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### **REPORT OF THE END-OF-BIENNIUM ASSESSMENT OF THE PAHO PROGRAM AND BUDGET 2016-2017/SECOND INTERIM REPORT OF THE PAHO STRATEGIC PLAN 2014-2019**

**PAHO Results Report: 2016-2017**

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## **I. Foreword by the Director**

This end-of-biennium results report comes at a critical time for the Region. Not only have we transitioned to a new biennium, but we also rise to meet the challenge of implementing the ambitious commitments made by Member States in the Sustainable Health Agenda for the Americas 2018-2030. This report provides an opportunity to reflect on health gains, challenges, and lessons learned as the Region works to achieve the Sustainable Health Agenda while also fulfilling the commitments in the current PAHO Strategic Plan 2014-2019 during the period 2018-2019.

This report is a cornerstone of accountability and transparency for the Organization, and an expression of its ongoing commitment to make a measurable impact on health in all countries and territories of the Region. It also responds to the mandate from PAHO Member States (Resolution CD52.R8) for joint accountability and responsibility for implementation of the PAHO Strategic Plan and its respective Program and Budgets. The focus on high-level impact results sets the tone for what I hope will be substantive discussions and reflection on the successes and challenges of the past biennium.

There were many notable achievements in health in the Americas during 2016-2017: elimination of mother-to-child transmission of HIV and syphilis in six additional countries and territories, elimination of measles in the Region, elimination of maternal and neonatal tetanus in Haiti, verification of the elimination of onchocerciasis in Guatemala, and validation of the elimination of trachoma as a public health problem in Mexico. Countries have expanded access to quality care using a primary health care approach, such as through the *Mais Médicos* program that provides care for 40 million underserved Brazilians. Innovative approaches to improving maternal and child health proved successful in reducing mortality, as evidenced by the implementation of the Zero Maternal Deaths from Hemorrhage initiative and programs such as Casas Maternas in Nicaragua. Effective evidence-based interventions were implemented throughout the Region, such as the application of front-of-package nutritional warnings on food products. Finally, the Organization provided a timely and appropriate response to all emergencies with potential health impacts during 2016-2017, including the Zika virus response.

I would like to take this opportunity to thank Member States for their commitment to the joint assessment process, and I recognize the challenges some of our countries have faced in completing the exercise. Unique in the World Health Organization and in the United Nations community, this process has become a key means for the Pan American Sanitary Bureau and the countries to work together to ensure accountability for results. This assessment provides a critical perspective on our collective achievements, as well as on challenges that are hindering our progress.

I am confident that the lessons learned in this assessment will serve us well as we move forward to successfully close out the PAHO Strategic Plan 2014-2019 and redouble our efforts to implement the Sustainable Health Agenda for the Americas 2018-2030.

## **II. Introduction**

1. Pursuant to Resolution CD52.R8 (2013), the Pan American Sanitary Bureau (PASB) is pleased to present this report on the second interim assessment of the implementation of the Pan American Health Organization (PAHO) Strategic Plan (SP) 2014-2019 and the end-of-biennium assessment of the Program and Budget (PB) 2016-2017. These assessments form an integral part of the Organization's commitment to accountability and transparency, building upon PAHO's strong tradition and best practices in the implementation of results-based management (RBM).

2. The assessment reports on progress made toward achieving the health impact goals, outcomes, and outputs set out in the Strategic Plan 2014-2019 and the Program and Budget 2016-2017, and notes the main challenges faced. Consistent with the Organization's country focus approach, success stories are highlighted to showcase PAHO's technical cooperation with countries. The report also presents an analysis of budget implementation, risks managed, and lessons learned that inform recommendations for the 2018-2019 biennium.

3. It should be noted that this report relies on information from the joint assessment and other information available to PASB as of July 2018. At that time, approximately 80% of outcome and output indicator assessments were agreed between Member States and PASB. Some assessments could not be completed, due to certain unforeseen circumstances (the impact of emergencies and outbreaks as well as political changes in some Member States). Nonetheless, PASB has completed this report covering the full PB16-17 and SP14-19 using all available information to measure achievement.

4. This report incorporates recommendations made by Member States during the 12th Session of the Subcommittee on Program, Budget, and Administration (SPBA) and the 162nd Executive Committee. The findings in this report also served as the main input from the Region of the Americas to the World Health Organization (WHO) Programme Budget 2016-2017 assessment that was presented to the World Health Assembly in May 2018. Finally, looking forward, PASB will be working with the Strategic Plan Advisory Group for the development of the PAHO Strategic Plan 2020-2025 to ensure that the results and lessons learned from the 2016-2017 biennium serve as an input for its development.

### **III. Delivering on Results**

5. This section summarizes the progress made in achieving the results of the PAHO Strategic Plan 2014-2019 and the PAHO Program and Budget 2016-2017. After analyzing the regional situation with regard to the impact goals in the Strategic Plan, it highlights some of the most significant achievements, challenges, and country success stories during the biennium. Finally, the section illustrates how the interventions carried out jointly by PASB and Member States contribute to outcomes and impacts through a multi-level results chain. Details on the methodology for the assessment of impact-, outcome-, and output-level results are available in Annex A.

#### ***Progress toward Achieving the Impact Goals of the Strategic Plan***

6. In the Strategic Plan, Member States and the PASB committed to achieving 26 targets under nine impact goals by 2019. Consistent with the Plan's strategic vision, the impact goal indicators measure the regional progress in improving health and well-being with equity.<sup>1</sup> In addition to measuring regional trends, the Plan sets out equity measurements under the following rationale:

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

7. As demonstrated in the assessment that follows, the Region has made great strides in improving health and well-being, yet there remain significant challenges that require immediate attention if the Region is to reach the targets set by 2019. As depicted in Figure 1, five of the nine goals are on track (Goal 1, healthy life expectancy; Goal 2, healthy start for newborns; Goal 3, safe motherhood; Goal 8, communicable diseases; and Goal 9, death, illness, and disability from emergencies). Three are at risk (Goal 4, mortality due to quality of care; Goal 5, premature mortality due to noncommunicable diseases; and Goal 7, premature mortality due to violence and injuries). Goal 6, mortality due to communicable diseases, is in trouble. Meanwhile, 11 of the 26 impact targets are on track to be achieved by 2019.

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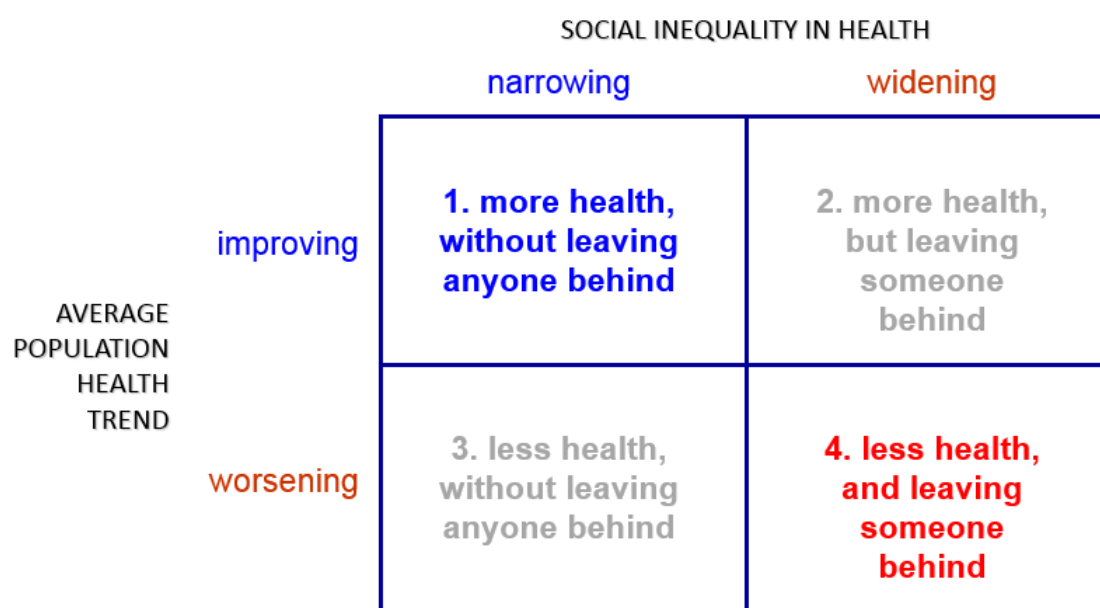
<sup>1</sup> Pan American Health Organization, 2014. Official Document 345: Strategic Plan of the Pan American Health Organization 2014-2019.

**Figure 1. Projected Status of Impact Goal Targets in 2019<sup>2</sup>**

<sup>2</sup> Figure 1 shows the targets defined in the PAHO Strategic Plan 2014-2019 and the projected status for 2019. As explained in Annex A, baseline and target values may have changed because mortality information is continuously updated.

8. For those impact goals in which the equity dimension was explicitly considered, a common monitoring framework was adopted to simultaneously assess changes over time in the regional average trend of the health indicator as well as in its degree of inequality. Figure 2 depicts this framework schematically, highlighting four possible outcomes. Only one of these scenarios is ideal, namely number 1 in the upper-left quadrant. If we apply this rubric to a specific impact goal, such as Goal 3 on safe motherhood, the ideal scenario would be one in which the Region improves its health on average (e.g., a reduction between 2014 and 2019 in the average regional maternal mortality ratio) and reduces its inequality gradient (e.g., a reduction between 2014 and 2019 in the maternal mortality slope index of inequality). When we review the overall achievement of an impact goal, analyzing whether the ideal scenario has been realized will indicate if the Region is achieving the goal without leaving anyone behind.

**Figure 2. Framework for Assessment of Equity-sensitive Regional Trends**



Modified from Minujin and Delamónica. Mind the Gap! 2002

### **Goal 1: Improve health and well-being with equity**

9. The health-adjusted life expectancy (HALE) trend for the Americas shows a 3.3% increase between 2000 and 2015.<sup>3</sup> Estimates of HALE values between 2016 and 2019 are computed based on projections that are developed by PAHO using a regression model. The regional HALE is projected to rise by 0.6%, from 67.0 in 2014 to 67.3 in 2017. If this trend holds, there will be an increase of up to 0.9% in the regional HALE between 2014 and

<sup>3</sup> HALE values are produced by the Institute for Health Metrics and Evaluation.

2019 (bringing it to 67.6), which shows that the target of increasing it by 1% may be achieved in 2019.

10. Although not explicitly considered as targets for this goal, both the relative gap inequality (that is, the HALE ratio between the bottom and top country groups on the Health Needs Index expanded, or HNIE) and the absolute gradient inequality (that is, the excess HALE across the HNIE gradient as quantified by the slope index of inequality) are expected to be reduced by 2019.<sup>4</sup> The relative gap shrinks from 0.92 in 2014 to 0.94 in 2019 (i.e., 1.8% closer to equity reference); the slope index of inequality drops from 4.3 to 2.9 years (i.e., 1.4 years less in the inequality between the bottom and the top extremes of the HNIE gradient).

### **Goal 2: Ensure a healthy start for newborns and infants**

11. Infant mortality rate (IMR) values from 2016 to 2019 are based on projections developed by PAHO using statistical modeling.<sup>5</sup> The regional IMR fell by approximately 44% between 2000 and 2015, with an average decline of 3.8% per year. The regional IMR reduction between 2014 (12.9) and 2017 (11.6) is 10.1%. Also, the regional IMR reduction between 2014 and 2019 (10.9) is projected to be 15.8%, indicating that the target of a 15% reduction might be reached in 2019.

12. The absolute equity target for this goal is also on track to be achieved by 2019, based on the projected absolute reduction of 4.5 excess infant deaths per 1,000 live births between 2014 and 2019 across the HNIE country gradient (target: a reduction of at least 3 excess infant deaths per 1,000 live births). However, although the relative equity gap is narrowing, it is projected to shrink at a somehow slower pace than expected (currently a 5.8% reduction instead of the 10% target). This signals the need to boost the intensity of targeting interventions in PAHO key countries.

### **Goal 3: Ensure safe motherhood**

13. With reported data available through 2015, the trend in the estimated maternal mortality ratio (MMR) shows a rapid decline, from 76.0 maternal deaths per 100,000 live births in 2000 to 53.6 deaths per 100,000 in 2014 and 52.0 deaths per 100,000 in 2015. Estimates for the years after 2015 project further reductions to 50.2 deaths per 100,000 live births in 2017 and 48.2 deaths per 100,000 in 2019. The overall projection for the period

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<sup>4</sup> The HNIE identifies the countries in the neediest quintile and the reference group (countries in the least needy quintile) based on socioeconomic and health indicators. It was developed by PAHO to focus technical cooperation efforts and resources on key countries, that is, those countries that are most in need of PAHO/WHO's technical cooperation in the Region (PAHO Budget Policy, 2012). It was also adopted in the PAHO Strategic Plan 2014-2019 as a stratifier to measure closing of health equity gaps between countries. Four of the nine impact goals of the Strategic Plan have explicit measurements for equity gaps and represent the commitment of Member States and PASB to go beyond the regional averages in order to reach those in most need – consistent with PAHO's values of equity and solidarity and with the mandate of the 2030 Agenda for Sustainable Development to leave no one behind.

<sup>5</sup> The IMR values from 2000 to 2015 are obtained from the most recent infant mortality estimates by the UN Inter-agency Group for Child Mortality Estimation (IGME).

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2014-2019 is a 10.2% reduction, which shows that the target of an 11% reduction might be achieved in 2019.

14. Nonetheless, there are two primary reasons for concern. First, preliminary data show that the MMR reduction has stagnated in some countries, and some have even seen an increased rate in 2017. Second, the 10 countries with the highest MMR in the Americas show little improvement in their maternal mortality figures, if not an increase.

15. The absolute equity target for this goal is on track to be achieved by 2019 based on the projected absolute reduction of 32.4 excess maternal deaths per 100,000 live births between 2014 and 2019 across the HNIE country gradient (target: a reduction of at least 18 excess maternal deaths per 100,000 live births). However, although the relative equity gap is narrowing, it is projected to shrink at a somehow slower pace than expected (currently a 16.7% reduction instead of the 25% target). This situation signals the need to boost interventions in PAHO key countries.

#### **Goal 4: Reduce mortality due to poor quality of health care**

16. The rate of mortality amenable to health care was calculated using the most complete set of mortality data reported by Member States through 2013. Values from 2014 to 2019 are based on projections developed by PAHO using a statistical model. The trend in mortality amenable to health care shows a decrease of 22.4% between 2000 and 2013. The rate is estimated to have declined a further 4.4% between 2014 and 2017 (from 118.7 to 113.5 per 100,000 population). The regional rate reduction between 2014 and 2019 (110.1 per 100,000 population) is projected to be 7.2%; therefore, the target of a 9% reduction is at risk of not being achieved by 2019.

17. The absolute equity target for this goal is not on track to be achieved by 2019, based on the projected absolute increase of 1.9 excess preventable deaths per 100,000 population between 2014 and 2019 across the HNIE country gradient (target: a reduction of at least 8 excess preventable deaths per 100,000 population). However, although the relative equity gap is actually widening – mainly because mortality amenable to health care is declining faster in the least needy HNIE country group than in the neediest group – it is still projected to be on track by 2019 (6.6% increase projected, just slightly above the target of no more than a 6.0% increase).

#### **Goal 5: Improve the health of the adult population with an emphasis on noncommunicable diseases (NCDs) and risk factors**

18. Between 2000 and 2013, the regional premature NCD mortality rate (PNMR)<sup>6</sup> declined by 18.4%, with a 1.4% average annual percentage of reduction (AAPR). This trend is projected to continue for the period 2014 to 2017 (with a reduction from 265.4 to 254.3 per 100,000 population), with the same AAPR of 1.4%. However, the projected

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<sup>6</sup> The PNMR was calculated using the most complete set of mortality data reported by Member States through 2013. Values from 2014 to 2019 are based on projections developed by PAHO using a statistical model.

reduction for the regional PNMR between 2014 and 2019 (247.2 per 100,000 population) is 6.9%, which shows that the target of a 9% reduction is at risk of not being achieved by 2019.

19. The absolute equity target for this goal is not on track to be achieved by 2019 based on the projected absolute increase of 6.8 excess premature deaths due to NCDs per 100,000 population between 2014 and 2019 across the HNIe country gradient (target: an absolute gap of no more than 18 excess premature deaths per 100,000 population). Likewise, the relative equity gap is widening at a faster pace than expected (11.6% projected increase as compared with a target of no more than a 6% increase). Premature mortality due to NCDs is projected to increase in the neediest HNIe country group, whereas it is projected to decrease in the least needy country group, worsening the inequality in premature mortality due to NCDs at the expense of the neediest countries.

20. Overall, the goal is at risk, given that the PNMR is indeed projected to continue its decline, although not quite as fast as the rate necessary to achieve the target. However, that both equity targets are in trouble at this point should be a wakeup call for accelerated action during the remainder of the Strategic Plan period and beyond.

#### **Goal 6: Reduce mortality due to communicable diseases**

21. Despite significant progress under this goal, considering that three of its four targets are in trouble and one is at risk, it could only be considered in trouble with regard to meeting the ambitious targets that were set for 2019. Specific comments by disease follow.

22. *HIV/AIDS*: The regional mortality rate due to HIV/AIDS declined by 28.8% between 2000 and 2013, with an AAPR of 2.3%.<sup>7</sup> A further decrease is projected between 2014 and 2017, from 3.6 to 3.3 per 100,000 population, with a reduction of 6.5% and an AAPR of 2.3%. It is projected that mortality rates will continue to decrease, to 3.2 per 100,000 population in 2019. However, the 10.6% reduction for the 2014-2019 period overall means that the regional target of a 15% reduction is in trouble.

