responsible and rational use of safe, effective, accessible, and affordable quality-assured drugs	**Impact Indicator 25** Number of bloodstream infections per 1,000 patients per year caused by carbapenem-resistant organisms **Outcome Indicator 12.c** Number of countries and territories with increased antimicrobial resistance (AMR) surveillance capacity to guide public health interventions for decreasing the risk and preventing the spread of multidrug-resistant infections through intersectoral action
	10.9 Mitigate food safety risks	**Outcome Indicator 12.d** Number of countries and territories that have adequate mechanisms in place to prevent or mitigate risks to food safety
	10.10 Control the transmission of dengue, chikungunya, Zika, and yellow fever with an integrated and intersectoral approach	**Impact Indicator 23** Case-fatality rate due to dengue **Outcome Indicator 4.f** Number of countries and territories with capacity to conduct integrated surveillance of arbovirus cases **Outcome Indicator 24.b** Number of endemic countries and territories with ≥80% coverage for yellow fever vaccine

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
11. Reduce inequality and inequity in health through intersectoral, multisectoral, regional, and subregional approaches to the social and environmental determinants of health	**11.1** Demonstrate a marked reduction in health inequity gaps as measured by any of the following equity stratifiers: place of residence (rural/urban), race, ethnicity, occupation, gender, sex, age, education, and socioeconomic status using simple inequality measures (absolute and relative gap)	**Impact Indicator 1** Reduction of within-country health inequities **Outcome Indicator 18.a** Number of countries and territories with capacity to implement and monitor policies to address social determinants of health **Outcome Indicator 26.a** Number of countries and territories with institutional responses and accountability mechanisms that are advancing health equity, gender and ethnic equality in health, and human rights
	11.2 Reduce substantially the number of deaths and diseases "caused by hazardous chemicals [and by] air, water, and soil pollution, especially where environmental risk may be disproportionately impacting disadvantaged populations or communities	**Impact Indicator 26** Mortality rate attributed to household and ambient air pollution **Outcome Indicator 18.e** Proportion of population with primary reliance on clean fuels and technology **Outcome Indicator 18.f** Number of cities with population ≥500,000 inhabitants (or at least the major city of the country) in each country and territory that are within or making progress toward meeting the WHO Air Quality Guidelines for the annual mean of fine particulate matter (PM2.5)

SHAA2030 Goal	SHAA2030 Target	SP20-25 Indicator that Contributes to the SHAA2030 Target
		Outcome Indicator 18.g Number of countries and territories with capacity to address health in chemical safety (including human health exposure to metals and/or pesticides) **Outcome Indicator 18.h** Number of countries and territories with capacity to address the health-related effects of climate change
	11.3 Reduce significantly inequities related to water quality and sanitation by moving forward with the responsible sectors on access to water and sanitation services and the safe management thereof	**Impact Indicator 27** Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene **Outcome Indicator 18.c** Proportion of population using safely managed drinking water services **Outcome Indicator 18.d** Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water
	11.4 Generate policies that incorporate the safe and healthy mobility and migration of people	*This can be addressed through output indicators in the Program Budgets*
	11.5 Promote healthy, safe, and risk-free working environments for workers, including migrant workers and persons in precarious employment	**Outcome Indicator 18.b** Number of countries and territories with capacity to prevent key occupational diseases

Annex C. Prioritization Results

The process for national prioritization consultations for the Strategic Plan 2020-2025 was officially launched in December 2018. As of the date of publication for the Directing Council, 47 countries and territories in the Region identified their programmatic priorities using the PAHO-adapted Hanlon method. Table C.1 presents the regional consolidated prioritization results for outcomes 1-25 in the Strategic Plan 2020-2025.[1]

Table C.1. Consolidated Prioritization Results for the Strategic Plan 2020-2025

Priority Tier	Outcome No.	Outcome
High	5	Access to services for NCDs and mental health conditions
	13	Risk factors for NCDs
	12	Risk factors for communicable diseases
	25	Health emergencies detection and response
	23	Health emergencies preparedness and risk reduction
	14	Malnutrition
	1	Access to comprehensive and quality health services
	24	Epidemic and pandemic prevention and control
Medium	4	Response capacity for communicable diseases
	8	Access to health technologies
	2	Health throughout the life course
	10	Increased public health financing
	20	Integrated information systems for health
	16	Intersectoral action on mental health
	7	Health workforce
	17	Elimination of communicable diseases
	11	Strengthened financial protection
Low	9	Strengthened stewardship and governance
	3	Quality care for older people
	6	Response capacity for violence and injuries
	18	Social and environmental determinants
	19	Health promotion and intersectoral action
	15	Intersectoral response to violence and injuries
	21	Data, information, knowledge, and evidence
	22	Research, ethics, and innovation for health

[1] Outcomes 26, 27, and 28 were excluded from the prioritization exercise due to the corporate nature of their scope. For more details, see para. 74 of the Strategic Plan.

