Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

58th DIRECTING COUNCIL

72nd SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Virtual Session, 28-29 September 2020

Provisional Agenda Item 4.1

CD58/5, Add. I
3 September 2020
Original: English

REPORT OF THE END-OF-BIENNIUM ASSESSMENT OF THE PAHO PROGRAM AND BUDGET 2018-2019 / FINAL REPORT ON THE IMPLEMENTATION OF THE PAHO STRATEGIC PLAN 2014-2019

PAHO Results Report: 2018-2019

Contents

I. Foreword by the Director

The Strategic Plan 2020-2025 period begins with one of the greatest public health challenges in recent memory, the COVID-19 pandemic. The breadth and depth of the social and economic impact of this crisis is unprecedented in the modern era. At the time of writing, it is still not clear how the situation will evolve during the coming months and years.

You may ask why I write this in the foreword to a document that looks back. The reason is clear: as we take stock of the past six years, we cannot help but view the progress made in the context of where we are today, when much of that progress is in jeopardy. We faced challenges in attaining the 2030 Sustainable Development Goals before COVID-19 struck, but now those challenges are multiplied tenfold. At best, countries in the Region of the Americas will come under stress in trying to maintain their current public health achievements. Their capacity to undertake the new actions needed to reach the ambitious targets set in the Sustainable Health Agenda for the Americas 2018-2030 will be severely compromised.

During this difficult period, the Pan American Health Organization remains steadfast in its evidence-based approach to providing technical cooperation and support to its Member States, building on lessons learned and promoting proven successful models to improve health at country level and in the most vulnerable communities. Despite fiscal challenges in many countries, adequate financing of the Organization is necessary to respond effectively and efficiently to the mandates and priorities of Member States. As has been noted in the past, investment in public health is never more critical than in the midst of economic difficulties, for that is when the poor, the marginalized, and the vulnerable are most in need.

So, I ask that you look back with me on what seems to have been a happier time, pre-COVID-19, and celebrate the many milestones you have achieved across Latin America and the Caribbean in recent years. But I also ask you to keep focused on our big health challenges—noncommunicable diseases do not go away in a pandemic—and redouble our collective efforts to implement science-based solutions to the multitude of public health problems we face. Together in solidarity we can learn from the past, build on our successes, and move forward united to improve the health and well-being of every child, woman, and man in the Americas.

II. Introduction

1. Resolution CD52.R8, adopted at the 52nd Directing Council of the Pan American Health Organization (PAHO) in 2013, requests the Director of the Pan American Sanitary Bureau (PASB) to report on implementation of the Strategic Plan of the Pan American Health Organization 2014-2019 (*Official Document 345*) through biennial performance assessment reports. Additionally, the approved PAHO Program and Budget 2018-2019 (*Official Document 354*) specifies that an end-of-biennium final assessment of its implementation shall be prepared by PASB. The present report addresses both requirements. It should be noted that the report considers the version of the PAHO Strategic Plan 2014-2019 that was amended in 2017 and approved by Member States at the 29th Pan American Sanitary Conference through Resolution CSP29.R5.

2. The end-of-biennium assessment is the principal instrument of accountability and transparency for the Organization. It provides a chance for the Region of the Americas to reflect on its health gains and remaining gaps, as well as on challenges, opportunities, and lessons learned. Consistent with the country focus approach adopted by PAHO, success stories are highlighted to showcase the Organization's technical cooperation with countries. The report also presents an analysis of programmatic and budgetary performance by PAHO, particularly budget implementation and risk management. The lessons learned and conclusions from this assessment provide important input to guide interventions in the 2020-2021 biennium and beyond. In this period the Organization will transition to the Strategic Plan of the Pan American Health Organization 2020-2025 (*Official Document 359),* and, together with Member States and partners, continue to implement the Sustainable Health Agenda for the Americas 2018-2030 (Document CSP29/6, Rev. 3) in the context of the Sustainable Development Goals (SDGs).

3. A key element in the end-of-biennium assessment is the assessment of the achievement of impact, outcome, and output indicators that were defined in the Strategic Plan 2014-2019 (SP14-19) and the Program and Budget 2018-2019 (PB18-19). Due to the difficulties of conducting the joint assessment of outcome and output indicators at a time when countries are responding to COVID-19, the results in this report do not include information from the joint assessment. Instead, indicators were assessed based on information available to PASB. Individual national health authorities may complete the joint assessment when they are able in order to reflect the country assessment of the indicators and document the results to inform future planning.