23. It should be noted that the increase in persons on antiretroviral therapies (ART) continues to positively influence HIV/AIDS-related mortality. Considering the impact of such interventions, other models, such as those used by SPECTRUM<sup>8</sup> (based on trends and country estimates of persons on ART in the upcoming years), suggest that a decrease in mortality of over 20% by 2019 is possible; if so, the regional target of a 15% reduction in HIV/AIDS mortality could be achieved. The assessment in future periods will consider the development of such new models and tools.

24. *Dengue*: The target of at least a 30% reduction in the case-fatality rate due to dengue by 2019 (0.050% in 2019 as compared to 0.070% in 2012) is has shown progress,

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<sup>7</sup> The regional mortality rate due to HIV was calculated using the most complete set of mortality data reported by Member States through 2013. Values from 2014 to 2019 are based on projections developed by PAHO using a statistical model.

<sup>8</sup> SPECTRUM was developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with WHO and in coordination with countries.

but it is at risk of being achieved by 2019. The overall case-fatality rate continues to decrease in the Region (0.053% in 2017); however, Brazil, Colombia, Dominican Republic, and Peru have encountered challenges. To overcome them during 2018-2019, PAHO/WHO will support the strengthening of national capacities for integrated management of dengue and other arboviral diseases, with an emphasis on primary care to prevent severe cases and deaths from dengue.

25. *Tuberculosis:* The regional tuberculosis (TB) mortality rate decreased 22.4% between 2000 and 2013, with an AAPR of 3.7%. The rate is projected to have declined by 9.5% between 2014 and 2017 (from 1.27 to 1.15 per 100,000 population), with an AAPR of 3.3%. The regional TB mortality rate reduction between 2014 and 2019 (1.08 per 100,000 population) is projected to be 15.3%, which means that the target of a 24% reduction most likely will not be achieved by 2019. High mortality rates in cases of TB/HIV and multidrug-resistant tuberculosis (MDR-TB) persist in several countries, which is adversely affecting the overall rate of decline.

26. *Malaria:* The target of reducing the number of deaths due to malaria by at least 75% by 2019 is in trouble. Malaria mortality and morbidity have increased, especially due to an increase in transmission in Venezuela in 2016 and 2017. In 2016, an epidemic in the Pacific Coast region of Colombia also increased the number of deaths compared to 2015.

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

27. Rates of suicide, homicide, and mortality due to road traffic injuries among youth 15-24 years of age were calculated using the most complete set of mortality data reported by Member States through 2013. Values from 2014 to 2019 are based on projections developed by PAHO using a statistical model.

28. The regional homicide rate in this age group fell by 0.51% between 2000 and 2013. Further reduction between 2014 and 2017 was minimal, from 27.7 to 27.6 per 100,000 population, and the rate is expected to remain unchanged through 2019. This puts the target of a 6% reduction in homicides in this age group in jeopardy.

29. The regional suicide rate in youth 15-24 years of age increased by 8.7% between 2000 and 2013. The projected rate for 2014 to 2017 shows the same pattern (from 7.7 to 7.9 per 100,000 population), and the projected rate for 2019 shows an increase of 3.9% (to 9.0 per 100,000 population). This indicator is therefore at risk of not meeting the target of no increase in the suicide rate for the 2014-2019 period.

30. The regional rate of mortality due to road traffic injuries in youth 15-24 years of age fell by 5.3% between 2000 and 2013. The reduction between 2014 and 2017 (17.4 to 17.2 per 100,000) is projected to be 1.2%, and further reduction of up to 2.0% is projected for 2019, reaching a rate of 17.1 per 100,000. Hence, the target of no increase in mortality most likely will be achieved by 2019.

**Goal 8: Eliminate priority communicable diseases in the Region**

31. *EMTCT of HIV and syphilis*: The original measurement of this impact target was based on data reported by countries to a WHO/UNICEF/UNAIDS global platform called Global AIDS Monitoring (GAM). However, one of the sub-indicators used for the composite assessment (reported cases of perinatal HIV) was discontinued by the global platform. Without this information, it is difficult to assess progress in countries as originally envisaged. Therefore, the indicator has changed to “number of countries validated by WHO as having eliminated mother-to-child transmission of HIV and syphilis.”

32. Using this measurement, the baseline for 2013 was zero countries, and the target for 2019 is 10 countries. Seven countries and territories have received validation for elimination of mother-to-child transmission (EMTCT) of HIV and congenital syphilis, including six during 2016-2017. This means that the Region is on track to achieve the revised target by 2019.

33. *Onchocerciasis*: Elimination has been certified in Colombia, Ecuador, Guatemala, and Mexico, so the target of elimination in four countries has been achieved.

34. *Chagas transmission in endemic countries*: The two countries that have not been able to advance toward the elimination of Chagas disease are Venezuela, where there is no up-to-date information available on prevention and control interventions, and Ecuador, where prevention and control activities have not been implemented as planned. Actions are required in coastal areas where *Triatoma dimidiata* is the cause of transmission. Due to this situation, this target is at risk.

35. *Malaria*: Elimination was maintained in Argentina and Paraguay; both countries are expected to be certified in 2018-2019, and Belize is also working toward elimination. Unfortunately, Costa Rica reported a small number of autochthonous cases in 2017. Nonetheless, the target of three countries achieving elimination by 2019 is on track.

36. *Human rabies transmitted by dogs*: The target of zero cases in 35 countries is on track to be achieved by 2019. In 2014, 17 Member States reported no human cases of dog-transmitted rabies. In 2017, the number of countries with no cases increased to 33; only Bolivia and Haiti reported cases in 2017. There is a need to enhance high-level advocacy and increase resource mobilization to support the commitment of priority countries to combat this disease, including Dominican Republic and Guatemala in addition to Bolivia and Haiti, which present the main challenges.

**Goal 9: Prevent death, illness, and disability arising from emergencies**

37. Between 2014 and 2017, there were 41 individual country emergency events that met the Grade 2 and 3 criteria as indicated in the technical specifications for target 9.1. Of these, eight could be considered for this assessment; the others were excluded due to the indicator criteria or non-availability of data. In three of these eight events, the crude mortality rate returned to accepted baseline (pre-disaster levels) within three months.

Underlying cause of death from the other five events did not show any reasonable causal relationship with the events. Based on these early indications, the impact goal seems to be on track. However, PASB technical teams will continue to discuss methodological alternatives to best monitor it.

### ***Key Achievements, Challenges, and Country Success Stories by Category***

38. This section highlights the main achievements, challenges, and country success stories by category of the Strategic Plan. The category reports available from the PAHO Program and Budget Web Portal contain detailed programmatic, budget, and risk analysis.<sup>9</sup>

### **Category 1: Communicable Diseases**

39. During 2016-2017, the Pan American Health Organization worked toward the overarching goal of reducing the burden of communicable diseases, including HIV/AIDS, sexually transmitted infections (STIs), and viral hepatitis; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; and vaccine-preventable diseases. This work included efforts toward the surveillance, prevention, control, and elimination of infectious diseases.

#### ***Key Achievements***

- a) Six additional countries and territories were certified by WHO as having achieved targets for EMTCT of HIV and congenital syphilis.<sup>10</sup> Cuba was also recertified for another two years.
- b) In September 2016, the Region of the Americas became the first WHO region to eliminate measles. The Region also declared the elimination of maternal and neonatal tetanus in Haiti, the last country in the Americas to achieve this goal.
- c) Elimination of malaria was maintained in Argentina and Paraguay.
- d) In 2016, WHO verified the elimination of onchocerciasis in Guatemala, and in 2017 Mexico received validation of the elimination of trachoma as a public health problem.
- e) Significant progress is being made toward attaining the regional goals of universal access to and coverage of HIV care and treatment services, known as the 90-90-90 targets. As of 2016, 81% of estimated people living with HIV know their status; 72% of people diagnosed with HIV are receiving antiretroviral therapies; and 79% of people receiving ART have robust viral suppression. The number of people on ART in the Region has increased on average by more than 8% yearly over the last five years.
- f) There has been an overall increase in the introduction of new vaccines throughout the Region. By the end of the biennium, 90% of the birth cohort are living in

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<sup>9</sup> Category Reports are published on the PAHO Program and Budget Web Portal, available at: <https://open.paho.org/>.

<sup>10</sup> Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat, and Saint Kitts and Nevis.

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countries where pneumococcal conjugate vaccine (PCV) is used; 85% of countries have introduced rotavirus vaccine; 80% of the cohort of girls aged 9-14 years are living in countries where human papillomavirus (HPV) vaccine has been introduced; and 42 countries and territories are using the influenza vaccine.

- g) By the end of 2017, all countries had incorporated the End TB strategy into their national plans and guidelines.
- h) The approval of the Plan of Action for Malaria Elimination 2016-2020 (Resolution CD55.R7) reinforced country engagement toward disease elimination. Significant progress has been made in the development and adaptation of plans and strategies for malaria elimination, with 14 of the 21 malaria-endemic countries having completed their national malaria elimination plans or road maps.

### ***Challenges***

- a) **Countries show uneven progress toward HIV care and treatment goals**, with persistent gaps in access to HIV testing, care, and treatment services and to affordable lab monitoring (of HIV viral load). There is HIV resistance to ART currently used in the preferred first-line regimen, while there is limited access to the new class of therapies recommended by WHO. Furthermore, sustainability of HIV prevention interventions for key populations and engagement with civil society continues to be problematic, although it is crucial for the HIV response. The majority of countries in the Region (27 of 35) depend on international funding to carry out prevention activities for key populations, and only 60% (15 of 25 reporting countries in Latin America and the Caribbean) have resources from their national budgets to finance civil society initiatives.
- b) **High prices of hepatitis C medicines and diagnostics**, combined with restrictions related to intellectual property, prevent the majority of countries from establishing viral hepatitis programs and providing the necessary hepatitis services.
- c) **Gaps in case detection for TB and MDR-TB persist**. These include the non-recognition of TB symptoms by the general population, delayed diagnosis by health personnel, barriers to accessing health services, and in the case of MDR-TB, limited diagnostic capacity. The TB pre-elimination stage presents a new scenario for countries. The definitions of criteria and processes related to pre-elimination in low-burden countries need to be established, in collaboration with WHO, in order to inform technical cooperation with countries.
- d) **The increase in malaria transmission** in Venezuela presents a challenge for the achievement of regional goals for elimination of this disease. Additionally, current gaps in health systems coverage in malaria-endemic countries hinder the access of rural populations to prompt diagnosis and treatment, and need to be addressed.
- e) **Recent evidence of immunological cross-reactions between dengue and Zika** has hindered the accurate and timely laboratory diagnosis of dengue cases. Additionally, the ongoing transmission of chikungunya, Zika, and dengue has led to significant financial, technical, and management challenges.

- f) **Elimination of dog-transmitted rabies** in Bolivia, Haiti, Dominican Republic, and Guatemala remains a challenge. Intensified advocacy and resource mobilization efforts are needed to enhance the provision of technical cooperation activities.
- g) **Insufficient investment and support for national immunization programs** continue to affect program sustainability in some countries. As a result, the Region is now at risk of losing its certification as measles-free, declared by the International Expert Committee for Documenting and Verifying Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Americas in September 2016. Ongoing support for immunization programs is also needed, with a clear message regarding program benefits, in light of conflicting messages from the anti-vaccination movement.

### *Success Stories in Countries*

#### Americas | The Region declared free of measles



In September 2016, the Americas became the first region in the world to have eliminated measles, a viral disease that can cause severe health problems, including pneumonia, brain swelling, and even death. This achievement concludes a 22-year effort involving mass vaccination against measles, mumps, and rubella throughout the Americas. Measles is the fifth vaccine-preventable disease to be eliminated from the Americas, following the regional eradication of smallpox in 1971, poliomyelitis in 1994, and rubella and congenital rubella syndrome in 2015.

Before mass vaccination was initiated in 1980, measles caused nearly 2.6 million deaths annually worldwide. In the Americas, more than 100,000 deaths were attributable to measles in the period from 1971 to 1979. A cost-effectiveness study on measles elimination in Latin America and the Caribbean has estimated that through vaccination, 3.2 million measles cases will have been prevented in the Region and 16,000 deaths averted between 2000 and 2020.



## Caribbean | More babies born free of HIV and syphilis

Six countries and territories were certified by WHO as having eliminated mother-to-child transmission of HIV and syphilis: Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat, and Saint Kitts and Nevis. With Cuba having received certification in 2015, this makes for a total of seven in the Region. The achievement is testament to a key factor, namely that the integration of maternal and child health (MCH) in sexual, reproductive health, and HIV services increased buy-in to this effort. An integrated approach to MCH programs underpins PAHO/WHO's new health sector strategies on HIV, viral hepatitis, and sexually transmitted infections.

## Guatemala and Mexico | Eliminating neglected diseases that persist in vulnerable and indigenous populations



Guatemala and Mexico made great strides in the elimination of onchocerciasis and trachoma, respectively. PAHO/WHO has been committed to the active fight against onchocerciasis, a blinding disease that mainly affects indigenous populations in Guatemala. In response to PAHO's Directing Council Resolution CD35.R14, the Onchocerciasis Elimination Program for the Americas was created in 1993. Guatemala obtained WHO's certification of onchocerciasis elimination in mid-2016, becoming only the fourth country in the world to achieve this.



In Mexico, the last focus of trachoma was located in five municipalities with predominantly poor and indigenous populations in Chiapas State. In 2017 Mexico became the first country in the Americas and third in the world to receive WHO's validation of trachoma elimination as a public health problem. This was achieved by intensifying efforts to fight trachoma through field brigades implementing the four components of the SAFE strategy (surgery, antibiotics, facial cleanliness, and environmental improvement) and by addressing social determinants of health. PAHO and other partners supported national and subnational health authorities to compile the evidence on the elimination of the disease.

## **Category 2: Noncommunicable Diseases and Risk Factors**

40. During the 2016-2017 biennium, efforts continued to address the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of NCDs and their risk factors.

### ***Key Achievements***

- a) The percentage of children less than 5 years of age who are stunted dropped to 6.3% in the Region, exceeding the 2019 target of 7.5%.
- b) Regional prevalence of visual impairment decreased to 2.78% in all ages and to 10.37% in people over 50 years of age. This was achieved in part by increasing the availability of cataract surgery within the Region (by 30% in some public hospitals).
- c) Uruguay won a dispute initiated by Philip Morris International that contested the country's policies on tobacco packaging and labeling. This was upheld by the World Bank's International Centre for Settlement of Investment Disputes (ICSID) on the grounds that the policies do not violate the terms of an investment treaty. ICSID considered the arguments that PAHO put forth in its *amicus curiae* brief.
- d) In February 2017, a road safety strategic plan was approved in the Dominican Republic, and a lead agency on road safety was established. This is significant progress in a country with one of the highest rates of death due to road traffic injuries in the Region and globally.
- e) Front-of-package nutritional warning systems are being applied or considered in 12 countries and two subregional integration mechanisms, following evidence-based scientific information provided by PAHO/WHO.
- f) In partnership with the Harvard School of Public Health, PAHO pioneered the generation of evidence to promote an understanding of the economic impact of NCDs, the cost of inaction, and the return on investment, including partnering with organizations to train officials from finance and health ministries on fiscal measures affecting tobacco, alcohol, and sugar-sweetened beverages.

- g) The Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018-2022 was approved by the 29th Pan American Sanitary Conference with the objective of accelerating implementation of the WHO Framework Convention on Tobacco Control.
- h) Integration of mental health into primary health care expanded to 34 countries and territories. Furthermore, indigenous communities from several countries have agreed on the identification of mental health and suicide prevention as priorities for intervention.
- i) The number of countries with national alcohol policies increased from seven to 13.
- j) With the adoption of the Ministerial Declaration on Migration and Health in Mesoamerica and launching of the Joint Initiative of the Health of Migrants and their Families with the International Organization for Migration (IOM), ministers of health for the first time agreed on a comprehensive, people-centered, and context-specific road map for interventions to promote and protect the health of refugees and migrants.
- k) The REGULA Initiative, aimed at strengthening the institutional capacity of the health authorities in Member States to regulate NCD risk factors, has developed a registry of legislation on risk factors for 19 Latin American countries.