Annex D. Relevant Regional and Global Mandates

This annex contains the regional and global mandates that already are or will be supporting the achievement of the 2020-2025 results. New mandates that emerge during the period of the SP20-25 should be guided by this Plan and will contribute to its implementation.

Table D.1. Regional Mandates[1]

Resolution	Document Title
CD56.R2	Plan of Action on Entomology and Vector Control 2018-2023 (Document CD56/11)
CD56.R5	Plan of Action on Human Resources for Universal Access to Health and Universal Health Coverage 2018-2023 (Document CD56/10, Rev. 1)
CD56.R8	Plan of Action for Women's, Children's, and Adolescents' Health 2018-2030 (Document CD56/8)
CD56.R9	Plan of Action for Cervical Cancer Prevention and Control 2018-2030 (Document CD56/9)
CSP29.R2	Sustainable Health Agenda for the Americas 2018-2030 (Document CSP29/6, Rev. 3)
CSP29.R3	Policy on Ethnicity and Health (Document CSP29/7, Rev. 1)
CSP29.R4	Plan of Action for the Strengthening of Vital Statistics 2017-2022 (Document CSP29/9)
CSP29.R11	Plan of Action for the Sustainability of Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Americas 2018-2023 (Document CSP29/8)
CSP29.R12	Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018-2022 (Document CSP29/11)
CSP29.R15	Strategy on Human Resources for Universal Access to Health and Universal Health Coverage (Document CSP29/10)
CD55.R2	Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan (Document CD55/7)
CD55.R3	Framework of Engagement with Non-State Actors (Document CD55/8, Rev. 1)
CD55.R5	Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021 (Document CD55/14)
CD55.R6	Strategy for Arboviral Disease Prevention and Control (Document CD55/16)

[1] The list of regional mandates includes active mandates of the Pan American Sanitary Conference or Directing Council for the 2020-2025 period, per Directing Council document CD57/INF/3. Mandates whose periods of implementation expired prior to the 2020-2025 period, but whose resolutions nonetheless have yet to be closed in accordance with the requirements for reporting to Governing Bodies, have been included. Mandates that are being proposed for the 2019 Governing Bodies cycle will be considered to be part of this list, with the provision that the resolutions must be approved by the 57th Directing Council in order to be active. Similarly, mandates that are approved in Governing Bodies cycles for 2020, 2021, 2022, 2023, and 2024 will be developed in line with this Strategic Plan and will therefore be added to this list by virtue of their approval.

Resolution	Document Title
CD55.R7	Plan of Action for Malaria Elimination 2016-2020 (Document CD55/13)
CD55.R8	Resilient Health Systems (Document CD55/9)
CD55.R9	Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016-2022 (Document CD55/15)
CD55.R10	Plan of Action for Disaster Risk Reduction 2016-2021 (Document CD55/17, Rev. 1)
CD55.R11	Analysis of the Mandates of the Pan American Health Organization (Document CD55/18, Rev. 1)
CD55.R12	Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies (Document CD55/10, Rev. 1)
CD55.R13	Health of Migrants (Document CD55/11, Rev. 1)
CD54.R6	Plan of Action on Workers' Health (Document CD54/10, Rev. 1)
CD54.R7	Plan of Action for the Prevention and Control of Viral Hepatitis (Document CD54/13, Rev. 1)
CD54.R8	Plan of Action on Immunization (Document CD54/7, Rev. 2)
CD54.R9	Strategy on Health-related Law (Document CD54/14, Rev. 1)
CD54.R10	Plan of Action for the Prevention and Control of Tuberculosis (Document CD54/11, Rev. 1)
CD54.R11	Strategy and Plan of Action on Dementias in Older Persons (Document CD54/8, Rev. 1)
CD54.R12	Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women (Document CD54/9, Rev. 2)
CD54.R15	Plan of Action on Antimicrobial Resistance (Document CD54/12, Rev. 1)
CD54.R18	Method for the Estimation of Maternal Mortality in the Period 1990-2015 (Document CD54/23)
CD53.R2	Plan of Action on Health in All Policies (Document CD53/10, Rev. 1)
CD53.R6	Plan of Action for Universal Access to Safe Blood (Document CD53/6)
CD53.R7	Plan of Action on Mental Health (Document CD53/8, Rev. 1)
CD53.R8	Plan of Action for the Prevention of Blindness and Visual Impairment (Document CD53/11)
CD53.R9	Plan of Action for the Coordination of Humanitarian Assistance (Document CD53/12)
CD53.R12	Plan of Action on Disabilities and Rehabilitation (Document CD53/7, Rev. 1)
CD53.R13	Plan of Action for the Prevention of Obesity in Children and Adolescents (Document CD53/9, Rev. 2)
CD53.R14	Strategy for Universal Access to Health and Universal Health Coverage (Document CD53/5, Rev. 2)
CD52.R5	Principles of the Pan American Health Organization Revolving Fund for Vaccine Procurement (Document CD52/17)
CD52.R6	Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons (Document CD52/18)
CD52.R10	Chronic Kidney Disease in Agricultural Communities in Central America (Document CD52/8)
CD52.R13	Human Resources for Health: Increasing Access to Qualified Health Workers in Primary Health Care-based Health Systems (Document CD52/6)
CD52.R14	Evidence-based Policy-making for National Immunization Programs (Document CD52/9)