4. Finally, it should be noted that the results of the interim end-of-biennium assessment by PASB served as the main input by the Region of the Americas to the World Health Organization (WHO) Programme Budget 2018-2019 assessment, to be presented to the World Health Assembly at its resumed Seventy-third session later this year.

III. Delivering on Results

5. This section presents an analysis of the Region's public health status and progress made in advancing the priorities of the Strategic Plan 2014-2019 and the Program and Budget 2018-2019.[1] Particular attention has been given to the country-level impact of the work of PAHO, including progress toward achieving the SP14-19 impact goals and increasing equity in health. A final appraisal of the Strategic Plan's six categories has also been made, highlighting some of the most significant achievements, challenges, and country success stories. Details on the methodology for assessment of impact-, outcome-, and output-level results are available in Annex B.

Achieving the Impact Goals of the Strategic Plan

6. Member States and PASB committed in the SP14-19 to achieving 26 targets under nine impact goals by 2019. Consistent with the Plan's strategic vision, the impact targets measure the regional progress in improving health and well-being with equity. The assessment conducted by PASB shows that by the end of the SP14-19 period, the Region had made great strides in improving health and well-being, yet there remained significant challenges that will require attention during the next Strategic Plan, particularly given the impact of COVID-19 on health systems in countries. As shown in Table 1, a slim majority of the 26 impact targets are estimated to have been either achieved (eight) or exceeded (six) by 2019. Five targets showed partial advances, and the remaining seven were not achieved.

7. Among the most positive signs were reductions in infant mortality, mortality due to HIV/AIDS, dengue case-fatality rate, mortality due to suicide, and mortality due to road traffic injuries at the regional level. Additionally, although the maternal mortality ratio did not reach the target reduction of 11%, its reduction by 9.4% remains a significant achievement. Notable progress was also made in six of the eight absolute inequality gradient and relative inequality gap targets. Regarding the elimination of communicable diseases, the target for elimination of mother-to-child transmission (MTCT) of HIV and congenital syphilis was achieved, as were the targets for elimination of onchocerciasis and malaria.

8. Finally, based on the 16 emergencies that were assessed for the 2014-2019 period, Target 9.1 can be considered as achieved. Mortality for six emergency events returned to baseline levels within three months. The underlying cause of death that was observed at the time of 10 of the 16 events did not show any reasonable causal relationship with those events. In nine of these 10 events, there were no deaths from exposure to forces of nature in the country's mortality database for the year in which the event occurred.

[1] This is the first results report during the implementation period of the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030). Given that the report primarily covers the Strategic Plan 2014-2019, originally developed in 2013, the primary focus will be on the Strategic Plan. A progress report on the SHAA2030 will be provided as part of the reporting on the new Strategic Plan 2020-2025.

Table 1. Status of Impact Targets in 2019

Exceeded (6)	Achieved (8)	Partially achieved (5)	Not achieved (7)

Rating	Target	Change	2019 Status
Goal 1. Improve health and well-being with equity			
●	1.1 Healthy life expectancy (HALE) ↑ 1%	↓ 0.2%	66.47 years
Goal 2. Ensure a healthy start for newborns and infants			
●	2.1 Infant mortality rate (IMR) ↓ 15%	↓ 13.9%	11.0 deaths per 1,000 live births
●	2.2 IMR relative inequality gap ↓ 10%	↓ 8.3%	Ratio of 4.5
●	2.3 IMR absolute inequality gradient ↓ 3 excess deaths	↓ 4.1	15.2 excess deaths
Goal 3. Ensure safe motherhood			
●	3.1 Maternal mortality ratio (MMR) ↓11%	↓ 9.4%	54.9 deaths per 100,000 live births
●	3.2 MMR relative inequality gap ↓ 25%	↓ 24.4%	Ratio of 8.5
●	3.3 MMR absolute inequality gradient ↓ 18 excess deaths	↓ 31.1	100.5 excess deaths
Goal 4. Reduce mortality due to poor quality of health care			
●	4.1 Mortality amenable to health care (MAHR) ↓ 9%	↓ 6.5%	173.8 deaths per 100,000 pop.
●	4.2 MAHR relative inequality gap ↑ no more than 6%	↓ 14.8%	Ratio of 2.5
●	4.3 MAHR absolute inequality gradient ↓ 8 excess deaths	↓ 41	144.7 excess deaths
Goal 5. Improve the health of the adult population with an emphasis on NCDs and risk factors			
●	5.1 Premature NCD mortality rate (PNMR) ↓ 9%	↓ 4.9%	287.8 deaths per 100,000 pop.
●	5.2 PNMR relative inequality gap ↑ no more than 6%	↑ 10.6%	Ratio of 1.36
●	5.3 PNMR absolute inequality gradient ↓ 18 excess deaths	↓ 18.3	97.1 excess deaths
Goal 6. Reduce mortality due to communicable diseases			
●	6.1 Mortality due to HIV/AIDS ↓ 15%	↓ 14.3%	4.5 deaths per 100,000 pop.
●	6.2 Dengue case-fatality rate ↓ 30%	↓ 30%	0.049%
●	6.3 Mortality due to TB ↓ 24%	↓ 4.1%	1.7 deaths per 100,000 pop.
●	6.4 Deaths due to malaria ↓ 75%	↑ 200%	336 deaths
Goal 7. Curb mortality due to violence, suicides, and accidents among adolescents and young adults (15-24 years of age)			
●	7.1 Mortality due to homicide ↓ 6%	↑ 14.3%	38.8 deaths per 100,000 pop.
●	7.2 No increase in the suicide rate	↓ 1.9%	9.5 deaths per 100,000 pop.
●	7.3 No increase in mortality due to road traffic injuries	↓ 4.1%	19.0 deaths per 100,000 pop.