### ***Challenges***

- a) **Need to strengthen NCD programs.** Competing national priorities contribute to continued insufficient funding to address the growing NCD burden. Furthermore, capacity to define and implement needed NCD-related policies and regulations is low. There are persistent difficulties in including substance use problems in the priority agendas of ministries of health, a key step needed to strengthen the public health approach to the drug problem in the Region. The topic of violence in general, and violence against women and children specifically, while high on the political agendas of countries, is not necessarily high on the agendas of health ministries. Vision, hearing, and rehabilitation services are not given high priority and are not well integrated or well financed in many countries, despite evidence to suggest a growing need for such services. Availability of these services is often limited, fragmented across different sectors, and in some countries is heavily reliant on the work of nongovernmental organizations (NGOs) and faith-based organizations.
- b) **There is limited multisectoral engagement** to address NCDs and risk factors, which require sustained political commitment and efforts beyond the health sector. Violence, road safety, and human security also require multisectoral collaboration and engagement in order to achieve the expected results.
- c) **Generally, countries have weak information systems** on mental health needs, alcohol indicators, and substance use. Significant data gaps exist with regard to migrant health issues, road traffic injuries and related preventive/risk factors, as well as violence. Limited data on need for and availability of rehabilitation services

- pose a challenge; these services are poorly mapped across the Region, making strategic planning difficult.
- d) **Poor implementation of commitments undermines performance in several areas.** Despite the participation of government officials and partners in the development of mental health plans, implementation of these plans remains low. In most cases, policies and plans do not translate into action, frequently due to limited commitment or know-how. Limited health planning capacity exists at national and local levels to incorporate the human security approach as well as the development of programs to strengthen health resilience. Law enforcement related to drink-driving, speeding regulations, and use of helmets, seatbelts, and child restraints is weak across the Region, particularly in the Caribbean. More efforts are required from the health sector to promote road safety legislation and enforcement.
  - e) **The chronic and multifactorial nature of NCDs constrains funding** by external donors, and governments still fail to commit sufficient domestic funds to support the implementation of NCD policies and programs.
  - f) **Disability, rehabilitation, community-based rehabilitation, and social inclusion continue to be regarded as a single issue** and are often misunderstood or misinterpreted. A greater emphasis on functioning is necessary and would also more closely link the work of this area to the health domain.
  - g) **Salt reduction is a very difficult goal to achieve.** Measures intended to decrease salt content are not popular, and monitoring of salt intake is complex and expensive (requiring collection of 24-hour urine samples). As a result, it is difficult to establish baselines or monitor the progress of the measures implemented.
  - h) **Reformulation of food products is extremely challenging in the Caribbean,** especially in the smaller islands with small local manufacturing industries.

*Success Stories in Countries*

## Uruguay | Renewed high-level commitment to action on NCDs

The 2011 High Level Meeting on the Prevention and Control of Non-communicable Diseases, convened by the United Nations General Assembly, was a landmark for the NCD agenda, reflecting the global political commitment to tackle chronic diseases. However, a review of progress by WHO in 2015 showed that if the trends of premature mortality due to the principal NCDs were to remain the same, the target of reducing premature mortality from NCDs by one-third by 2030 (Target 3.4 under the Sustainable Development Goals) would not be achieved.

In order to revitalize the political commitment on NCDs, WHO, in collaboration with the government of Uruguay, convened a Global Conference on Noncommunicable Diseases in October 2017, hosted by the Honorable President of Uruguay, Dr. Tabaré Vázquez. The goal of the conference was to highlight the critical links between reducing premature deaths from NCDs, promoting mental health and well-being, and enhancing policy coherence across areas that impact the governance, prevention, management, and surveillance of NCDs. The conference was attended by four additional heads of state (from Argentina, Chile, Paraguay, and Zimbabwe), by the Princess of Morocco, and by representatives of the Region's ministries of health. There were approximately 400 participants from around 90 countries.

A key conference outcome was development of the "Montevideo Roadmap 2018-2030 on NCDs as a Sustainable Development Priority," supported by all participants. While it is still too early to draw conclusions as far as the impact of the conference in increasing country commitment and progress toward the achievement of Target 3.4, this collaboration highlights the importance of a coordinated response from WHO, following the vision of "One WHO." It also showcases the leadership of the Region in addressing NCDs and their risk factors ahead of the Third United Nations High-Level Meeting on NCDs, to take place in 2018.



## Chile | Increasing consumer awareness of healthier products

Chile has the highest per capita soft drink consumption in the world, and the second-highest per capita sales of ultra-processed foods in the Americas. In order to reduce the demand for and supply of unhealthy products, and following PAHO/WHO recommendations, the executive and legislative branches developed a new regulatory framework on food labelling and marketing. The effort benefitted from a whole-of-government approach and from the support of academia, civil society, and international agencies. Law 20606 was approved by the legislature in 2012, and implementation began in June 2016.

The law regulates the food environment through front-of-package labels that inform consumers when products are high in sugars, saturated fats, sodium, and/or calories. It restricts promotion of such products to children and their sale in schools. Such regulatory policies have been coupled with a range of actions to promote nutrition education and physical activity.

An initial evaluation shows that Chileans have welcomed implementation of the law and have shifted their purchases toward healthier choices. Another positive impact of the regulations has been the reduction of sodium, sugars, saturated fats, and/or calories in many products.

Key success factors in adopting the front-of-package labeling law in Chile include the strong commitment of the authorities to urgently address the problem of overweight and obesity in the population. The policies were developed based on strong evidence that such regulatory measures are a cost-effective means to improve diets and prevent obesity. The policies were established through a human rights, political, and social approach. They were formulated and implemented with active participation by civil society throughout the policy cycle, from formulation to the development of monitoring and accountability mechanisms, ensuring buy-in by all sectors of the population.

## Dominican Republic | Breakthrough advances in the mental health care system



During 2016-2017, the Dominican Republic reformed mental health services to fit within the structure of the National Health Care Model. With technical cooperation from PAHO/WHO, the Ministry of Health succeeded in transforming the country's psychiatric hospital into a Psychosocial Rehabilitation Center. This restructuring was aimed at improving the quality of care, timely access to care, and community rehabilitation of patients with mental health disorders. The focus was on human rights and the humanization of care and on integrating mental health into the health system, thereby strengthening the well-being of families and communities.

Within the framework of this health reform, other actions were developed, including the development of the National Mental Health Plan 2017-2020; capacity building for health providers at the first level of care, based on the mhGAP strategy; the incorporation of mental health conditions in the National Epidemiological Surveillance System; and the definition of a mental health community services network. The budget allocated to mental health was increased to allow for this transformation. Together, these actions will ensure the sustainability of the policy changes.

As a result of these reforms, patients are receiving comprehensive mental health care in primary care units. Crisis Intervention Units were established in national hospitals to ensure appropriate and continuous treatment of people with mental disorders using a life course approach, including integration with pediatric units and timely access to psychiatric medication.

Hundreds of people with mental disorders, including those residing in the old psychiatric hospital and their caregivers, have received guidance and appropriate health care, achieving personal development and improving their quality of life by returning to their communities to lead a productive and healthy lifestyle.

### **Category 3: Determinants of Health and Promoting Health throughout the Life Course**

41. The Organization accelerated efforts to promote good health at key stages of life, considering the need to address the social determinants of health (societal conditions in which people are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

#### ***Key Achievements***

- a) As a result of the implementation of the Zero Maternal Deaths from Hemorrhage initiative, in four countries maternal deaths due to hemorrhage were prevented in the hospitals where the interventions took place.
- b) The WHO Age-Friendly Cities and Communities Initiative has been adopted by 66 cities in Canada and 171 cities in the United States. Furthermore, 12 countries have established mechanisms to engage communities and civil society in the policy development process across sectors, using the Healthy Municipalities, Cities and Communities approach.
- c) Fifteen countries are fulfilling their commitment to review and address inequities and inequalities in health as part of the Commission on Equity and Health Inequalities in the Americas.
- d) Fifteen countries have developed or updated their policies and strategies on adolescent health.
- e) Twelve countries have adapted and reviewed their national plans on aging based on the WHO Global Strategy and Action Plan on Ageing and Health.
- f) The regional Policy on Ethnicity and Health was approved by the 29th Pan American Sanitary Conference in 2017. This marked a significant step forward in establishing a commitment across the WHO system to address ethnic inequities in health, recognizing the need to adopt an intercultural approach to health.
- g) In line with PAHO's Strategy and Plan of Action on Climate Change, and consistent with the United Nations Framework Convention on Climate Change (UNFCCC), 27 countries completed their vulnerability and adaptation assessments on climate change and health, and five countries published their WHO-UNFCCC country profiles on climate change.

#### ***Challenges***

- a) **Gaps in data and information systems should be reduced.** The coverage and quality of data on health throughout the life course continues to be a challenge in the Region. To reduce inequities, it is necessary to strengthen surveillance systems and monitor health inequities with disaggregated data and epidemiological analysis, which are not available in the majority of countries.



- b) **Holistic approaches are not yet widespread.** The approaches taken by different Member States toward gender, equity, human rights, and ethnicity are sometimes unclear and uncertain. It is important to continue working toward a cohesive and holistic way of addressing these four cross-cutting themes, which are central to the determinants of health.
- c) **Aging and ethnicity continue to receive low priority.** Despite mounting evidence that demographic changes are shifting disease patterns, some countries still have not defined aging as a priority health issue. There is a lack of aging focal points, and in some cases the focal points, where they exist, are outside the ministries of health. Commitment to addressing ethnic inequities in health also varies across countries, and further attention is required to consolidate consistent approaches to intercultural health across Member States' policies and plans.
- d) **Resource allocation and institutional development remain insufficient.** Gender equality in health continues to face institutional shortfalls related to budget and staffing, hobbling efforts by some countries to address this emerging area. Similarly, environmental determinants are not always incorporated in core public health activities, and environmental health projects at the local level are often fragmented. Responses from ministries of health are limited with regard to designating staff and funding for specific activities on climate change.
- e) **There is limited collaboration with non-health stakeholders.** Working with governmental agencies outside the health sector that make important decisions on the right to health and related human rights remains a challenge. With a few exceptions, the health sector has not fully participated in the climate change agenda. In the implementation of national strategies and programs to reduce the use of solid fuels for cooking, progress is sometimes slowed by the need to raise awareness in a field where the health sector has not traditionally been involved.

### *Success Stories in Countries*

Trinidad and Tobago |  
Preventing postpartum  
hemorrhage through  
inexpensive life-saving  
techniques



In Trinidad and Tobago, 99% of births occur in health facilities, both private and public, and are attended by trained health professionals. However, up until recently, maternal deaths were still happening in hospitals, usually 48 hours after delivery, mainly due to postpartum



hemorrhage (PPH). PAHO collaborated with the Ministry of Health and with the country's Regional Health Authorities on several initiatives during 2016-2017 to improve maternal and child health. Specific measures included an assessment mission and the implementation of the resulting plan of action. Forty-five health professionals were trained in the medical management of PPH, and local hospitals implemented low-cost technologies for PPH interventions to save mothers from bleeding to death.

Using PAHO/WHO tools, the Regional Health Authorities assessed the performance of the health system in improving maternal, newborn, child, and adolescent health and the key conditions for hospital obstetric services. Concurrently, the Perinatal Information System was introduced in all Regional Health Authorities so that clinicians can have readily accessible data to conduct audits, and training has also been conducted on maternal death surveillance and response. Implementation of this comprehensive and integrated approach is proving successful in preventing maternal deaths in Trinidad and Tobago.



## Nicaragua | Maternity Waiting Home strategy: Ensuring safe motherhood and a healthy start for newborns

In Nicaragua, despite advances and the many interventions conducted by government, rural populations face poverty and harsh living conditions. PAHO/WHO, in partnership with the Ministry of Health, local governments, midwives, and local communities, is supporting the strategy of Maternity Waiting Homes (*"Casas Maternas"*), inpatient facilities located throughout the country that are designed to reduce maternal and infant mortality.

The Maternity Waiting Home provides critically needed clinical services in reproductive, maternal, newborn, and child health. Pregnant women are admitted to the Maternal House for care and monitoring during the final weeks of their pregnancies. They are then

transferred to a health institution for the birth, attended by a trained health professional. Following birth, the woman and newborn are transferred back to the Maternity Waiting Home for postpartum care, normally for a period of seven days. Family and community health teams also follow up at home to ensure continuous maternal and child care.

The Maternity Waiting Homes contribute to the improvement of reproductive and sexual health, early postpartum health care, and neonatal care within a culturally appropriate environment. There is an emphasis on newborns with low birthweight, including promotion of the “kangaroo care” strategy. Implementation has required coordination with the Ministry of Health, SILAIS (Local Systems of Comprehensive Health Care), municipal governments, the Midwives’ Association, and Health Brigades. The Maternal Houses also support community education and networks of women’s support groups.

During the past three years of this initiative, no maternal deaths have occurred among the women who have participated. In addition, the Maternal Houses have strengthened and empowered participating communities.



## Cuba | Building gender equality at an early age

Gender identity, which is one of the social determinants of health, begins to form at an early age. In light of this understanding, the National School of Public Health and the Faculty of Communications of the University of Havana worked with PAHO/WHO to design an educational proposal to develop capacities related to gender for teachers and families. The objective is to advance toward gender equality, which is SDG5.

Toward this end, products and interventions were created and implemented as part of a project targeting girls and boys from 7 to 12 years old. Materials on gender were produced, including a handbook for children, a manual of good practices, a virtual library for teachers, informative banners for classrooms, a hobby book, and multimedia for girls and boys. A course on gender and popular education for teachers was designed and implemented.

Results show that the project has been successful. The boys and girls involved in it were able to apply the knowledge that this initiative gave them in their daily lives and at school, helping them to see life in a different way.

## Category 4: Health Systems

42. During the biennium, efforts continued to strengthen health systems based on primary care; improve governance and financing toward progressive realization of universal access to health and universal health coverage; organize people-centered, integrated service delivery; promote access to and rational use of health technologies; strengthen health information and research systems and the integration of evidence into health policies and health care; facilitate transfer of knowledge and technologies; and develop human resources for health.

### *Key Achievements*

- a) Fifteen countries expanded access and quality of care through different focused strategies, including by reforming the model of care to improve access through a primary health care approach. In Brazil, 60 million additional people are benefiting from the Mais Médicos program, with 40 million served by Cuban medical doctors through PAHO technical cooperation.
- b) At the end of 2017, 22 countries had developed comprehensive national health policies, strategies, and/or plans within the context of the regional Strategy for Universal Access to Health and Universal Health Coverage; 16 were implementing financial frameworks for universal health; and 13 were implementing the monitoring framework for universal health.
- c) The PAHO Strategic Fund increased its procurement levels to US\$178 million, with 23 out of 30 signatory countries using the Fund.
- d) Member States continued strengthening their information systems for health (IS4H): 21 countries expanded birth registration coverage and 16 countries achieved their death certification targets, with important improvements noted in the quality of vital statistics.
- e) The regional strategy on human resources for health (HRH) was adopted in 2017. HRH policies were developed in seven countries of the Eastern Caribbean, and another 12 countries in Latin America updated their policies.
- f) The PAHO flagship publication Health in the Americas+ (2017), which provides evidence-based progress and challenges in health over the last 5 years, was completed in collaboration with all Member States.

### *Challenges*

- a) **Funding levels** needed to strengthen health systems and achieve the goals set for them are often **insufficient**. PAHO/WHO continues to provide guidance to promote understanding of health financing policy challenges and to facilitate an informed and constructive dialogue on these issues.
- b) Efforts are underway in the Region to implement initiatives aimed at health systems transformation and strengthening as a means to advance toward universal health

coverage and access. Addressing the challenge of **segmentation and fragmentation of health systems** should be central to these initiatives.

- c) **Transparency and accountability in the allocation of medicines and health technologies requires further regulation.** Unbiased information, free of conflicts of interest, is necessary for the sound selection, incorporation, prescription, and use of medicines and health technologies.
- d) Major efforts and resources are needed to develop and implement technologies and tools to **bridge the digital divide and increase access to information in remote areas.**
- e) Although the Region has made some progress in HRH, **inequities persist in the availability, distribution, and quality of the health workforce.** There are gaps between and within countries, between different levels of care, and between the public and private sectors. This hinders the progressive expansion of services, particularly at the primary care level.

### *Success Stories in Countries*

#### Brazil | Mais Médicos program expanding health services toward universal health



Brazil's large territory and extensive forest cover poses a challenge to efforts to achieve universal health coverage and access. Due to recruitment and retention problems, certain areas and populations, mainly poor and indigenous people, critically lack physicians.

In 2013 the government created the Mais Médicos program to help alleviate the shortage of medical doctors in underserved communities. Through collaboration between Brazil and Cuba, with the support of PAHO/WHO, the Mais Médicos program brought in approximately 12,000 doctors and incorporated them into the National Family Health Program in 27 Brazilian states. About 700 municipalities have received a doctor for the first time, providing access to an additional 60 million people. The program has helped expand primary health care to remote and underserved populations.



## Nicaragua | Expanding access to quality products through technology transfers

Ensuring sustainable access to quality, safe, and effective vaccines is a challenge that developing countries face due to lack of local and/or regional production, which leads to full dependence on global markets that do not always guarantee timely availability of these products. One means to address this problem is the promotion and support of local vaccine manufacturing, coupled with transfer of technology.

In line with this approach, a bilateral cooperation agreement between the governments of Nicaragua and the Russian Federation provides for a plant that will produce influenza vaccine in Nicaragua, with capacity to satisfy the needs of the country and other countries in the Region. PAHO/WHO has provided technical support in this technology transfer project. Construction of the plant is in the final stages and it is close to validation and certification, with plans to start production in early 2018.

Together with the Nicaraguan Social Security Institute (INSS), the Ministry of Health, the St. Petersburg Research Institute of Vaccines and Serums, and the newly created Mechnikov Institute, PAHO/WHO has promoted and supported the participation of other stakeholders such as the National Autonomous University of Nicaragua (UNAN-Managua, UNAN-Leon), as well as the support of countries that have experience in the development of vaccines, such as Cuba, Venezuela, and Chile, using the modality of Cooperation among Countries for Health Development (CCHD).

The process of technology transfer for influenza vaccine production in Nicaragua offers an opportunity to increase access to influenza vaccines in the country and the Region, while strengthening the National Regulatory Authority. It has also generated demand for a new skilled workforce in Nicaragua and for research and development infrastructure.