Resolution	Document Title
CD52.R15	Cooperation for Health Development in the Americas (Document CD52/11)
CSP28.R9	Health Technology Assessment and Incorporation into Health Systems (Document CSP28/11)
CSP28.R13	Strategy for the Prevention and Control of Noncommunicable Diseases (Document CSP28/9, Rev. 1)
CSP28.R15	Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards (Document CSP28/17, Rev. 1)
CSP28.R19	Coordination of International Humanitarian Assistance in Health in Case of Disasters (Document CSP28/13)
CD51.R4	Strategy and Plan of Action on Urban Health (Document CD51/5)
CD51.R7	Plan of Action on Psychoactive Substance Use and Public Health (Document CD51/9)
CD51.R8	Strategy and Plan of Action on Epilepsy (Document CD51/10, Rev. 1)
CD51.R14	Plan of Action to Reduce the Harmful Use of Alcohol (Document CD51/8, Rev. 1)
CD50.R2	Strategy on Substance Use and Public Health (Document CD50/18, Rev. 1)
CD50.R6	Strengthening the Capacity of Member States to Implement the Provisions and Guidelines of the WHO Framework Convention on Tobacco Control (Document CD50/26)
CD50.R8	Health and Human Rights (Document CD50/12)
CD50.R9	Strengthening National Regulatory Authorities for Medicines and Biologicals (Document CD50/20, Rev. 1)
CD50.R16	Health, Human Security and Well-being (Document CD50/17)
N/A	PAHO Results-Based Management Framework (Document CD50/INF/2)
CD49.R10	Policy on Research for Health (Document CD49/10)
CD49.R12	Plan of Action for Implementing the Gender Equality Policy (Document CD49/13)
CD49.R14	Plan of Action on Adolescent and Youth Health (Document CD49/12)
CD49.R15	Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (Document CD49/8)
CD49.R18	Policy Framework for Human Organ Donation and Transplantation (Document CD49/14)
CD49.R20	Health and Tourism (Document CD49/15)
CD48.R2	WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas (Document CD48/12)
CD48.R5	Regional Strategy for Improving Adolescent and Youth Health (Document CD48/8)
CD48.R9	Population-based and Individual Approaches to the Prevention and Management of Diabetes and Obesity (Document CD48/5)
CD48.R11	Preventing Violence and Injuries and Promoting Safety: A Call for Action in the Region (Document CD48/20)
CSP27.R10	Regional Policy and Strategy for Ensuring Quality of Health Care, Including Patient Safety (Document CSP27/16)
CD46.R16	PAHO Gender Equality Policy (Document CD46/12)
CD45.R7	Access to Medicines (Document CD45/10)

Table D.2. Global Mandates[2]

Resolution	Document Title
A/RES/70/1	Transforming our world: the 2030 Agenda for Sustainable Development
A71/4	Thirteenth General Programme of Work 2019-2030
N/A	International Health Regulations (2005), Second Edition
N/A	WHO Framework Convention on Tobacco Control (FCTC)

[2] Selected global mandates are included. The Strategic Plan will operationalize other global mandates as applicable.