Rating	Target	Change	2019 Status
Goal 8. Eliminate priority communicable diseases in the Region			
🟡	8.1 Eliminate mother-to-child transmission of HIV and congenital syphilis in 10 countries[2]	↑ 7	7 countries
🟢	8.2 Eliminate onchocerciasis in 4 countries	↑ 3	4 countries
🟡	8.3 Eliminate Chagas transmission in 21 endemic countries	None	15 countries
🟢	8.4 Eliminate malaria in 3 endemic countries	↑ 3	3 countries
🟡	8.5 Eliminate human cases of dog-transmitted rabies in 35 countries	↑ 16	33 countries
Goal 9. Prevent death, illness, and disability arising from emergencies			
🟢	9.1 Crude mortality rate returns to baseline levels within three months for at least 70% of emergencies	100%	100% of emergencies

9. Achievement of more than half the targets would not have been possible without concerted action by Member States, including the expansion of health promotion and access to services, and greater collaboration with different sectors at country level. Throughout the SP14-19 period, PAHO played a catalytic role in addressing the priorities of Member States through its technical cooperation and through implementation of the PAHO core functions.

10. Several challenges emerge from the analysis of the impact indicators. These include the slight decrease in healthy life expectancy; the inability to accelerate the reduction of mortality due to causes that are amenable to health care, mortality due to noncommunicable diseases (NCDs), and mortality due to tuberculosis (TB); the rapidly increasing relative inequality gap for premature mortality due to NCDs; and the upward trend in homicides among youth aged 15-24 in the Region.

11. It is important to emphasize that although the regional trend suggests difficulties for some indicators, in many cases individual countries have made good progress on these same indicators. Success stories like the ones presented under each category should be replicated in areas where PAHO can have the greatest impact. At the same time, there were significant variations in performance between and within countries, with indicators lagging for many vulnerable and marginalized populations. Considering the enduring inequality that exists in the Region, there is a need to boost efforts where they are needed most, particularly among the PAHO key countries and for populations in conditions of vulnerability. These findings reinforce the relevance of an equity focus in implementation of the Strategic Plan 2020-2025.

12. Many other recurring and emerging factors have hindered the achievement of results at impact level, including gaps in coverage and quality of care; the increasing burden

[2] In the Results Report for 2016-2017, PAHO reported that the original SP14-19 target 8.1 was no longer measurable. The revised indicator was "Number of countries and territories validated by WHO as having eliminated mother-to-child transmission of HIV and congenital syphilis," and a 2019 target of 10 countries was set.

of care for aging populations that are living longer than ever before; insufficient progress in addressing the determinants of health and reducing risk factors with a focus on prevention; high attrition and inadequate succession planning that limit the availability of qualified personnel; and the impact of emergencies, among others. In order to continue making progress toward the health-related SDGs, the Region must overcome these challenges while protecting gains that include reductions in mortality and morbidity, expanded vaccination coverage, and progress toward disease elimination.

13. To contribute to health impacts, PAHO works together with countries and partners, principally through the achievement of outcome- and output-level results. Analysis in different technical areas has shown that higher-level impacts are possible, but reaching them depends on many different factors that are external to interventions by the health sector; hence the need for a multisectoral approach. Finally, this analysis has revealed once again the importance of expanding information systems for health (IS4H) and strengthening countries' vital and health statistics to improve data quality in terms of completeness, accuracy, consistency, and accessibility.