### Ecuador and Peru | Binational collaboration to improve the health of populations in conditions of vulnerability

The Ecuador-Peru binational project entitled “Improving the health of population groups in situations of vulnerability” was implemented in one of the five border areas between Ecuador and Peru. People living in the area have a greater chance of living in vulnerable conditions and consequently suffer worse health outcomes. This is manifested in a higher prevalence of infectious diseases, maternal and neonatal mortality, teenage pregnancy, gender violence, and malnutrition in early childhood. In addition, geographic and cultural barriers as well as other social determinants limit their access to comprehensive quality health care.

In 2017, interventions with an intercultural approach were implemented to reduce cultural barriers to access to services. These interventions, which focused mainly on components of the health system and services, included progressive improvements in the treatment of patients at health centers for obstetric and neonatal emergencies; nutrition interventions; as well as health promotion and prevention during prenatal health care. The use of “knowledge dialogues” strengthened the participation of indigenous populations in managing their health and built consensus on intervention strategies. The interventions also linked the traditional and conventional health systems, promoting and strengthening a mutual cultural recognition and creating a synergy needed to address priority health problems.

## Category 5: Preparedness, Surveillance, and Response

43. The Region continued to reduce mortality, morbidity, and societal disruption resulting from epidemics, disasters, conflicts, and environmental and food-related emergencies by focusing on risk reduction, preparedness, response, and recovery activities that build resilience and use a multisectoral approach to contribute to health security.

### *Key Achievements*

- a) Timely and appropriate responses were mounted to all emergencies with potential health impacts in 33 countries and several territories within 72 hours of onset.
- b) In Haiti, the overall cholera institutional case fatality rate was maintained below 1%.
- c) Emergency Medical Teams (EMT) in two countries, Costa Rica and Ecuador, were verified through the WHO Global Classification process and added to the global roster of WHO-classified teams. The EMT Regional Group of the Americas was consolidated.
- d) Twelve States Parties in the Caribbean have obtained membership in the International Atomic Energy Agency (IAEA), thanks in large part to PAHO/WHO's continuous close collaboration with this agency.
- e) The Organization maintained 24/7 coverage for urgent communications from Member States and PAHO/WHO Representative (PWR) offices and issued alerts on public health threats.
- f) All countries are part of at least one formally established regional laboratory network with capacity to respond to emerging and reemerging viral pathogens in the Region.
- g) Fourteen countries and territories have developed national action plans for combatting antimicrobial resistance (AMR).
- h) Implementation of the Smart Hospitals initiative continued. Three health facilities are currently being retrofitted to improve their resilience to disasters and reduce their impact on the environment: Princess Alice Hospital in Grenada, La Plaine Health Centre in Dominica, and Chateaubelair Hospital in St. Vincent.
- i) To combat foot-and-mouth disease, a regional antigens/vaccines bank (BANVACO) was created.
- j) The new PAHO Health Emergencies Program was established, pursuant to WHA Resolution A69/30.

### *Challenges*

- a) **Political support for priorities continues to lag, and collaboration has been challenging at times.** There is a dwindling presence of NGOs and donors involved in cholera control in Haiti. The political situation in some Member States, in

- particular the “verticalization” of response to and control of outbreaks, has affected PASB collaboration with the national level. Regarding food safety, no country in the Region has established it as a priority for public health, and this directly affects technical cooperation activities.
- b) **Delays in disseminating information persist.** There have been bottlenecks in national-level processes for revising information prepared for dissemination in Member States through channels established by the International Health Regulations (IHR). Texts prepared for dissemination are often submitted to high-level officials in Member States for revision and approval, which can significantly affect turnaround time.
  - c) **Disasters and emergencies adversely impacted the capacity of the Organization to implement some of its planned activities during 2016-2017.** A spate of emergencies and crises across the Region during the biennium consumed time and resources, particularly the yellow fever and Zika outbreaks and their associated complications, the earthquake in Ecuador, Hurricane Matthew in Haiti, and Hurricanes Maria and Irma in several Caribbean territories. Logistical and human resource capacity was pressed to respond to multicountry impacts, as when successive hurricanes raked the Caribbean in September 2017. Alternative means for delivery of goods and for transport of critical health personnel need to be established. Financial transactions with some suppliers have been affected by disruption of national financial/banking systems in affected countries (at times cash payments are required).
  - d) **Weak information systems remain a problem.** Gaps in information systems and methodologies in some countries made it difficult to implement established procedures for the request, sending, and coordination of Emergency Medical Teams to ensure continuity of clinical medical care in emergencies and disasters. There is a need for more efficient data management mechanisms to integrate information on human and animal health topics between ministries for efficient surveillance, control, and prevention of foodborne and zoonotic diseases and AMR. In most countries, different ministries are responsible for human and animal health, and as a result there are gaps in data collection and analysis, as well as in risk analysis evaluation.
  - e) **Difficulties persist in measuring the impact of AMR interventions.** Antimicrobial resistance is a complex problem that crosses many sectors (e.g., health, agriculture, and environment). It is difficult to demonstrate the public health impact of the AMR program due to challenges in identifying and measuring impact-level indicators, such as a decrease in mortality attributable to AMR.
  - f) **Gaps in laboratory coordination related to influenza preparedness** hindered the implementation of planned capacity-building activities.
  - g) **Interagency Emergency Health Kits lack medicines and supplies** for treatment of chronic diseases in emergencies.



*Success Stories in Countries*

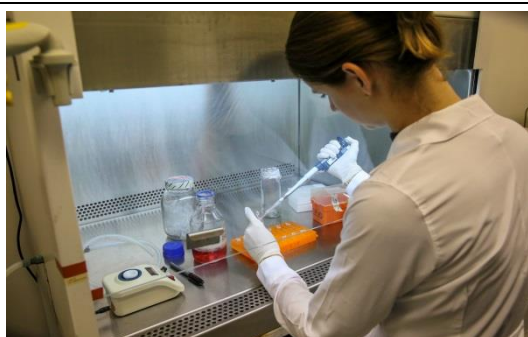
### Costa Rica and Ecuador | Emergency Medical Teams certified by WHO

In an emergency, ensuring the timely deployment of international medical teams providing quality clinical care is essential for saving lives, preventing disabilities, and protecting the health of affected populations. Emergency Medical Teams (EMTs) consist of health professionals (physicians, nurses, physical therapists, paramedics, and others) who provide clinical care directly to populations affected by sudden-onset emergencies and disasters, along with support for local health systems. The teams work under global guidelines that set classification criteria and minimum standards for them. The purpose is to have a global roster of medical teams that meet the minimum EMT standards set by WHO and that can be deployed to emergencies as rapidly as possible.

Since 2015, PAHO has worked with countries of the hemisphere to strengthen the mechanisms for requesting and sending EMT support, as well as flexible tools for developing and registering the teams, in accordance with the Plan of Action for the Coordination of Humanitarian Assistance, approved by the PAHO Directing Council in 2014.

In February 2017, the Costa Rican Social Security Fund EMT Type 1 became the first team in the Americas to receive EMT classification from WHO. This EMT can serve at least 100 people per day on an outpatient basis, in addition to stabilizing patients who need to be transferred to higher-level services. In September 2017, Ecuador received WHO certification for two Type 2 EMTs and one Specialized Surgical Cell. These teams, in addition to performing the functions of the Type 1 EMT, have inpatient capacity of at least 20 beds and can provide 24-hour emergency care, perform general and emergency surgeries including obstetric surgeries, and treat fractures and trauma injuries.

Ecuador became the first country in the Americas to utilize a Medical Information and Coordination Cell (CICOM) for the coordination and deployment of EMTs when 21 national and five international teams responded to its April 2016 earthquake. PAHO's EMT training in Ecuador, which by chance took place just days before the earthquake, enabled Ecuador to respond to the disaster following EMT guidelines and standards.



## Americas | Improved laboratory diagnosis capacity to detect arboviral diseases, including Zika virus

Zika virus infection is an emerging disease, transmitted through the bite of an infected mosquito (primarily *Aedes aegypti*, which also transmits chikungunya, dengue, and yellow fever). Autochthonous circulation of Zika virus in the Americas was first confirmed in February 2014 on Easter Island, Chile. By the end of December 2016, 48 countries and territories in the Region reported confirmed autochthonous, vector-borne transmission of Zika virus (ZIKV). In addition, five countries reported non-vector-borne transmission of ZIKV, likely through sexual contact (Argentina, Canada, Chile, Peru, and the United States).

PAHO worked closely with countries to build their capacity for response to Zika virus. Among other interventions, PAHO provided support and advice on Zika detection and differential diagnosis with other arboviral diseases, trained professionals from 22 countries on laboratory diagnosis of ZIKV infection, and procured critical reagents and supplies for the reference laboratories of 23 countries.

As a result of this technical cooperation, the number of confirmed cases of ZIKV infection grew steadily in the supported countries, demonstrating increased in-country diagnosis capacity for timely detection of arbovirus, including ZIKV. This improved capacity will support regional efforts for integrated surveillance, prevention, and control of arboviral diseases of public health importance in the Americas.

## Brazil | Timely situation analysis, risk assessment, and response monitoring for controlling the yellow fever outbreak



The 2016-2017 yellow fever outbreak was the largest reported in Brazil in decades, with 777 laboratory-confirmed human cases, including 261 deaths, and 1,659 epizootics among non-human primates. The last laboratory-confirmed case in that outbreak was reported on 15

June 2017. Most of the cases and epizootics were reported in the southeastern part of the country.

PAHO/WHO deployed epidemiologists and data managers to affected Brazilian states to support local authorities with data collection, analysis, and reporting. In all affected states, situation rooms with adequate management systems for data collection and case investigation were established. Additionally, PAHO/WHO supported provision of data for use in planning the implementation of the use of fractional doses of the vaccine in outbreaks, and in the design of action plans for active detection of unvaccinated pockets in selected municipalities. PAHO/WHO also supported national authorities in strengthening the surveillance for AEFIs (adverse events following immunization).

The critical actions implemented by PAHO/WHO provided timely and authoritative situation analysis and risk assessment, facilitating the response monitoring of this acute public health event.

## **Category 6: Leadership, Governance and Enabling Functions**

44. The Organization continued to provide leadership in health and strengthen its enabling functions and corporate services for the effective and efficient implementation of technical cooperation.

### ***Key Achievements***

- a) The Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), developed with Member States and approved at the 29th Pan American Sanitary Conference, represents the first long-term, regional health sector response to the Sustainable Development Goals.
- b) The Organization established platforms and mechanisms to promote policy dialogue across sectors at the regional and country levels, maintaining an effective response to health problems affecting the populations of countries during complex political situations.
- c) Sixteen Country Cooperation Strategies (CCS) were developed over the biennium, resulting in a total of 26 current CCSs.
- d) The development of the PAHO Program and Budget 2018-2019, using a bottom-up approach and prioritization with Member States, culminated in its full endorsement by Member States with an increase of 1.1% in budget space. The new PAHO Program and Budget Web Portal, launched in September 2017 at the 29th Pan American Sanitary Conference, allows Member States and other external stakeholders to obtain an up-to-date view of programmatic and financial implementation of the PAHO Program and Budget.
- e) The portfolio of financial partners was diversified and strengthened. The Organization signed financial agreements with 11 new partners, as well as with organizations with which there were no agreements in the past five years.

- f) The Directing Council and the Pan American Sanitary Conference approved a total of 29 resolutions covering policies, strategies, and plans of action that will guide the work of the Organization in the medium and long term.
- g) PAHO obtained another unmodified audit opinion for 2016. This is the result of the Organization's ongoing compliance with International Public Sector Accounting Standards (IPSAS).
- h) The PASB Management Information System (PMIS) was fully implemented on time and on budget; processes were documented, users were trained, and the PMIS Advisory Committee was established. Continuous PMIS system enhancements were adopted, and processes and operations streamlined.
- i) The Internal Control Framework was completed and the compliance function was created and staffed.
- j) A new PAHO Communications Strategic Plan for 2018-2022 was approved at the end of the biennium. The plan envisions a major shift in organizational communications based on a new PAHO brand positioning strategy and greater focus on stories from countries.
- k) Institutional communications on the Zika outbreak and emergency response were managed through effective platforms and key networks to strengthen and improve outreach in close collaboration with Member States and other key stakeholders.

### *Challenges*

- a) **Changes in the political landscape in Member States** have required strategic intelligence and frequent analyses at the country and regional levels to ensure that the Organization provides appropriate technical cooperation.
- b) **An unprecedented number of natural disasters and disease outbreaks** affected countries of the Region during 2016-2017. This required the Organization to provide urgent additional support while ensuring the continuity of its regular technical cooperation programs.
- c) **Repositioning of the United Nations (UN) development system** to deliver the 2030 Agenda for Sustainable Development, part of the UN reform requested by the Secretary-General, requires PAHO to examine its collaboration with the UN System.
- d) Within the context of globalization, priority issues affecting the Region – such as the attainment of universal health, the impact of climate change on health, and access to affordable and quality medicines and vaccines – increasingly require **concerted action across WHO regions**.
- e) **Resource mobilization efforts** continue to be affected by a highly competitive environment and a complex political context.
- f) **The introduction of PMIS and institutional changes, such as the integrated budget approach**, have required additional staff time, training, and ongoing

communication to effect a smooth transition from old systems and practices while ensuring that technical cooperation is not adversely affected.

- g) **Varying levels of communication capacity**, especially in PWR Offices, make it difficult to achieve the consistent and high-quality communications needed to support PAHO's technical cooperation.

### *Success Stories in Countries*

#### Americas | Region approves pioneering Sustainable Health Agenda for the Americas 2018-2030



The Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) became the highest-level policy and strategic planning reference document for the Organization when it was approved by the 29th Pan American Sanitary Conference in September 2017. The SHAA2030 demonstrates the Region's leadership in developing the first long-term, strategic regional health sector agenda in response to the Sustainable Development Goals. It will also guide the development of two PAHO Strategic Plans and help focus collective action by Member States and partners throughout the third decade of the 21st century to achieve the highest attainable level of health and well-being, with an emphasis on leaving no one behind.

The SHAA2030 is a product of extensive consultation with Member States and intensive collaboration between PASB and the Countries Working Group, which worked over a period of nine months to develop this seminal document. The group included 16 Member States from all subregions (Antigua and Barbuda, Argentina, Barbados, Brazil, Chile, Costa Rica, Ecuador, El Salvador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, United States, and Uruguay). Building on sound strategic planning practices developed in the Region, a country-led, democratic, and inclusive process was used to arrive at consensus on the goals and targets set in the SHAA2030. The development of the SHAA2030 has also provided useful lessons for negotiation and consensus building among Member States for health development in the Region.

More information is available at: [www.paho.org/health-agenda-americas](http://www.paho.org/health-agenda-americas).



## Americas | Supporting the country response to Zika through strategic communications

During the Zika virus outbreak, PAHO helped build effective platforms and networks to manage institutional communications and strengthen outreach to the population with timely messaging. A number of communication products about PAHO's work in the Region were produced, and ministries either adapted those materials by adding their logos or designed their own materials to incorporate PAHO's key messages. The Organization also provided support to communication officers from ministries of health at national and local levels. PAHO reported on key aspects of the response in Barbados, Brazil, Colombia, Cuba, El Salvador, Puerto Rico, and Trinidad and Tobago.

In leading the communication response, PAHO maintained strong coordination with WHO, PWR Offices, and regional offices of UN agencies. New partnerships were forged with non-traditional actors, such as Sesame Street and the Cartoon Network, to deliver key messages around the virus and prevention. Sesame Street estimates that more than 40 million people in Latin America and the Caribbean saw these public service announcements.

PAHO also explored partnerships with Facebook to expand its outreach on Zika. A case study from Facebook found that PAHO country accounts in Brazil and Colombia increased their number of followers during the outbreak. For instance, PAHO's office in Brazil increased its Facebook followers from 3,000 before the outbreak to almost 40,000 after it.

### *Categories and Program Area Assessment Summary*

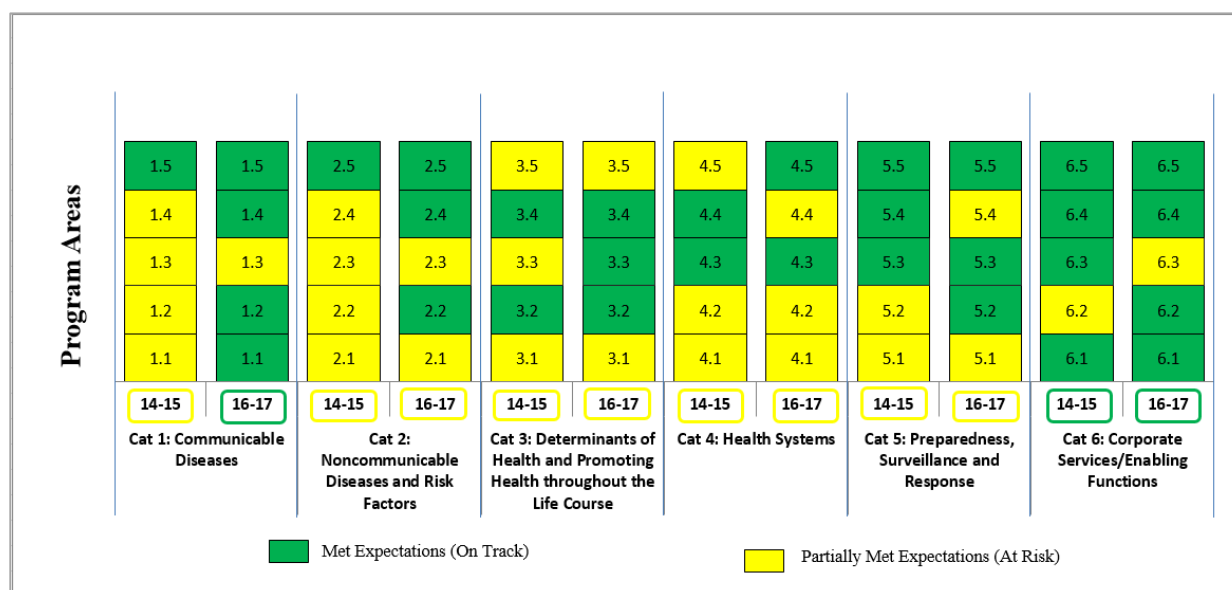
45. This section summarizes the results of the implementation of the PAHO Program and Budget 2016-2017 and the PAHO Strategic Plan 2014-2019. It outlines the status of the categories and program areas, including progress in achieving the 83 outcome indicators and 122 output indicators through joint efforts by the Member States and PASB. Detailed reports by category and program area, including assessment of outcome and output indicators, are available from the PAHO Program and Budget Web Portal.