Annex E. Accountability Mechanisms

1. Accountability is a critical component of any well-functioning organization that implements a Results-based Management approach (RBM) based on performance. PAHO is a leader in RBM, and the Organization also has multiple mechanisms in place to ensure that it is a good steward of donor funds and complies with established financial and human resource regulations and rules.

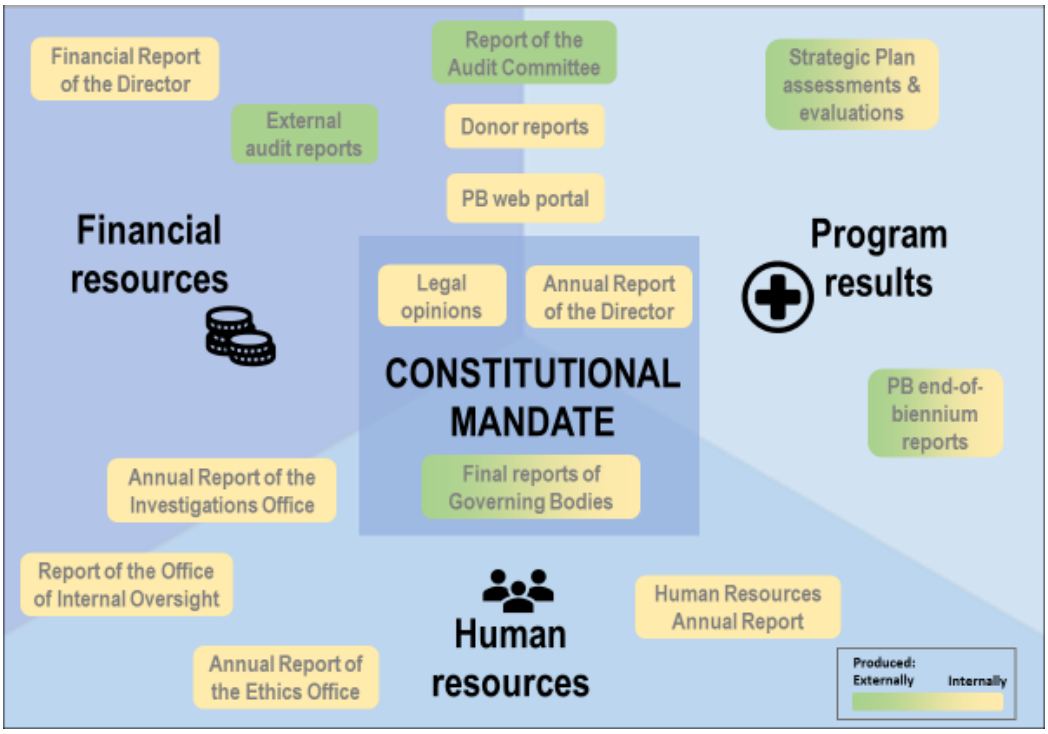
2. These mechanisms bring together the various elements of responsibility, transparency, and authority and are a part of the overall internal institutional governance and oversight framework of the Organization. Furthermore, they are based on PAHO's constitutional mandate and internal control systems and are linked with a series of products that demonstrate responsible use of financial resources by the Pan American Sanitary Bureau (PASB) for achieving programmatic objectives and results and PASB's compliance with financial and human resources regulations and rules.

3. PAHO's constitutional mandate and related institutional obligations are detailed in the Basic Documents of the Organization.[1] The foundational documents are the basis for all PAHO operations and contain many elements of the Organization's institutional accountability toward Member States.

4. Figure E.1 shows how the various external accountability mechanisms of the Organization relate to each other and where they fall in terms of financial, programmatic, and human resources, with PAHO's constitutional mandate at the center.

[1] The Basic Documents can be accessed at: https://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=11&Itemid=270&lang=en.

Figure E.1. Main Accountability Mechanisms



5. The remainder of this annex provides a short overview of the main mechanisms for corporate accountability during the 2020-2025 period. Where applicable, links are provided that give additional detail regarding each mechanism.