Key Achievements, Challenges, and Country Success Stories by Category

14. This section summarizes the status of the categories and program areas, including progress in achieving the outcome and output indicators through joint efforts by the Member States and PASB. The analysis draws on the internal assessment by PASB. Detailed reports by category and program area, including detailed programmatic and budget analysis and the complete assessment of indicators, are available on the PAHO Program and Budget Web Portal.[3]

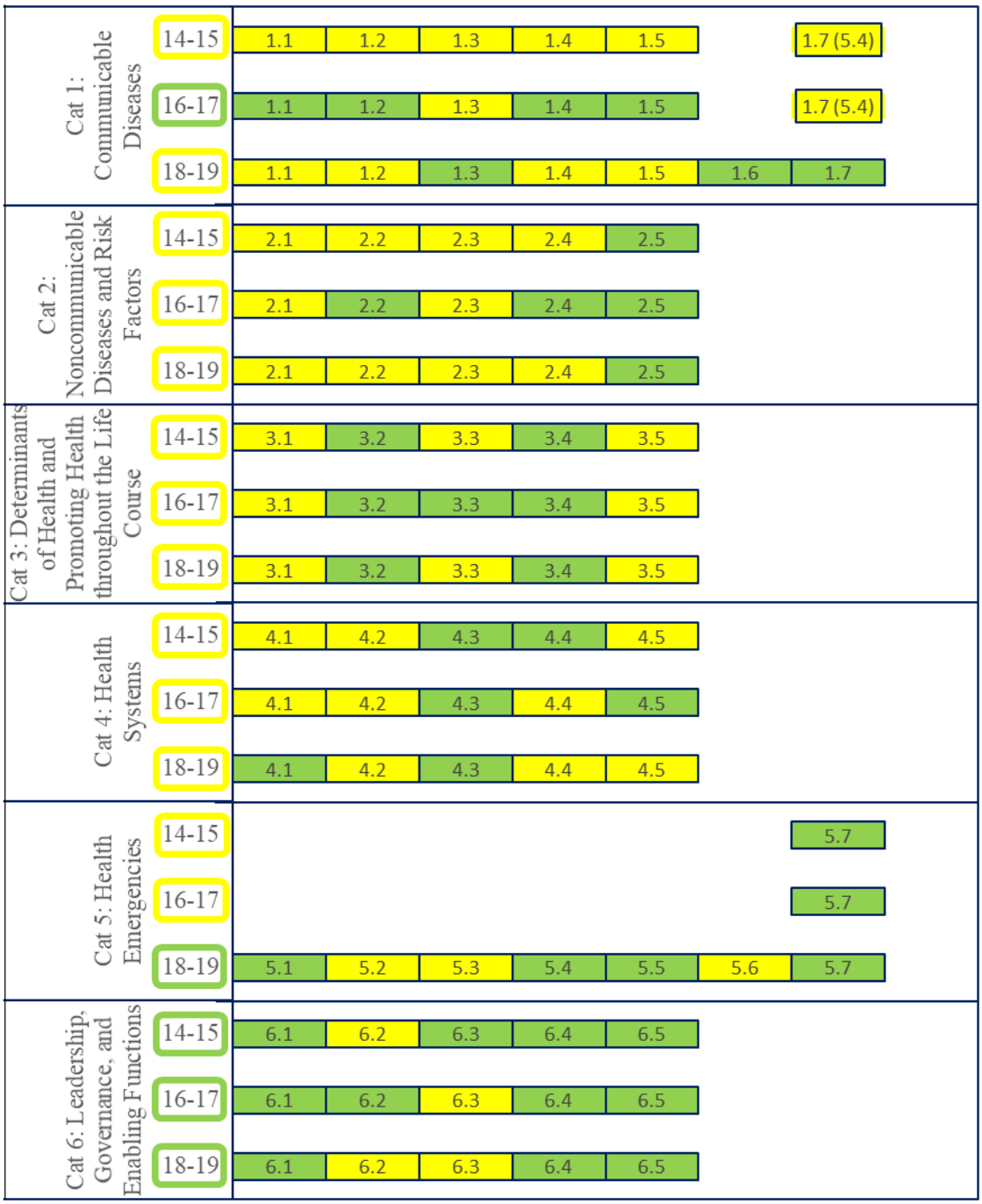
15. As seen in Figure 1, two of the six categories met expectations for the 2018-2019 biennium, while the other four only partially met expectations. The improved performance, compared to previous biennia, of Health Emergencies (Category 5) is notable, as is the consistent performance of the Organization's Leadership, Governance, and Enabling Functions (Category 6). However, despite some positive signs, the persistent inability to shift course on Noncommunicable Diseases and Risk Factors (Category 2), Determinants of Health and Promoting Health throughout the Life Course (Category 3), and Health Systems (Category 4) is of concern. There was significant progress on Communicable Diseases (Category 1), but some challenges persist.