46. As seen in Figure 3, two of the six categories were on track during the biennium, while four are at risk of not achieving the results set for 2019. Nineteen out of 30 program areas were on track, while the remaining eleven program areas were assessed as at risk, although important progress was made in each of them. This overall assessment



marks an improved outlook in comparison with the assessment made in 2014-2015, when five categories partially met expectations (at risk) and only 13 program areas were assessed as being on track.

**Figure 3. Categories and Program Areas Assessment (2014-2015 and 2016-2017)**



### Assessment of Outcome and Output Indicators

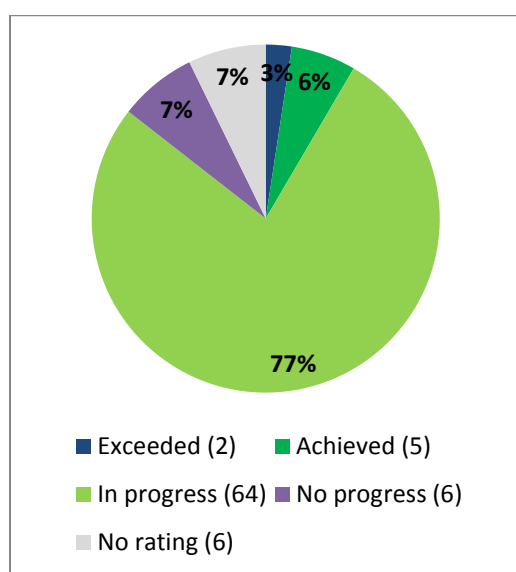
47. During the second biennium of the PAHO Strategic Plan 2014-2019, despite some setbacks, the Region continued to make progress on the outcome indicators.<sup>11</sup> As shown in Figure 4, seven of 83 outcome indicators have already been achieved or exceeded (9%), while 64 are in progress (77%), and six showed no progress (7%). Another six indicators (7%) could not be assessed, due to unavailability of data or methodological constraints, including changes in the methodology of assessment. Figure 5 indicates that 43 of 122 output indicators (35%) were achieved or exceeded, 74 (61%) were partially achieved, and 4 (3%) showed no progress. One output indicator was not rated due to lack of data (1%).

48. The main issues that affected the non-achievement of both outcome and output indicators included lack of reliable information, insufficient political support, limited institutional capacity, and weak intersectoral actions, as well as competing priorities on the regional and national agendas. To address these challenges, interventions in these programs need to be accelerated and closely monitored over the next two years. Additional reflections on the lessons learned are offered in Section VII.

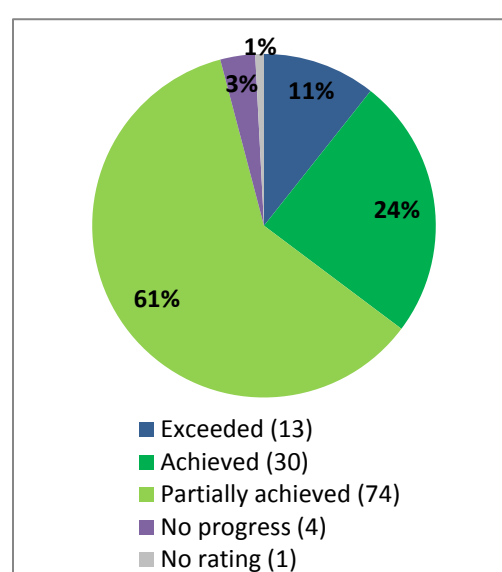
<sup>11</sup> As defined by the results chain in the Strategic Plan, outcomes are “collective or individual changes in the factors that affect the health of populations, to which the work of the Member States and PASB will contribute”. They are reached by the cumulative achievement of outputs, which are “changes in national systems, services, and tools derived from the collaboration between PASB and Member States, for which they are jointly responsible”.

49. In addition, during the technical validation of the joint assessment results, in several instances it was observed that the country status was potentially under-assessed. While many country self-assessments were revised upward through the technical validation, not all assessments could be agreed jointly at the time of this report. Therefore, the potential under-assessment of indicators, which was also reported during the end-of-biennium assessment report for 2014-2015, remains a challenge. To address this moving forward, joint validation of indicator linkages and subsequent verification of baseline and target values must be undertaken for the 2018-2019 biennium.

**Figure 4. Overview of Outcome Indicators Assessment**



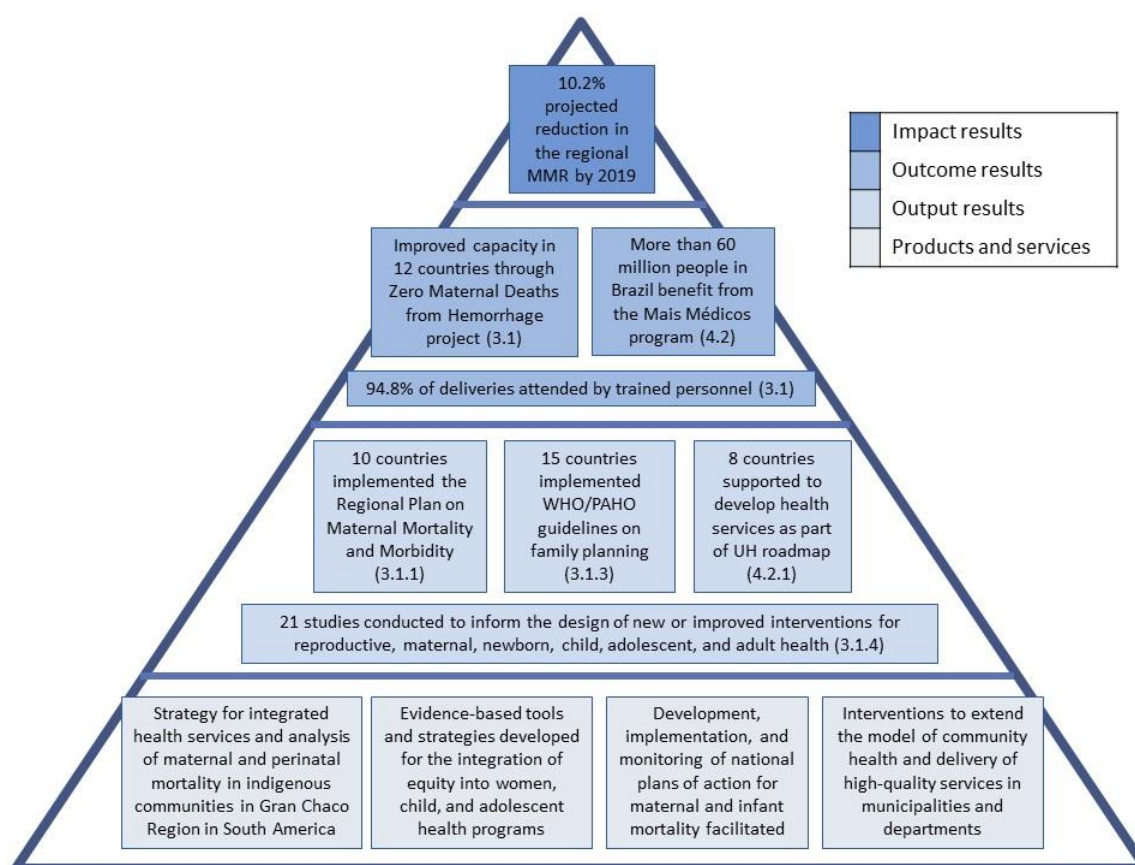
**Figure 5. Overview of Output Indicators Assessment**



### ***Promoting Impact Achievement across the PAHO Results Chain***

50. To contribute to the impacts, PASB works together with countries and partners, principally through the achievement of outcomes and outputs. Analysis in different technical areas has shown that the implementation of programs does contribute to higher-level impacts, but this positive relationship can be complex, and it depends on many different factors that are external to interventions by the health sector; hence the need to engage other sectors. To show how the interventions from PASB, carried out jointly with Member States, contribute to outcomes and impacts, Figure 6 provides an illustration using the maternal mortality impact goal target.



**Figure 6. Illustration of the Results Chain, from PASB's Contribution to Impact**

51. At the output level (3.1.1), Member States and PASB are jointly responsible for the development and implementation of national plans of action on maternal and perinatal mortality in line with the Regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity, which concluded in 2017. This assessment shows that at the end of 2017, ten out of 20 target countries implemented such plans, meaning that the expected result was not achieved, although some progress was made.

52. At the outcome level, the aim is to increase capacity and coverage of services and reduce risks. In that regard, progress was noted in the proportion of hospital births attended by trained personnel (3.1).<sup>12</sup> For 2017 this indicator is assessed at 94.8%, which shows progress in comparison to the 94.1% reported in the PAHO Core Indicators 2016, which measured this new indicator for the first time.

53. As reported above, a 10.2% reduction in maternal mortality is projected between 2014 and 2019, which shows that the regional target of an 11% reduction might be achieved

<sup>12</sup> Although the indicator of this outcome (3.1.2) remains in force in the PAHO Strategic Plan, the indicator has been changed by PAHO in the Core Indicators Publication. Since 2015, PAHO has measured hospital births as a proxy for qualified birth care (as qualified care is provided by trained personnel in hospitals), and countries have been reporting on the new indicator.

in 2019. However, the analysis shows significant variations between and within countries, which suggests the need to boost efforts where they are needed most, particularly among PAHO's key countries, in order to leave no one behind. Toward this end, the Organization has been implementing the Zero Maternal Deaths from Hemorrhage project, which aims to improve capacity to respond to obstetric emergencies. In addition, projects in Colombia, Nicaragua, and Paraguay have focused on specific communities as models, implementing actions to reduce inequities in access to good-quality health services, particularly among women and children from rural, indigenous groups, as well as Afro-descendant people, in the hope that these activities can be scaled up and shared as good practices.

54. Moving forward, the Global Strategy for Women's, Children's and Adolescents' Health and the launch of the Every Woman Every Child Latin America and the Caribbean (EWEC-LAC) movement provide a framework for the promotion and implementation of specific interventions aimed at improving the health of women, pregnant women, and newborns within the life course approach.

#### IV. Budget Implementation

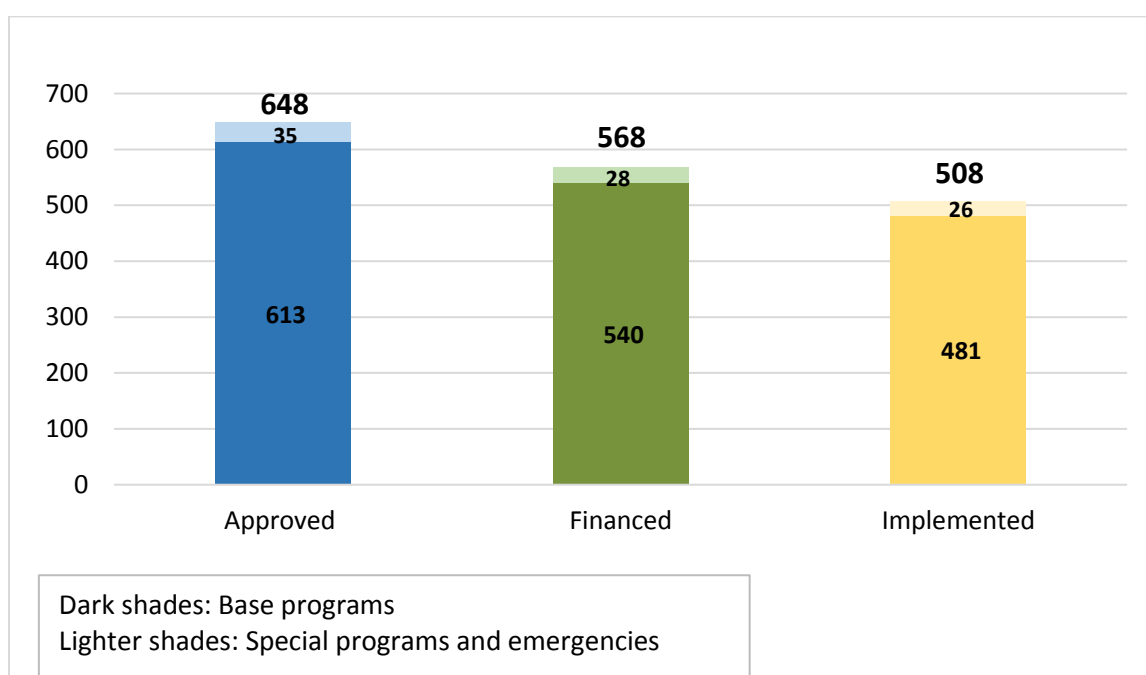
55. The budget implementation and resource analysis considers the funds available to implement the approved Program and Budget 2016-2017, the level of implementation of these funds, funding gaps, and efforts to mobilize resources to fill those gaps.

56. The Program and Budget establishes the estimated level of resources required by PASB to implement the program of work, including estimated resource requirements for each category and program area. During the biennium, resources are mobilized to fill the Organization's funding gap in relation to the approved Program and Budget. The corporate funding gap is progressively reduced during the biennium as resources are mobilized and awarded. The allocation of resources by category, program area, programmatic priority, and functional level is analyzed to determine whether the Organization was able to follow the guidance from Governing Bodies to provide appropriate allocations to priority program areas.

#### Budget Overview: 2016-2017

57. The approved Program and Budget for the 2016-2017 biennium was \$612.8 million for base programs and \$35 million for special programs and emergencies, for a total of \$647.8 million (Figure 7). Additional to the Program and Budget levels, \$990 million was estimated as resources from government-sponsored initiatives at national level.

**Figure 7. PAHO Program and Budget 2016-2017:  
Overview of Approved, Financed, and Implemented Funds  
(US\$ millions)**



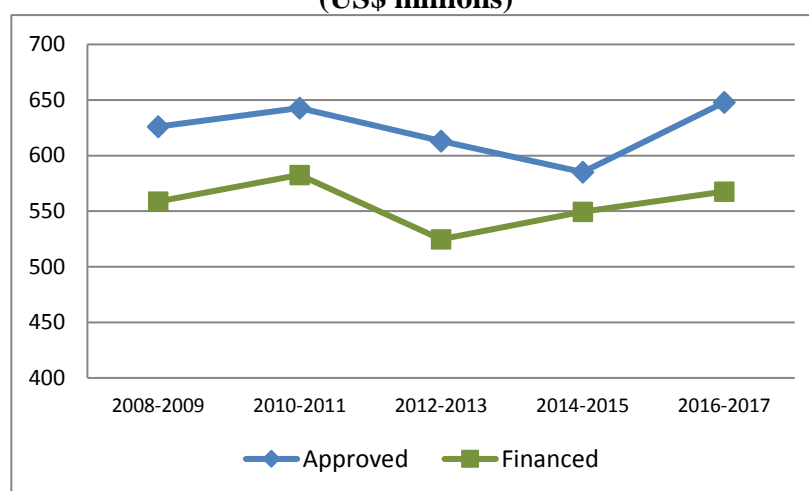
**Table 1. Sources of Financing of the Program and Budget, 2014-2015 and 2016-2017 (US\$)**

Source of Financing	2014-15 Financed	2016-17 Financed	% Change in 2016-17	Difference
<b>PAHO assessed contributions and miscellaneous revenue</b>	198,400,000	217,735,000	10%	19,335,000
<b>Other sources</b>	211,900,000	208,994,000	-1%	(2,906,000)
<b>WHO allocation to the Americas</b>	139,100,000	140,992,000	1%	1,892,000
<b>TOTAL</b>	<b>549,400,000</b>	<b>567,721,000</b>	<b>3%</b>	<b>18,321,000</b>

Note: Includes undistributed and carried-over funds.

58. As summarized in Table 1, total funds received in 2016-2017 were \$567.7 million (including funds carried forward from 2014-2015). Of this amount, \$521.6 million was available for implementation during 2016-2017; the remaining \$46.1 million was carried forward into 2018-2019.<sup>13</sup> The \$521.6 million available constitutes 81% of the approved Program and Budget.

59. Figure 8 shows PAHO's Program and Budget trends in terms of amounts approved and financed for the last 10 years. Financing for the Program and Budget 2016-2017 reached a level consistent with previous biennia, but did not meet the approved budget level.