CONSTITUTIONAL MANDATE

Final Reports of Governing Bodies Sessions (produced by the Office of Governing Bodies in collaboration with the rapporteur of each Governing Bodies meeting)

6. The final reports of the Governing Bodies sessions are produced in accordance with the rules of procedure of each organ: the Pan American Sanitary Conference, the Directing Council, the Executive Committee, and the Subcommittee on Program, Budget, and Administration. Final reports include a report on the proceedings and all resolutions and decisions adopted by each organ. They are issued in the official languages of the Organization and also contain the agenda, list of documents discussed, and list of participants, with the names and titles of the delegates of each Member State present in the session. The President of the meeting and the Secretary ex officio sign the final report. The signed original copy of the final report is deposited in the archives of the Organization. An audio record of the verbatim proceedings is retained in the archives of the Organization and on request a copy must be made available to a Member or Associate Member. Final reports for each session are available on the Governing Bodies website.

Annual Report of the Director of the Pan American Sanitary Bureau

7. This report is submitted to Governing Bodies and provides a high-level overview of major achievements and challenges in the work of the Organization during the annual period covered. It summarizes PASB's technical cooperation with Member States, collaboration with key partners and stakeholders, and progress in realizing relevant public health objectives for the year within the framework of the Strategic Plan. Sample: CD56/3.

Legal Opinions (produced by the Office of the Legal Counsel)

8. The Office of the Legal Counsel provides unified and central legal services, advice, and counsel to PASB, Executive Management, and the Organization's Governing Bodies. Legal opinions, written and verbal, promote good governance, respect for the Organization's constitutional, legal, and administrative framework, and achievement of the Strategic Plans and objectives. Legal opinions also promote the achievement of the Organization's mission by safeguarding its privileges and immunities, reputation, and integrity and its status as an international public health organization

9. The Office of the Legal Counsel also works closely with other members of PAHO's Integrity and Conflict Management System to foster ethical behavior and compliance with the Organization's regulations and rules and to ensure effective conflict management, the right to due process, and consistency in decision making within the Organization. Web link: Office of the Legal Counsel (LEG).

GOVERNING BODIES DOCUMENTS

Financial Report of the Director (produced by the Department of Financial Resources Management)

10. The Financial Report of the Director contains the Financial Statements of the Pan American Health Organization and is prepared annually in accordance with International Public Sector Accounting Standards (IPSAS) and PAHO's Financial Regulations and Financial Rules. Where IPSAS does not address a particular issue, the appropriate International Financial Reporting Standard (IFRS) is applied.

11. The Financial Statements comprise the Statement of Financial Position, Statement of Financial Performance, Statement of Changes in Net Assets, Statement of Cash Flow, Statement of Comparison of Budget and Actual Amounts, and related notes. The Financial Statements form the definitive accountability mechanisms for all income and expenditures of the Organization. The Financial Report of the Director includes an annual Statement on Internal Control.

12. The Financial Statements of the Organization are authorized for issue by the Director of PAHO under the authority vested in her or him by the Pan American Sanitary Conference as stated in Resolution CSP28.R7 of September 2012. No other authority has the power to amend the Financial Statements after issuance.

13. The Financial Statements are supported by Annual Letters of Representation submitted by all cost center managers to the Director. These provide assurance on the functioning of internal controls within the managers' responsibilities as well as periodic (monthly or quarterly) financial closure and compliance certification reports by cost center managers. Sample: OD356.

External Audit Report

14. This report provides an independent opinion and Letter of Assurance on the annual consolidated Financial Statements of the Pan American Health Organization in accordance with International Standards on Auditing of the International Federation of Accountants (IFAC), the Audit Standards and Guidelines formulated by the United Nations Board of Auditors, and the International Standards of Supreme Audit Institutions (ISSAI). This report also summarizes the findings and recommendations of the external auditors with respect to internal control and governance matters.

15. The aim of the audit is to collaborate with PAHO in order to reach its objectives while supporting compliance with principles of transparency, legality, and sound financial management. Sample: OD351.

Report of the Audit Committee of PAHO

16. The Audit Committee presents an annual report to the Executive Committee. The report provides an independent assessment of findings and advice to the Director and the PAHO Member States on the operation of the Organization's financial control and reporting structures, on its risk management processes, and on the adequacy of the Organization's systems of internal and external controls, in accordance with internationally accepted standards and best practices. The Audit Committee meets twice per year. Audit Committee reports are available in each of the June sessions of the Executive Committee on the Governing Bodies website.