16. Of the 34 program areas, 15 met expectations fully in 2018-2019, while the remaining 19 did so partially. The overall situation fluctuated over the three biennia of the Strategic Plan. Notably strong performance was recorded throughout the period for Nutrition (2.5), Aging and Health (3.2), Social Determinants of Health (3.4), Access to Medical Products and Strengthening of Regulatory Capacity (4.3), and Outbreak and Crisis Response (OCR) (5.7), as well as three program areas internal to PASB: Leadership and Governance (6.1), Management and Administration (6.4), and Strategic Communications

[3] Category Reports are published on the PAHO Program and Budget Web Portal, available at: https://open.paho.org/.

(6.5). Several program areas showed improvements, including Malaria and Other Vector-borne Diseases (including Dengue and Chagas) (1.3), Food Safety (1.7), and Health Governance and Financing; National Health Policies, Strategies, and Plans (4.1).

Figure 1. Assessment of Categories and Program Areas throughout the PAHO Strategic Plan 2014-2019 (Biennia 2014-2015, 2016-2017, and 2018-2019)



Note: Green = met expectations, yellow = partially met expectations.

17. However, five program areas did not fully meet expectations during any of the three biennia: Noncommunicable Diseases and Risk Factors (2.1), Violence and Injuries (2.3), Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health (3.1), Health and the Environment (3.5), and People-Centered, Integrated, Quality Health Services (4.2). The situation of others worsened in the latter biennia, including Health Systems Information and Evidence (4.4) and the (internal PASB) Strategic Planning, Resource Coordination, and Reporting (6.3). Several others showed varied performance. With regard to the nine program areas in the top tier of Member State priorities, none of them consistently met expectations for all three biennia, and only 1.3 and 4.1 were assessed as having met expectations for the 2018-2019 period. The reasons for less satisfactory outcomes and considerations as to how PAHO can turn the tide during the Strategic Plan 2020-2025 are detailed below.

18. Due to the health emergencies reform, the 2017 amendment of the SP14-19 changed the structure of the Category 5 program areas (except for OCR, which remained constant). Therefore, comparison of progress is difficult. For both the 2014-2015 and 2016-2017 assessments, three of five program areas were on track, and by 2018-2019, four of seven had met expectations.

Assessment of Outcome and Output Indicators

19. By the end of the PAHO Strategic Plan 2014-2019, the Region had made significant collective progress toward the achievement of the outcome indicators. As shown in Figure 2, 30 of 89 outcome indicators were achieved or exceeded (33%), while 39 were partially achieved (44%) and 14 were not achieved (16%). Another 6 indicators (7%) could not be assessed due to unavailability of data or methodological constraints, including changes in the methodology of assessment. Figure 3 indicates that 103 of 173 output indicators (59%) were achieved or exceeded, 58 (34%) were partially achieved, and 9 (5%) showed no progress. Three output indicators were not rated due to lack of data (2%).

20. Important milestones for Region were registered among the outcome indicators that were exceeded:

a) The percentage of unmet need with respect to modern methods of family planning dropped from 15% in 2013 to 9% in 2019 (3.1.1). The regional specific fertility rate in women 15-19 years of age fell from 60 per 1,000 in 2013 to 48.3 per 1,000 women in this age group (3.1.6). Twenty countries and territories reported improvements in regulating periodic medical occupational examinations (3.1.7). Eighteen countries and territories had at least one evidence-based self-care program for older adults (60 and over) living with multiple chronic conditions (3.2.1).

b) Forty-three countries and territories met or exceeded minimum capacities to manage public health risks associated with emergencies (5.2.1).

c) Fifteen of the 16 countries with emergencies meeting Grade 2 or Grade 3 criteria (94%) were able to provide an essential package of live-saving health services

(5.4.1). In addition, 75% of the funding for Health Emergencies was provided by flexible core resources and multi-year funding agreements (5.5.1).

21. The main issues that affected the under-achievement of both outcome and output indicators included the complex political context in many countries and low levels of political commitment to addressing priority areas of public health; disasters, disease outbreaks, social unrest, and the impact of migration on health systems; absence of, or insufficient, intersectoral action; weaknesses in information systems; insufficient progress on addressing inequities in health; limited institutional capacity; and shortage of human and financial resources, as well as competing priorities on the regional and national agendas. Specific areas of concern include treatment for schistosomiasis; prevalence of insufficient physical activity, raised blood glucose/diabetes, high salt intake, and overweight and obesity; control of hypertension, cervical cancer screening, and treatment of end-stage renal disease; use of seatbelts; access to habilitation and rehabilitation services and social services for persons with disabilities; and attendance of deliveries by trained personnel. Many of these were recurring issues throughout the period of the Strategic Plan and are discussed below, in Section VI, and in the detailed category reports online.