**Figure 8. Program and Budget: Financing Trends (US\$ millions)**

<sup>13</sup> Voluntary Contributions are not always given for a time period that coincides with the Organization's biennial budget. Therefore, carry-forward amounts from one biennium to the next are considered normal practice from a budgetary perspective. At the end of each biennium, analysis is performed to determine the nature of the carry-forwards and to confirm PAHO's timely utilization of funds as per donor agreements. The \$46.1 million carried forward consisted of funds that were always intended for implementation in 2018 and beyond, as well as funds that were originally intended for implementation in 2016-2017 but for various reasons were not expensed in that period (for these funds extensions of the implementation period are negotiated with the respective donor).

60. Overall implementation of the Program and Budget reached 78% of its approved level, and 97% of available funding. Table 2 provides a more detailed overview of the Program and Budget components, along with availability of funding and implementation levels by category and program area.<sup>14</sup> An analysis of each budget segment is presented in the following sections.

**Table 2. Program and Budget 2016-2017: Approved, Available, and Implemented Funds, by Category and Program Area (US\$ millions)**

Category and Program Area	Approved Budget	Available Funds	Implemented	Available as % of Approved	Implemented as % of Approved	Implemented as % of Available
<b>1. Communicable Diseases</b>	<b>102.4</b>	<b>81.5</b>	<b>80.6</b>	<b>80%</b>	<b>79%</b>	<b>99%</b>
1.1 HIV/AIDS and STIs	15.5	9.0	9.0	58%	58%	100%
1.2 Tuberculosis	7.3	6.9	6.9	95%	95%	100%
1.3 Malaria and other vector-borne diseases	19.5	17.6	17.4	91%	90%	99%
1.4 Neglected, tropical, and zoonotic diseases	13.4	12.1	12.1	90%	90%	100%
1.5 Vaccine-preventable diseases	46.7	35.9	35.2	77%	75%	98%
<b>2. Noncommunicable Diseases and Risk Factors</b>	<b>58.0</b>	<b>41.0</b>	<b>40.6</b>	<b>71%</b>	<b>70%</b>	<b>99%</b>
2.1 Noncommunicable diseases and risk factors	29.9	22.1	21.9	74%	73%	99%
2.2 Mental health and psychoactive substance use disorders	7.3	6.4	6.4	89%	88%	99%
2.3 Violence and injuries	6.2	4.9	4.8	79%	78%	99%
2.4 Disabilities and rehabilitation	5.4	2.4	2.4	44%	43%	99%
2.5 Nutrition	9.2	5.2	5.2	56%	56%	100%
<b>3. Determinants of Health and Promoting Health throughout the Life Course</b>	<b>81.2</b>	<b>48.6</b>	<b>48.3</b>	<b>60%</b>	<b>59%</b>	<b>99%</b>
3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health	44.9	24.8	24.6	55%	55%	99%

<sup>14</sup> Excludes funds that were carried over to the 2018-2019 biennium.

Category and Program Area	Approved Budget	Available Funds	Implemented	Available as % of Approved	Implemented as % of Approved	Implemented as % of Available
3.2 Aging and health	2.7	2.3	2.3	86%	85%	99%
3.3 Gender, equity, human rights, and ethnicity	9.2	6.9	6.9	75%	75%	99%
3.4 Social determinants of health	12.0	6.4	6.3	53%	53%	99%
3.5 Health and the environment	12.5	8.3	8.3	67%	66%	100%
<b>4. Health Systems</b>	<b>109.2</b>	<b>85.7</b>	<b>83.5</b>	<b>79%</b>	<b>77%</b>	<b>97%</b>
4.1 Health governance and financing; national health policies, strategies, and plans	17.4	17.8	17.7	102%	102%	100%
4.2 People-centered, integrated, quality health services	13.7	14.3	14.3	105%	105%	100%
4.3 Access to medical products and strengthening of regulatory capacity	24.7	19.8	18.1	80%	73%	91%
4.4 Health systems information and evidence	33.3	22.8	22.6	69%	68%	99%
4.5 Human resources for health	20.1	11.0	10.8	55%	54%	98%
<b>5. Preparedness, Surveillance, and Response</b>	<b>59.8</b>	<b>56.1</b>	<b>54.5</b>	<b>94%</b>	<b>91%</b>	<b>97%</b>
5.1 Alert and response capacities (for IHR)	9.9	7.4	7.4	75%	75%	100%
5.2 Epidemic- and pandemic-prone diseases	14.6	17.6	16.3	121%	112%	93%
5.3 Emergency risk and crisis management	30.3	23.9	23.9	79%	79%	100%
5.4 Food safety	5.0	7.2	6.9	143%	137%	96%
<b>Subtotal: Categories 1-5</b>	<b>410.7</b>	<b>313.0</b>	<b>307.6</b>	<b>76%</b>	<b>75%</b>	<b>98%</b>
<b>6. Corporate Services/Enabling Functions</b>	<b>202.1</b>	<b>181.1</b>	<b>173.9</b>	<b>90%</b>	<b>86%</b>	<b>96%</b>
6.1 Leadership and governance	46.5	42.3	41.6	91%	90%	99%
6.2 Transparency, accountability, and risk management	8.3	9.4	9.0	113%	109%	96%

Category and Program Area	Approved Budget	Available Funds	Implemented	Available as % of Approved	Implemented as % of Approved	Implemented as % of Available
6.3 Strategic planning, resource coordination, and reporting	24.0	13.0	12.5	54%	52%	96%
6.4 Management and administration	110.8	105.4	100.0	95%	90%	95%
6.5 Strategic communications	12.5	11.1	10.8	89%	86%	97%
<b>Subtotal: Base Programs (Categories 1-6)</b>	<b>612.8</b>	<b>494.1</b>	<b>481.4</b>	<b>81%</b>	<b>79%</b>	<b>97%</b>
<b>Special Programs and Emergencies</b>	<b>35.0</b>	<b>27.6</b>	<b>26.1</b>	<b>79%</b>	<b>75%</b>	<b>95%</b>
Polio eradication maintenance	1.2	3.1	3.0	259%	253%	98%
Foot-and-mouth disease eradication program	11.8	4.4	4.4	38%	38%	100%
Outbreak and crisis response	22.0	20.0	18.6	91%	85%	93%
<b>Program and Budget Total</b>	<b>647.8</b>	<b>521.6</b>	<b>507.5</b>	<b>81%</b>	<b>78%</b>	<b>97%</b>
Government-sponsored initiatives	990.0	1,077.6	1,071.6	109%	108%	99%

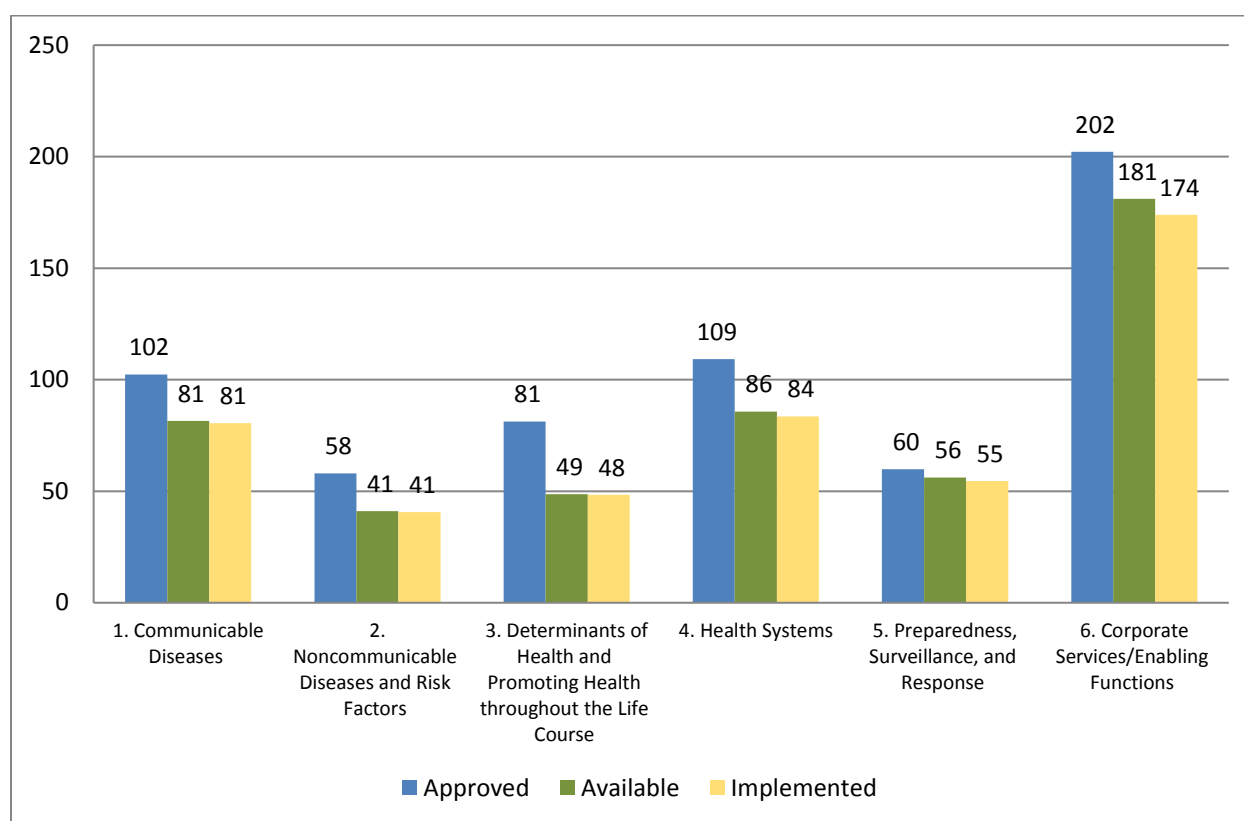
### Base Programs

61. The approved budget for the base programs segment was \$612.8 million (Table 2). The base programs segment was financed at 81%. The lower level of financing in this biennium was evident across all categories of the Program and Budget, though not evenly among program areas (see Table 2). Reduction in resource availability directly affected implementation levels against the approved Program and Budget.

62. Figure 9 presents a summary of the distribution of the base programs by category. Of the technical categories, Category 5 achieved levels of funding of over 90%, and both Categories 1 and 4 were financed at almost 80%. By contrast, Categories 2 and 3 remained underfunded, with 70% and 60% of their approved budget, respectively. Resource availability is key to achievement of results, and the serious underfunding of these two priority categories prevented them from moving further ahead in closing the programmatic gaps.



**Figure 9. Program and Budget 2016-2017: Base Programs Overview by Category (US\$ millions)**

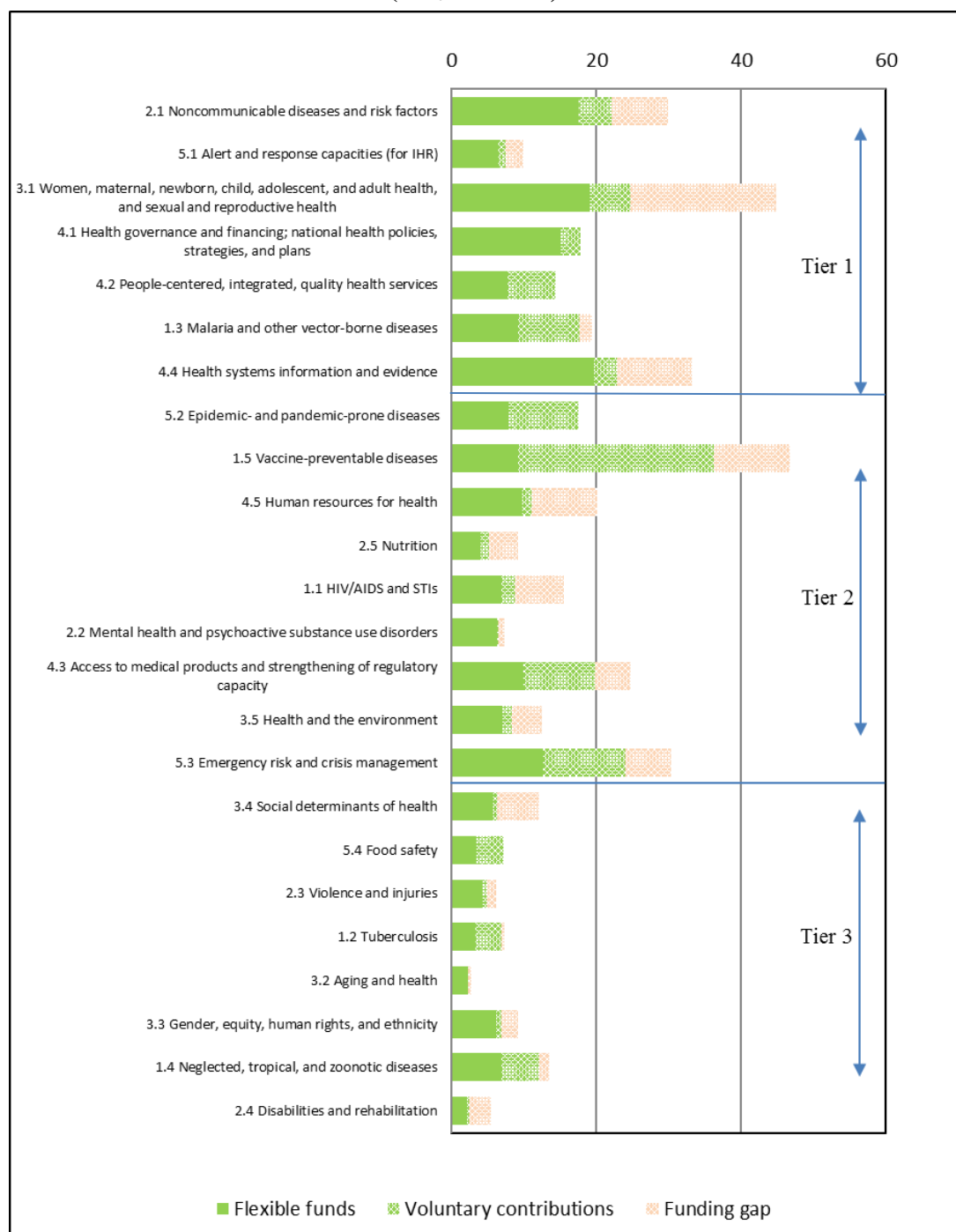


63. As previously mentioned, overall budgetary implementation was affected by the levels of available funding during the biennium, and also by the timing of the funds received. While implementation against the Program and Budget reached only 79% for base programs, funds available were fully implemented or nearly so.

64. Table 2 (above) presents an overview of the Program and Budget by category and program area and provides details on the availability of funds and implementation levels. As shown in the table, financing levels for base programs were not homogeneous across program areas. Of the 24 technical program areas, 15 were 75% financed or more, while six were notably lower. These six program areas are: 1.1 HIV/AIDS and STIs (58%), 2.4 Disabilities and rehabilitation (44%), 2.5 Nutrition (56%), 3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health (55%), 3.4 Social determinants of health (53%), and 4.5 Human resources for health (55%).

65. With regard to Category 6, there was reduction of about 10% in both funding and expenditure compared to 2014-2015. This was consistent with the Organization's ongoing efforts to shift resources to technical programs and implement efficiency measures in administrative areas.

**Figure 10. Program and Budget 2016-2017:  
Programmatic Prioritization and Resource Allocation in Base Programs  
(US\$ millions)**



66. When comparing levels of funding against programmatic prioritization, only five of the eight priorities of the Organization reached levels of available funding of 75% or more of their approved budget levels, pointing to the still-existing lack of alignment between Member State prioritization and donor financing of the Program and Budget. In particular, the low level of available funding of Program Area 3.1 (Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health) must be highlighted. This program area has been accorded a very high level of prioritization by Member States, and there is a strong mandate to the Organization to move forward on this public health topic, reflected in the decision of Member States to maintain its budget level high despite a history of low financing.

67. It should be noted that the formal budget structure does not always depict the cross-cutting nature of PAHO's work in many program areas. Programmatic work often covers more than one program area but may be attributed to only one of them. This is particularly relevant for program areas that attract more donors and can achieve common objectives with those program areas that attract fewer voluntary contributions, but reporting lines demand a specific linkage to the Program and Budget.

68. PASB, fulfilling its commitment to achieve the mandates given by Member States, has used flexible funding to strengthen those program areas in most need, with emphasis on those ranked as high priorities in the Program and Budget 2016-2017. As noted in Figure 10 above, the level of flexible funds allocated to the top three priority program areas (2.1, 5.1, and 3.1) was very high in comparison to the overall available funding (79%, 87%, and 77% respectively) received during the biennium.

69. PASB continues its resource mobilization efforts, at both programmatic and strategic levels, to deliver technical work that it has been mandated to do and to close financial gaps where they exist. During the biennium 2016-2017, these efforts resulted in approximately \$120 million in voluntary contributions (approximately 24% of total available funds for base programs). Of the total PAHO voluntary contributions, 42% were mobilized from the top 10 donors listed in Table 3. From these donors, \$20 million (39% of funds provided by the top 10 donors) was designated to support programs in Category 1. On the other hand, the level of prioritization for some program areas of Category 2 is very high, yet it received only 3% of top-10 donor funds. PASB commends our financing partners' willingness to support the Program and Budget while it calls for improved strategic alignment with priorities set by Member States.