Report of the Office of Internal Oversight and Evaluation Services

17. This annual report is submitted to PAHO's Governing Bodies and provides an overview of the work undertaken by the Office of Internal Oversight and Evaluation Services (IES). The report presents IES's recommendations for improving the effectiveness and efficiency of risk management and internal controls in order to assist management in achieving its objectives. The report includes a summary of IES's internal audit assignments and of the provision of advisory services for evaluation assignments. Sample: CE162/22.

Annual Report of the Investigations Office

18. The annual report of the Investigations Office is an independent report to PAHO's Executive Committee specifying statistics and general trends with respect to matters handled by the Investigations Office and the outcome of the Office's activities during the preceding calendar year.

19. To guarantee and maintain functional independence, the Investigations Office reports directly to the Governing Bodies of PAHO through the Executive Committee. This allows the Office to demonstrate integrity, objectivity, and confidentiality, as well as to perform its mandate free from fear of retaliation and without any influence from staff, management, or third parties outside of the Organization. Web link: Investigations Office.

Program Budget End-of-Biennium Reports (produced by the Planning and Budget Department in collaboration with Member States and all entities throughout the Organization)

20. The end-of-biennium (EoB) reports are the principal means of institutional accountability for achievement of the objectives set out in PAHO's biennial Program Budgets (PB). The EoB report is produced in the year following the biennium (e.g., the PB16-17 was submitted to PAHO Governing Bodies in 2018: see CD56/5 and CD56/5, Add. I). The report contains the joint assessment of health output results conducted with Member States at country level, along with PASB's self-assessment at all levels. The report also accounts for budget (financial) funding and implementation versus planned amounts, and identifies lessons learned for use in subsequent Program Budgets.

Strategic Plan Assessments and Evaluations (produced by the Planning and Budget Department in collaboration with Member States and all entities throughout the Organization)

21. PAHO's six-year Strategic Plans are reported on every two years as a part of the Program Budget EoB reports, which also serve as interim, and eventually final, reports on progress in implementing the Strategic Plan. These reports document progress in achieving the objectives set out in the respective Plan, present the joint assessment of health outcome results conducted with Member States at country level, and include lessons learned that can be applied in future planning efforts. They constitute the main means of corporate accountability for programmatic implementation in PAHO. Sample: OD348.

Human Resources Annual Report (produced by the Department of Human Resources Management)

22. The PASB Human Resources Management report highlights human resources initiatives taken, including advances made in implementation of the PASB human resources strategy, and provides statistics on trends in the PASB workforce in a calendar year. Sample: CE162/25.

Annual Report of the Ethics Office

23. This report is submitted to the Governing Bodies of PAHO and outlines the activities, achievements, and challenges of the Ethics Office in a specific year. Areas covered include: *a)* advice and guidance provided to PASB personnel in response to consultations on ethical issues; *b)* training activities that have been undertaken to heighten awareness and mitigate against the risk of fraud and corruption, harassment, and other types of misconduct; *c)* new initiatives that have been implemented to ensure that PAHO remains an ethical organization with policies that reflect the latest industry practices; and *d)* future actions that will be taken to further enhance the ethical culture in PASB. Sample: CE162/8.

OTHER MECHANISMS (NOT SUBMITTED TO GOVERNING BODIES)

PAHO Program and Budget Web Portal (produced by the Planning and Budget Department)

24. The PAHO Program and Budget Portal provides a detailed view of the Organization's work, financing, and budgetary implementation progress. Information available through the portal presents a breakdown of PAHO's Program Budget, including budget and expense figures by results chain component and by country office. Link: https://open.paho.org/.

Donor Reports (produced by various organizational entities)

25. Progress reports are submitted to partners at varying intervals. These reports include programmatic and financial information on the results achieved through a project during a specific time frame, using a partner's financial contribution and corresponding PAHO inputs. The technical reports compare the stated anticipated results and targets with the results achieved, note the progress of related activities, and provide an assessment of the project's overall performance. These reports may vary significantly in terms of format, detail, and periodicity in accordance with the reporting requirements in the corresponding legal agreement.

Annex F. 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	**3**
40	French Guiana	GUF
41	Guadeloupe	GLP
42	Martinique	MTQ
	Kingdom of the Netherlands	**3**
43	Bonaire	BON
44	Saba	SAB
45	Sint Eustatius	STA
	United Kingdom of Great Britain and Northern Ireland	**6**
46	Anguilla	AIA
47	Bermuda	BMU
48	British Virgin Islands	VGB
49	Cayman Islands	CYM
50	Montserrat	MSR
51	Turks and Caicos	TCA

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