Figure 2. Overview of Outcome Indicators Assessment

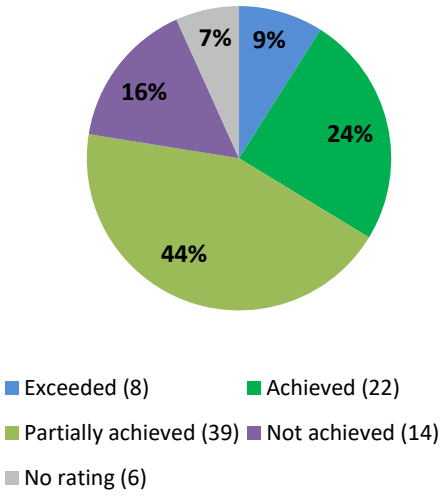
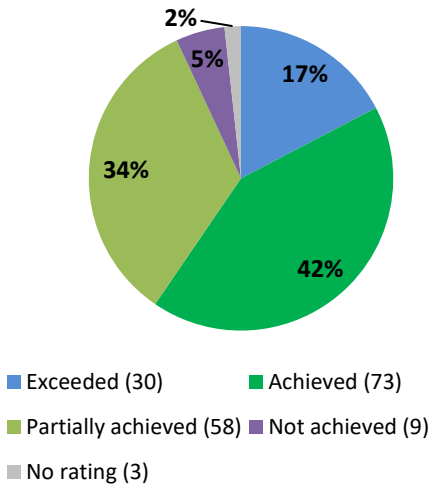


Figure 3. Overview of Output Indicators Assessment



Category 1: Communicable Diseases

Key priorities

Reduce the burden of communicable diseases	**Eliminate vaccine-preventable diseases and maintain the Region's achievements**	**Increase the multisectoral approach to reducing the impact of antimicrobial resistance and foodborne diseases**

Main Achievements

22. The following are the main achievements for Category 1:

a) Six countries and territories were revalidated for another two years by WHO for the dual elimination of mother-to-child transmission (EMTCT) of HIV and syphilis. The initiative for the elimination of mother-to-child transmission of HIV, syphilis, hepatitis B, and congenital Chagas (EMTCT Plus) is being implemented throughout the Region. In 2019, 16 countries reported data compatible with the EMTCT of HIV and congenital syphilis, while evidence suggests that 13 have achieved the target for the elimination of perinatal hepatitis B.

b) Countries with the highest burden of tuberculosis (Brazil, Colombia, Haiti, Mexico, and Peru) strengthened implementation of the End TB Strategy.

c) Argentina and Paraguay were certified as malaria-free countries. Others made important progress, including El Salvador, which completed three years without local transmission, and Belize, which had no indigenous transmission during 2019. There was a reduction in local malaria transmission in Guatemala, Honduras, and Peru, where the approach has been to address priority foci. Control of malaria among indigenous groups in Nicaragua and Peru has improved malaria response in foci with populations in conditions of vulnerability. These strategies have guided new initiatives, such as the Regional Malaria Elimination Initiative and Municipalities for Zero Malaria.

d) Colombia was confirmed in October 2019 as having interrupted the transmission of Chagas disease by *Rhodnius prolixus* in 34 additional municipalities of seven endemic departments.

e) Mexico became the first country in the world certified by WHO for having eliminated human rabies transmitted by dogs as a public health problem.

"Eliminating rabies doesn't happen by accident. It takes political resolve, careful planning and meticulous execution. I congratulate the Government of Mexico on this wonderful achievement and hope many other countries will follow its example."

- Dr. Tedros Adhanom Ghebreyesus
WHO Director-General

Strengthening antimicrobial resistance detection and surveillance in CARICOM

Antimicrobial resistance (AMR) affects all countries and endangers the effectiveness of prevention and treatment of infections. AMR occurs when medicines become ineffective against pathogens and infections persist in the body, increasing the risk of spread to others. In recent years, the Americas have seen a series of outbreaks caused by multidrug-resistant bacteria, impacting lives and hospital costs.

In response, PAHO brokered a partnership between Argentina and countries of the Caribbean Community (CARICOM). Within the framework of Cooperation among Countries for Health Development (CCHD), the parties embarked on a project to strengthen laboratory capacity for AMR surveillance. The project aimed to obtain reliable microbiological data and timely and replicable information to improve patient care and strengthen surveillance through sustainable quality assurance programs.