**Table 3. Top 10 Donors to PAHO Program and Budget 2016-2017**

<b>Donor</b>	<b>Funds Available (US\$)</b>	<b>1. Communicable Diseases</b>	<b>2. Noncommunicable Diseases and Risk Factors</b>	<b>3. Determinants of Health and Promoting Health throughout the Life Course</b>	<b>4. Health Systems</b>	<b>5. Preparedness, Surveillance, and Response</b>	<b>6. Corporate Services/Enabling Functions</b>
US Agency for International Development (USAID)	13,654,630	62%	1%	16%	8%	14%	
US Centers for Disease Control and Prevention (CDC)	10,385,695	67%	8%			25%	
Department of Foreign Affairs, Trade and Development (Canada)	6,963,566	12%	9%	44%	24%	11%	
GAVI Alliance	6,702,681	41%			59%		
UK Department for International Development (DFID)	5,501,834					100%	
Agencia Española de Cooperación Internacional para el Desarrollo (AECID)	1,631,269			1%	52%	45%	3%
Government of Luxembourg	1,592,533			19%	81%		
United Nations Development Programme (UNDP)	1,551,706	3%	14%	3%	55%	25%	
European Commission	1,526,930	5%		7%		88%	
Bill and Melinda Gates Foundation	1,416,487	72%			28%		

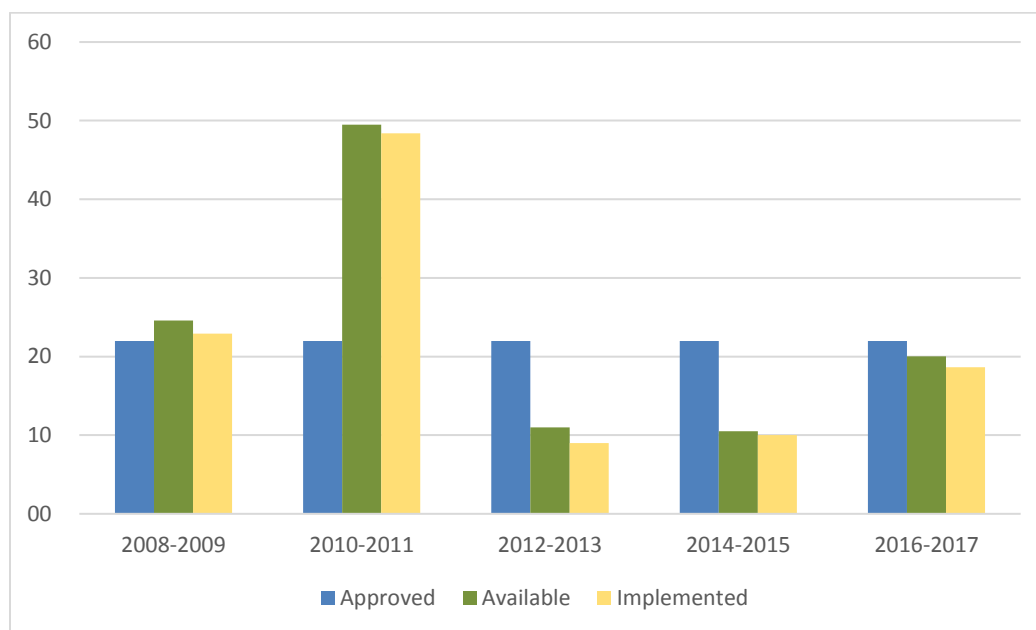
### **Special Programs and Emergencies**

70. The budget segment for special programs and emergencies approved by Member States was \$35 million. Available funding for that segment reached \$27.5 million, or 79% of the approved budget. While the polio eradication and outbreak and crisis response (OCR) components were well funded, the foot-and-mouth disease eradication program received funding for only 38% of its approved budget. This is partly because some related activities were carried out within base programs. For the three programs, implementation levels as a percentage of approved budget was on par with their funding levels, reaching over 90% of available funds.

71. The Organization responded strongly to the call by Member States to keep the Americas safe from the health consequences of emergencies and disasters. As a result of

the increased number of such events, including Zika virus and associated complications, funding and implementation of the OCR component of the Program and Budget reached 85% in 2016-2017. Funds available increased considerably with respect to the two preceding biennia, reflecting the scale and severity of emergencies and outbreaks in 2016-2017 and the relative volatility of this component.

**Figure 11. Outbreak and Crisis Response:  
Overview of Budget, Financing, and Implementation**



### Government-Sponsored Initiatives

72. The modality of government-sponsored national agreements (also known as national voluntary contributions, or NVCs) is an increasingly important means of providing cooperation, with some governments making significant funds available to support and implement national technical cooperation programs. In the biennium 2016-2017, PAHO received \$142.4 million in NVCs, excluding the Mais Médicos project. Though distribution of the resources varied by country, most countries dedicated a considerable percentage of such funds to technical cooperation to strengthen health systems and services.

73. The level of NVCs varies greatly among countries and from biennium to biennium. Most of the countries that contributed NVCs in 2014-2015 contributed these funds again in 2016-2017, but five countries did not. The amount of NVCs received in this biennium was considerably lower than the amount in 2014-2015 (\$254.16 million), mainly due to a dollar-value reduction in NVCs from Brazil because of fluctuating exchange rates.

**Table 4. National Voluntary Contributions to PAHO, 2016-2017  
(US\$)**

Government	Available	Implemented
Government of Brazil (excluding Mais Médicos)	117,372,765	112,174,018
Government of Colombia	14,144,837	14,084,995
Government of Argentina	3,115,293	3,102,562
Government of Dominican Republic	2,626,680	2,626,680
Government of Mexico	1,923,128	1,836,226
Government of Peru	1,411,670	1,404,289
Government of Costa Rica	520,181	205,966
Government of Ecuador	560,337	560,337
Government of Trinidad and Tobago	304,890	45,634
Government of Chile	123,729	123,729
Government of Uruguay	121,118	121,118
Government of Paraguay	98,285	98,285
Government of Panama	81,624	80,938
Government of Guatemala	2,480	2,480
<b>Subtotal</b>	<b>142,407,016</b>	<b>136,467,255</b>
Mais Médicos (Brazil)	935,199,230	935,149,039
<b>Total NVCs 2016-2017</b>	<b>1,077,606,246</b>	<b>1,071,616,294</b>

## **V. Risks, Lessons Learned, Conclusions and Recommendations**

74. This section summarizes the main risks and mitigation actions, lessons learned, and conclusions and recommendations from the implementation of PAHO's Program and Budget 2016-2017. It elaborates upon the analysis in the preceding sections and responds to requests from Member States to present a more systematic review to guide the Organization's work in 2018-2019, looking ahead to the new Strategic Plan 2020-2025.

### ***Risk Analysis***

75. During 2016-2017, PAHO continued to implement its Enterprise Risk Management (ERM) program for identifying, monitoring, evaluating, and managing ongoing risks to PAHO's operations and technical cooperation activities. The scope of the ERM program also includes a review and determination of risks at national and corporate levels.

76. The PAHO Risk Register is the formal mechanism that captures risk-related information provided by the network of risk focal points. The Standing Committee for risk management (constituted by the top management level of PASB) reviews, validates, and prioritizes corporate risks. PASB Executive Management periodically reviews internal control measures within PASB and enforces compliance to ensure strong financial and programmatic stewardship. In general, the main risks to the performance of the Organization were identified and mitigated in a timely manner during 2016-2017.

77. In the Strategic Plan 2014-2019, a set of risks were identified for each of the Plan's six categories. More specifically, a narrower set of main risks have been identified through the 2016-2017 risk register and a review of information from the category assessment reports. These main risks are summarized below, along with a brief description of their potential impact and some of the mitigation activities implemented during the biennium.

78. **RISK: Shifts in health priorities at the global, regional, or national level result in diminished political and financial support for specific interventions, with a possible impact on health outcomes.**

- a) This risk continues to be relevant for most of the categories. To mitigate it, PAHO worked hand-in-hand with the national authorities and other relevant actors at regional and national levels, intensifying stewardship and governance for health financing, intersectoral work, and work toward the SDGs. The development of the Sustainable Health Agenda for the Americas 2018-2030 and programmatic prioritization conducted for the development of the PAHO Program and Budget 2018-2019 are examples of such collaboration.
- b) PASB intensified efforts to mobilize resources, bringing in new donors, renewing others that had lapsed for a period of time, and strengthening capacity for the mobilization of national voluntary contributions. At country level, advocacy will continue with ministers of health and finance, as well as with important partners such as the Organization for Economic Co-operation and Development (OECD), to increase fiscal space for health in the new biennium. The renewed global focus on



universal health, as observed in the 13th WHO General Programme of Work (GPW), represents an opportunity to mobilize additional resources in the upcoming biennium.

- c) Additionally, some interventions were carried out by maximizing the use of national human and financial resources. Cooperation among Countries for Health Development (CCHD) and triangular cooperation were expanded to better respond to country priorities and needs at all levels of the Organization, especially for PAHO's key countries.

**79. RISK: Mobility of people across borders brings increased pressure on services and programs for disease prevention, control, and elimination.**

- a) Human migration poses one of the greatest public health challenges worldwide, and this risk continues to be relevant for public health programs and services in the Region. The issue of migration is a very sensitive subject for geopolitical, economic, and humanitarian reasons. This risk requires a collective response from Member States, engaging all relevant sectors.
- b) To mitigate this risk, during 2016 the Member States approved the Health of Migrants policy document (Document CD55/11) to increase advocacy and promote mobilization of national resources to develop policies and programs that are sensitive to the health needs of migrant populations. In addition, PAHO, through its regional, subregional, and country offices, is strengthening interagency coordination and collaboration mechanisms to achieve synergies and efficiency in technical cooperation, in particular with the International Organization for Migration and other stakeholders, to improve the health and protection of migrants in countries of origin, transit, and destination.

**80. RISK: Emergencies, civil unrest, and other social disruptions affect PAHO operations.**

- a) This risk continues to be relevant for Member States and for PAHO's operations. During this biennium the Region had to confront and respond to the impact of several emergencies, including natural disasters (e.g., Hurricanes Matthew, Irma, and Maria, earthquakes in Ecuador and Mexico, and severe floods in Peru) and infectious disease outbreaks (e.g., Zika virus, dengue, yellow fever, and chikungunya). In addition to the impacts on affected populations, these events create pressure on PAHO's operations when staff and resources must be diverted away from their regular and planned activities.
- b) As part of the mitigation actions, PASB ensured that each PWR Office has a Business Continuity Plan in place to guarantee minimal disruptions to technical cooperation. A coordination mechanism was established within PASB to support countries affected by emergencies and to manage timely support to country teams. In addition, PAHO designed and approved a Business Continuity Plan for PAHO Headquarters. PASB also works with Member States in the stages of response and recovery.

**81. RISK: Weak health information systems and data analysis capacity prevent countries from implementing evidence-based policies and sustainable interventions to improve health outcomes.**

- a) Countries need robust health information systems and data to monitor the health situation and health outcomes, including the health-related SDG targets. Weakness in this area is making it difficult for countries to advance and focus their actions to reduce inequalities and to make sustainable decisions that improve the health and well-being of the population. There has been a notable shift in the willingness of countries to assign importance to this issue, with significant resources being allocated to develop better health information systems and strengthen data generation and analysis to improve health system management and support evidence-based decision making. Nonetheless, more effort is needed to extend data collection to reach the poorest and most marginalized populations.
- b) In addition, the lack of data has led to over-reliance on estimates and projections to report on certain indicators (e.g. UN IGME estimates on child mortality and UN MMEIG estimates on maternal mortality). This constitutes a specific risk for the monitoring and assessment of health outcomes and impacts, as well as for strategic decision making.
- c) Mitigation actions include continued advocacy with Member States to invest in this area and collaboration with them to build national capacities to strengthen health information systems. Addressing this particular risk requires intersectoral action at country level. Toward this end, PASB has created a dedicated department responsible for leading an integrated approach to this area.

**82. RISK: Security breaches of PAHO's information system may impact confidentiality, integrity, and/or availability of information.**

- a) PASB makes extensive use of information technology (IT) to carry out its work. With the increased dependence on technology, it is imperative to continuously maintain a high level of confidence in the security of PASB data. In 2016, PASB received strategic advisory services on cybersecurity from the United Nations International Computing Centre (UNICC). Existing cybersecurity measures were assessed against industry best practices outlined in the International Organization for Standardization's ISO 27001 standard, and a Cybersecurity Roadmap was defined.
- b) Mitigation actions were identified to strengthen PASB's cybersecurity capabilities, including introduction of a full-time information security officer position; continued engagement in efforts to implement externally managed security services on the network security; design of a consolidated framework for information security policies and procedures; and strengthening of data backup and recovery capabilities. More information is available in the Cybersecurity in PAHO document (CE162/INF/4).

***Lessons Learned***

83. Implementation of the Program and Budget 2016-2017 has provided important lessons learned that allow the Organization to build upon successes and avoid unproductive practices. Applying these lessons will improve PAHO's technical cooperation and increase its public health impact in future biennia: immediately in the implementation of the 2018-2019 Program and Budget, and medium-term in the development of the next Program and Budget 2020-2021.

**84. Ensuring universal access to health and universal health coverage, and promoting strong and resilient health systems**

- a) The Universal Health framework and its regional strategy increased the momentum and commitment of Member States to further promote equitable access to and coverage of services, strengthen stewardship and governance of the national responses, improve efficiency through more integrated health systems, and strengthen intersectoral coordination to address the determinants of health.
- b) Addressing governance through a comprehensive and integrated approach that creates interconnected regulation mechanisms is key to institutional transformations that promote equitable access to health services. Greater social participation has promoted more responsive policies, transparency, and sustainability. Effective governance and regulation have proven critical for developing, funding, and implementing policies and plans.
- c) Progress in serving marginalized and underserved populations requires involving and empowering communities to take charge of their own health. For example, in Guyana, detailed microplanning for a mass-drug administration campaign to combat lymphatic filariasis helped communities target hard-to-reach areas and populations, address barriers that hindered service delivery, estimate needed resources, and monitor results to demonstrate coverage. These efforts also provided an opportunity to improve dialogue with community leaders and strengthen country capacity in implementing such campaigns.
- d) Working in coordinated phases at the community level is an effective strategy for achieving change in the care of older people, by strengthening the role of the elderly in their own communities and implementing evidence-based programs that enhance their functional capacity.
- e) The decentralization of training institutions and recruitment of students from rural backgrounds can increase the production, deployment, and retention of health workers in remote rural settings.

**85. Strengthening health information systems to better inform policies and health interventions**

- a) Experience at country and regional levels has exposed gaps in both availability and quality of information on health. Timeliness of data collected continues to limit its usefulness for planning purposes.
- b) Capacity for interpretation and analysis of data is also lacking in many countries. Capacity building in this area is critical to ensure usability of data for policy-making purposes, and to ensure that health interventions are targeted where they are most needed.

**86. Identifying critical success factors in responding to health emergencies and outbreaks**

- a) One of the most critical lessons learned during the recent series of outbreaks and emergencies was that weak health systems cannot cope effectively with such events. To ensure that health systems can respond to future health emergencies, absorb shocks, and adapt to changing demands, countries need to make the necessary investments to build health systems that are strong and resilient.
- b) Investing in establishing national EMTs has proven to be an effective approach for timely response to emergencies.

**87. Mobilizing support for health priorities through effective multisectoral advocacy**

- a) Building a solid business case for investment in health has proven effective in mobilizing resources beyond the health sector. *Example:* In a number of countries, analyzing the economic and social costs of disease to build an investment case for combatting hepatitis has proven to be an effective advocacy and strategic planning tool to build a strong national response and mobilize partners and funding to address hepatitis.
- b) In the context of the SDGs, moving the health determinants agenda forward requires multisectoral action. This in turn depends in large part on the success of the health sector in mobilizing concrete action among its partners in other sectors, both public and private. This has proven particularly true when it comes to mobilizing support for health-related legislation that also has significant impact on other sectors.
- c) Interprogrammatic cooperation has also been a very useful strategy for pooling efforts, optimizing resources, and moving various programs forward (e.g., to address adolescent mental health; dementia and aging; mental health and ethnicity and human rights; psychosocial support in emergencies; aging and noncommunicable diseases; climate change and vector-borne diseases; Zero Maternal Deaths from Hemorrhage; Zika virus and rehabilitation services).

**88. High-level policy dialogue and replication of successful existing policies for addressing noncommunicable diseases**

- a) Addressing NCD risk factors requires legislative action and high-level policy dialogue. To have a significant impact on NCDs, changes in policies, behaviors, and health provider practices are essential, as is a shift from a system of sporadic, acute care toward long-term, continuous, chronic care. These changes require sustained political commitment, investment of resources, and a broader social dialogue among all stakeholders.
- b) Meeting regional targets at the impact and outcome levels, particularly with respect to NCDs and risk factors and increasing fiscal space for health, often takes longer to achieve because of the need to build consensus over time (see previous point). It is important to bear this in mind as it relates to target setting and ongoing monitoring and assessment.
- c) As an example of a successful initiative, preliminary results from the front-of-package labeling policy in Chile show that the warning has been effective in increasing consumer awareness at the point of food purchase. Making the label easy for the general public to understand was instrumental in this regard. In addition, the policy has led industry to reformulate certain products to reduce their unhealthy content.