Following a "One Health" approach to this intersectoral challenge, and leveraging technical expertise from Argentina, over 300 health professionals and human and veterinary laboratory technicians from seven Caribbean countries have been trained in sample collection and in the detection and assessment of AMR. Eight human health laboratories, one Caribbean Public Health Agency (CARPHA) laboratory, two food laboratories, and three veterinary laboratories in CARICOM were assessed on their capacity to detect AMR. Nine countries received supplies, reagents, and a detection guide, thus improving national laboratory capacity.

f) Vaccination coverage improved in many countries during the 2018-2019 biennium. Twenty-two countries increased their coverage between 2017 and 2018. In addition to supporting maintenance of measles elimination in most countries, PAHO played an important role in controlling the measles outbreak in Venezuela during the biennium. As a result of joint efforts by PAHO together with partners, 8.9 million children between the ages of six months and 15 years were vaccinated. The Region

remains a leader in the introduction of new vaccines (pneumococcal, rotavirus, HPV) and in use of the seasonal influenza vaccine (with more than 300 million doses administered each year). In 2019 the Region celebrated 25 years as certified polio transmission-free, and it was certified free of wild poliovirus type 3.

g) The European Union-supported Project on Antimicrobial Resistance (2020-2022) was launched. This project is being led by PAHO, in collaboration with the Food and Agriculture Organization of the United Nations (FAO) and the World Organization for Animal Health (OIE), to support countries in implementing their One Health AMR action plans. Under the auspices of the PAHO Cooperation among Countries for Health Development (CCHD) program, Argentina and CARICOM collaborated in strengthening AMR detection and surveillance capacity in the Caribbean.

h) In 2018, the entire Brazilian territory was certified by the OIE as free of foot-and-mouth disease (FMD), with and without vaccination. Additionally, Peru and Suriname reached the status of FMD-free countries without vaccination.

Challenges

23. The following are the main challenges for Category 1:

a) The EMTCT validation process is becoming more complex and burdensome to countries, which makes it difficult to keep pushing the initiative forward.

b) Fulfillment of the regional targets for malaria mortality and morbidity reduction were affected by increased transmission in Venezuela.

c) During 2019, 3.1 million cases of dengue were registered, the most ever recorded in the history of the disease in the Region. The disease profile is also shifting, with changing seasonal patterns and greater impact on younger populations.

d) Maintaining high, homogeneous, and equitable immunization coverage, while increasing coordination with health services to guarantee availability of vaccination services at local level for all populations, remains a challenge for many countries. This endangers efforts to maintain the Region free from the endemic transmission of measles and to regain elimination status in Brazil and Venezuela.

e) There is inadequate enforcement of regulations on antibiotic use in human and animal health and a lack of integrated surveillance of data for AMR control from laboratories, clinical settings, and the community.

f) There is a lack of awareness and commitment to food safety as a priority public health function that requires a multisectoral approach.

Preventing and treating tungiasis among indigenous communities in Brazil

Tungiasis is a localized, highly prevalent, neglected tropical disease that affects humans and animals in poor communities in South America, but is also suspected to affect Caribbean islands, and Sub-Saharan Africa. A parasitic skin infection caused by sand fleas, the disease mainly affects the most vulnerable people, such as children, the elderly, and persons with disabilities. Those who become ill (children in many cases) often have severe and chronic infections that lead to difficulty walking, finger deformities, and nail loss, resulting in a reduced quality of life.

In early 2018, the Brazilian government, through its Special Secretariat for Indigenous Health (SESAI), requested PAHO/WHO technical cooperation to address tungiasis in severely affected indigenous communities in the Yanomami area and Boa Vista. PAHO/WHO worked closely with SESAI, providing technical assistance and applying best evidence to introduce a set of control measures that included treating affected people and animals and establishing systematic community interventions to address household flea infestation. These control activities were successfully implemented in 80% of affected communities. The result has been an immediate and significant reduction in the number and severity of cases and an improvement in the health and lives of many people and animals who had been suffering from the infection. No medical evacuations for tungiasis were performed in 2019, safeguarding precious resources for the indigenous health services.