**89. Collaborating effectively with countries, partners, and the private sector to address health priorities**

- a) Sustained collaboration with Member States on strategic planning and optimization of the knowledge and expertise in the national health authorities and the PASB have improved the quality, country ownership, and sustainability of engagement. This has led to the development of best practices and innovative tools (e.g., strategic planning, joint assessment, bottom-up planning, and prioritization methodologies) that will contribute to increased efficiency and effectiveness of PAHO's technical cooperation and the attainment of health outcomes and impacts.
- b) Subregional approaches with political commitment have proven to be effective in implementing strategies to promote access to medicines, strengthen regulatory capacity, and share resources among Member States with limited capacity.
- c) An increasingly significant modality of technical cooperation consists of government-sponsored initiatives at national level, financed through national voluntary contributions. In many countries these initiatives form an important and integral part of the national package of technical cooperation that PAHO provides.
- d) The creation of alliances and trust relationships with national counterparts and other UN agencies has proven to be critical to ensure access to classified and/or limited information during emergencies. Currently, PAHO benefits from access to that information through websites administered by counterparts and other agencies. To ensure the creation of alliances and relationships based on trust, coordination with countries and meetings to share common objectives were key.

**90. Financing for the Pan American Sanitary Bureau, and administrative efficiency**

- a) In the integrated budget environment of 2016-2017, the provision of funding in the form of periodic tranches, with no guarantee of the total amount to be received, posed a challenge to the timely implementation of work plans. Many PWR Offices and technical divisions in Washington were financially conservative because of uncertainty about how much flexible funding they would receive, and when. For 2018-2019, the PASB has sought to remedy this situation by providing estimated flexible funding levels up front and by distributing as much flexible funding as possible at the start of the biennium. However, flexible funding from WHO for the Regional Office of the Americas (AMRO), estimated at approximately \$100 million for 2018-2019, continues to be distributed in unpredictable tranches.
- b) To enhance efficiency in the administrative and enabling services of the PASB, significant opportunities were identified to streamline processes and reduce costs. This resulted in a lower budget for Category 6 for the 2018-2019 biennium.

***Conclusions and Recommendations***

91. The assessment of the PAHO Program and Budget 2016-2017 shows significant progress toward fulfillment of the commitments in the PAHO Strategic Plan 2014-2019. Recently adopted global, regional, and subregional commitments (SDGs, SHAA2030, Montevideo Roadmap, Global Strategy for Women's, Children's and Adolescents' Health, EWEC-LAC movement, and Caribbean Subregional Cooperation Strategy, among others) constitute important achievements for the Organization, despite considerable challenges during their implementation phase. New integrated approaches to technical cooperation also emerged during the biennium, such as linking rehabilitation services as an inherent part of the health response during the Zika epidemic. Throughout the biennium, the Organization continued to exercise its leadership role in advocating for public health within the Region while simultaneously sharing best practices and lessons learned at the global level.

92. The role of PAHO and the health sector in facilitating intersectoral dialogue and the achievement of the SDGs has been acknowledged. However, processes and mechanisms at the country level are inconsistently developed. There is often insufficient know-how to enable intersectoral policy dialogue and processes. Capacities in countries and within PASB need to be strengthened, both for the development of national road maps that include a strong health component and to support countries in the measurement of health milestones.

93. By reviewing the complete results chain in this assessment, from outputs to impacts, the Organization gained important insights into how interventions at various levels have contributed to impacts. Progress toward the regional impact targets has required the commitment of all Member States, PASB, and partners. While preliminary results are available and are presented in this report, it should be kept in mind that a longer time period is required to yield higher-level results at the impact level. The implementation of the

Strategic Plan, through its Program and Budgets, has aimed to catalyze equitable health development throughout the Region, but a great deal remains to be done during the 2018-2019 biennium and thereafter.

94. While measuring regional trends provides an overall understanding of progress, disaggregated data (by subregion, country, and subnational level) and measurements of inequity (e.g., disparities across demographic quintiles) provide valuable information to inform policies and necessary interventions. The Region has made great strides in improving the measurement of equity at regional level, but it must continue to push this agenda. Health equity monitoring and action on the social determinants of health need to go hand-in-hand with the formulation and implementation of pro-equity national health development policies, plans, and programs.

95. The joint assessment with Member States represents further consolidation of results-based management. In addition, building on previous experiences, the country-led and participatory processes that were used by PASB to refine the prioritization methodology in 2016 (through the Strategic Plan Advisory Group) and the development of the SHAA2030 in 2017 (through the Countries Working Group) have seen Member States highly engaged, with notable resulting benefits in terms of ownership and commitment. The Organization will continue to work with Member States to expand this modality to strengthen transparency and corporate accountability.

96. Consistent with programmatic prioritization, the Organization used its flexible funds to address the persistent misalignment between prioritization (as expressed through Program and Budget allocations) and earmarked voluntary contributions from donors. The introduction of an integrated approach to budget management allowed for more strategic allocation of flexible funds, although it also presented challenges, as described above.

97. The following recommendations are offered with a view to taking the lessons learned from this report forward into the development of the new PAHO Strategic Plan 2020-2025 and Program and Budget 2020-2021, as well as strengthening implementation during the current biennium 2018-2019.

98. **RECOMMENDATION: Accelerate the push for universal health in the Region**

- a) Systematize and disseminate good practices toward universal health to showcase opportunities to introduce and sustain strategic changes.
- b) Identify the most vulnerable and at-risk populations and implement a holistic approach to address their health needs.
- c) Continue to work with the ministries of health on creating resilient health systems, while also building partnerships with other ministries and stakeholders to advance the public health agenda.



- d) Strengthen the leadership role of health authorities and their capacity to effectively manage processes of health system transformation in coordination with other Member State agencies and with the participation of social stakeholders.
- e) Develop a catalog of good practices in maternal and neonatal care that can be promoted.

**99. RECOMMENDATION: Strengthen health information systems**

- a) Provide support to Member States in the development of information systems that will enable them to identify health needs, effectively monitor the health status of the population, and monitor the performance of the health system.
- b) Increase the availability of information on the health situation of international migrants in surveillance systems.
- c) Improve the quality and comparability of data within the Region and globally regarding violence against women.
- d) Continue to develop HRH information systems and institutionalize a framework for analysis and use of the information.
- e) Invest in building country capacity to report on core health indicators, as well as on inequities, by subregion and country, in order to better monitor progress and target interventions; strengthen existing tools to monitor impact targets on a more regular basis.
- f) Renew efforts to align measurements between Strategic Plan indicators and other data collected by PASB – including, where possible, the harmonization of measurements and metrics with reporting frameworks (e.g., SDGs, WHO GPW, SHAA2030) – to ensure consistency and coherence and avoid duplication.

**100. RECOMMENDATION: Build national capacity for emergency and outbreak response**

- a) Promote and support full IHR implementation capacity, building on existing national health systems and national emergency management frameworks.
- b) Strengthen emergency response to vaccine-preventable diseases in the event that measles, rubella, and/or polio are reintroduced in the Region.
- c) Institute the incident management system at the national level as the primary approach to outbreak and disaster response.

**101. RECOMMENDATION: Ramp up multisectoral advocacy to support achievement of the SDGs**

- a) Accelerate multisectoral action and collaboration within and among countries.
- b) Strengthen networks to bring health promotion to the local level and contribute to sustainable development and health promotion initiatives.

- c) Develop or update national plans and strategies on the environmental determinants of health.

**102. RECOMMENDATION: Take action to reverse the tide of death and illness due to noncommunicable diseases**

- a) Advocate and promote Member States' participation and high-level engagement in the Third UN High Level Meeting on NCDs.
- b) Increase the political commitment at all levels to reduce harmful use of alcohol by adopting national policies and plans to reduce per capita consumption and alcohol-related harms.
- c) Establish strategic alliances with academics, civil society, and other sectors to advocate and defend regulatory measures when opposed by the food industry, using lessons learned from experiences with tobacco control.
- d) Advocate for community-based mental health systems as an integral part of the larger health system, with adequate funding, to guarantee access to mental health services to those who need them.

**103. RECOMMENDATION: Improve the quality, quantity, and timing of the PASB's financing, and further improve corporate efficiency**

- a) Expand efforts to enlarge and diversify the funding base of the Organization.
- b) Advocate with WHO for improved predictability and timing of flexible funds distribution to AMRO and other regional offices.
- c) Examine opportunities for further savings in Category 6, while maintaining and improving the performance of enabling and administrative functions.
- d) For the new PAHO Strategic Plan 2020-2025, split the leadership and governance functions from the administrative functions to more accurately reflect overhead costs of the Organization.

Annexes

## **Annex A: End-of-Biennium Assessment Process and Methodology**

1. This section briefly describes the components and methodology for the end-of-biennium assessment process, including the interim assessment of impact goals and the joint assessment with Member States. The assessment process follows the requirements approved by Member States (Resolutions CD52.R8, CD53.R3, and CD54.R16) and upholds the commitment of Member States and the PASB to joint accountability and transparency.

### **Assessment of Impact Goals**

2. The Strategic Plan 2014-2019 established nine impact goals with 26 targets and indicators to measure progress at the regional level. Impact goals are defined as “sustainable changes in the health of populations, to which PAHO Member States, the PASB, and other partners contribute.” Each goal has one or more indicators that measure progress toward achieving those changes. To establish and refine the impact goal indicators in the PAHO Strategic Plan, the 153rd Session of the Executive Committee (2013) formed the Countries Working Group (CWG) as a collaborative group with Member States and the PASB.

3. The indicators utilize observed mortality information available from countries. The data are not corrected – neither for misclassification nor for under-registration. In the case of maternal and infant mortality, countries agreed to use updated estimates from the interagency groups that produce these estimations. Because the health-adjusted life expectancy indicator requires information beyond mortality data, such as morbidity and risk factors, countries agreed to use HALE estimates computed by the Institute for Health Metrics and Evaluation, where appropriate.

4. At the time of the initial calculations (2013), the most complete series available for mortality were for the 1999 to 2009 period. Targets for the period 2014 to 2019 were based on projections developed by PASB, based on statistical modeling using exponential smoothing models, as agreed and approved by PAHO Member States and PASB. Therefore, it is important to note that the magnitude of indicators changed in some cases because the database is continuously updated as new data become available from the countries and the quality of information on mortality improves.

5. The impact goal indicators are monitored using the PAHO Core Health Data and other existing sources of information, namely, data from countries reported to PAHO, WHO, and other official mechanisms. The interim assessments in this report were made in accordance with the technical specifications in the compendium of indicators.<sup>15</sup> The overall assessment of the goal considered the integrated quantitative and qualitative analysis of

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<sup>15</sup> Pan American Health Organization, Compendium of Impact and Outcome Indicators: PAHO Strategic Plan 2014-2019. October 2014. Available at: [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_view&gid=23129&Itemid=&lang=en](http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=23129&Itemid=&lang=en)

their corresponding indicators, including equity dimensions where applicable, using the rating criteria below.

### **Joint Assessment of Outcome and Output Indicators with Member States**

6. Every two years, Member States and PASB jointly assess the status of the outcome and output indicators contained in the Strategic Plan and the Program and Budget, respectively, using the standard criteria in the compendium of indicators. The PAHO Strategic Plan Monitoring System (SPMS), created in 2015, is used to facilitate this process.

7. The outcome indicators under assessment for 2016-2017 remain the same as those in the version of the Strategic Plan approved in September 2014. The revised outcome indicators (approved in the amended Strategic Plan at the 29th Pan American Sanitary Conference in September 2017) became effective in 2018, and therefore could not be considered for this report.

8. Regarding the baselines and targets for the 2016-2017 output indicators, initial estimates were provided in the PAHO Program and Budget 2016-2017, approved in September 2015. However, following the conclusion of the End-of-Biennium Assessment for 2014-2015 in September 2016, a more accurate and up-to-date picture was made possible. Therefore, it was necessary to update the baselines and targets, as follows:

- a) Where output indicators were continuous across the two biennia (meaning the measurement criteria remained substantively unchanged), the results from the 2014-2015 assessment provided an initial input to determine whether a country would be included in the baseline for 2015 or in the target for 2017.
- b) In cases where a new commitment was introduced for 2016-2017 (for instance, antimicrobial resistance), PASB technical teams established the preliminary baselines and targets using the available information.

9. The joint assessment was launched in January 2018, and training was conducted for focal points designated by the national health authorities. Country assessments started in February in collaboration with the PAHO/WHO Representative office. In addition, the country assessment served to conduct the validation of the baselines and targets. Once countries completed the assessments, the results were validated by the PASB Category and Program Area Network (CPN).<sup>16</sup> The purpose of this validation was to ensure that the measurement criteria established in the compendium of indicators are consistently and correctly applied. Due to unforeseen delays, this process was completed in July 2018.

10. The results from the joint assessment, along with additional information available at the regional level, were consolidated to determine whether the targets were reached.

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<sup>16</sup> The CPN is a network of PASB management and technical teams, including representation from the country level. Category facilitators lead a team of outcome/program area and output facilitators, who assess the outcomes and outputs under their responsibility. The category and program facilitators include PASB Department Directors and Unit Chiefs, respectively.

Regional-type indicators are assessed by PASB. Taken together, this information formed the basis for assessing the status of output and outcome indicators,

### **Assessment of Categories and Program Areas**

11. The consolidated assessment of output and outcome indicators, together with other qualitative and quantitative information, was used to determine the status of program areas and categories of the PAHO Program and Budget 2016-2017 and Strategic Plan 2014-2019

### **Rating Criteria**

12. The Organization used the following rating criteria to determine the assessment status of impact goals, categories, and program areas:

- a) **Achieved:** The indicator target has already been fully met or exceeded (only for the assessment of impact goals).
- b) **On track:** Over 90% of the expected results are projected to have been met by the end of 2019.
- c) **At risk:** Between 75% and 89% of the expected results are projected to have been met by the end of 2019. There are obstacles that are impeding progress at the rate needed to achieve the results by the end of 2019. Corrective action may be required in order to get back on track.
- d) **In trouble:** Less than 75% of the expected results are projected to have been met by the end of 2019. There are major obstacles that are impeding progress. The results are unlikely to be achieved unless significant and immediate corrective actions are implemented.

13. Output and outcome indicators were assessed by measuring achievement of their indicator targets. Achievement was rated as follows:

- a) **Achieved:** The indicator target (number of countries/territories, number or % for regional indicators) has been reached. Those cases in which the indicator target has been exceeded are highlighted.
- b) **Partially achieved/in progress:** Progress was made over the baseline (number of countries/territories, number or % for regional indicators), but the target was not achieved. The reasons why the indicator was not achieved are highlighted.
- c) **No progress:** There was no increase over the baseline (number of countries/territories, number or % for regional indicators). Factors hindering progress and cases where there has been a decrease below the baseline are highlighted.

**Annex B: Abbreviations**

<b>Abbreviation</b>	<b>Description</b>
AAPR	average annual percentage of reduction
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
AMRO	Regional Office for the Americas
ART	antiretroviral therapies
CCS	Country Cooperation Strategy
CPN	PASB Category and Program Area Network
EMT	Emergency Medical Team
EMTCT	elimination of mother-to-child transmission
ERM	Enterprise Risk Management
EWEC-LAC	Every Woman Every Child Latin America and the Caribbean
GPW	General Programme of Work
HALE	health-adjusted life expectancy
HIV	human immunodeficiency virus
HNie	Health Needs Index expanded
HRH	human resources for health
IHR	International Health Regulations
ICSID	International Centre for Settlement of Investment Disputes
IGME	Inter-agency Group for Child Mortality Estimation
IMR	infant mortality rate
MCH	maternal and child health
MDR-TB	multidrug-resistant tuberculosis
mhGAP	WHO Mental Health Gap Action Programme
MMR	maternal mortality ratio
NCD	noncommunicable disease
NGO	nongovernmental organization
NVC	national voluntary contribution
OCR	Outbreak and Crisis Response
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PB	Program and Budget
PMIS	PASB Management Information System
PNMR	regional premature NCD mortality rate
PPH	postpartum hemorrhage
PWR	PAHO/WHO Representative
SDG	Sustainable Development Goal
SHAA2030	Sustainable Health Agenda for the Americas 2018-2030
SPBA	Subcommittee on Program, Budget, and Administration
SPMS	Strategic Plan Monitoring System
TB	Tuberculosis
UH	universal health
UN	United Nations
UNFCCC	UN Framework Convention on Climate Change
WHO	World Health Organization
ZIKV	Zika virus

Country			Country		
Acronym			Acronym		
Member States			Associate Members		
35			4		
1	Antigua and Barbuda	ATG	36	Aruba	ABW
2	Argentina	ARG	37	Curaçao	CUW
3	Bahamas	BHS	38	Puerto Rico	PRI
4	Barbados	BRB	39	Sint Maarten	SXM
5	Belize	BLZ			
6	Bolivia	BOL		Participating States	3
7	Brazil	BRA		France	4
8	Canada	CAN	40	French Guiana	GUF
9	Chile	CHL	41	French St. Martin	MAF
10	Colombia	COL	42	Guadeloupe	GLP
11	Costa Rica	CRI	43	Martinique	MTQ
12	Cuba	CUB			
13	Dominica	DMA		Kingdom of the Netherlands	3
14	Dominican Republic	DOM	44	Bonaire	BON
15	Ecuador	ECU	45	Saba	SAB
16	El Salvador	SLV	46	Sint Eustatius	STA
17	Grenada	GRD			
18	Guatemala	GTM		United Kingdom of Great Britain and Northern Ireland	6
19	Guyana	GUY			
20	Haiti	HTI	47	Anguilla	AIA
21	Honduras	HND	48	Bermuda	BMU
22	Jamaica	JAM	49	British Virgin Islands	VGB
23	Mexico	MEX	50	Cayman Islands	CYM
24	Nicaragua	NIC	51	Montserrat	MSR
25	Panama	PAN	52	Turks and Caicos	TCA
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	VEN			