Category 2: Noncommunicable Diseases and Risk Factors

Key priorities

Reduce the burden of noncommunicable diseases, mental health disorders, disability, violence, and injuries	**Address the underlying causes, risk factors, and determinants through health promotion and risk reduction**	**Strengthen the primary care response to NCDs through prevention, treatment, and surveillance**

Main Achievements

24. The following are the main achievements for Category 2:

a) The first comprehensive technical report on NCDs and risk factors for the Region was produced, enhancing the ability of PAHO to track progress on NCD and risk factor indicators. The report provides benchmarks for actions needed to reach the global NCD targets and SDG goals relevant to NCDs and mental health (including suicides).

b) High-level mandates were approved by PAHO Governing Bodies to tackle NCDs and risk factors during 2018-2019. The Plan of Action for Cervical Cancer Prevention and Control 2018-2030 (Document CD56/9) was adopted during the 56th Directing Council in September 2018, representing a commitment by national health authorities to reduce cervical cancer incidence and mortality by one-third by 2030. A Plan of Action for the Elimination of Industrially Produced Trans-Fatty Acids 2020-2025 (Document CD57/8) was approved by the 57th Directing Council in September 2019.

c) Brazil was the first country in the Region to implement the six MPOWER tobacco control measures at the level of best practice, becoming only the second country in the world (after Turkey) to achieve this target. This represents significant progress toward full implementation of the WHO Framework Convention on Tobacco Control in that country.

d) The Global HEARTS intervention to improve hypertension control in primary health care was implemented in four new countries, Argentina, Ecuador, Panama, and Trinidad and Tobago, which joined the four participating countries of Barbados, Chile, Colombia, and Cuba. A standardized package was implemented in over 30 health centers, resulting in improvements in patient hypertension control rates in these centers over a short period of time. Countries are working on scaling this up nationally.

e) Six countries approved legislation imposing taxes on sugar-sweetened beverages. Five countries have implemented regulations to protect children and adolescents from the impact of the promotion and marketing of sugar-sweetened beverages, fast food, and energy-dense nutrient-poor products. These countries also implemented

a front-of pack labeling system that provides clear information about processed or ultra-processed products that are high in sugar, fat, and salt.

f) The first standardized indicator of the tax share of alcoholic and sugar-sweetened beverages was developed to allow for monitoring of tax policies over time and making comparisons between countries, setting the basis for establishment of best practices. PAHO is pioneering the development of this indicator at global level.

Improved road safety governance in Costa Rica and Dominican Republic

Deaths and injuries caused by road traffic crashes represent an important morbidity, mortality, and disability burden in Costa Rica and the Dominican Republic, especially among people 14 to 29 years of age. Implementing appropriate public policies and strengthening the stewardship of national institutions on road safety can help prevent accidents.

To tackle this challenge, Costa Rica and the Dominican Republic embarked on a Cooperation among Countries for Health Development (CCHD) project with PAHO to develop best practices and tools that could contribute to the reduction of mortality, morbidity, disability, and property damage caused by road traffic crashes in both countries. Through this modality of cooperation, both countries seek to share knowledge, skills, and expertise. The exchange includes road safety manuals, guides, and regulations, as well as strategies for the collection, processing, and analysis of data on injuries and deaths. The resulting products can serve as models for other countries in the Region.

As a result of this collaboration, the Dominican Republic is revamping its vehicular inspection program, ensuring the adoption of safety features and guidelines informed by best practices in Costa Rica. Meanwhile, Costa Rica is implementing new communication techniques through social media, learning from the experience of the Dominican Republic.

g) Critical information on population risk for NCDs was gathered through the STEPS surveys. Three countries (the Bahamas, Bolivia, and Ecuador) completed STEPS surveys, marking the first time that population-level data have been available in Bolivia and Ecuador to monitor key NCD indicators.

"The message is clear: what has been achieved so far in the prevention of NCDs is far inadequate. Progress on NCDs depends on political commitment to put people's health first, ahead of politics, ahead of profits, and ahead of self-promotion."

- Dr. Carissa F. Etienne, PAHO Director, at a joint high-level session on NCDs of the Organization of American States Permanent Council and Inter-American Council for Integral Development, Washington, D.C., 19 March 2018

h) The integration of mental health in primary health care continued, primarily through training in the Mental Health Gap Action Programme (mhGAP). Initiatives under mhGAP have now been carried out in most of Latin America and the Caribbean. Standardized criteria for drug treatment advanced through an inter-agency initiative with the participation of 19 countries. An investment case for mental health in Jamaica was completed, the first of its kind, demonstrating that for every Jamaican dollar invested in scaling up treatment for depression, anxiety, and psychosis, one can expect to see a return on investment of 5.5 Jamaican dollars.

i) In addition to the CCHD project between Costa Rica and the Dominican Republic featured above, success stories from Brazil, Mexico, and Uruguay on road safety legislation were developed to serve as models for effective strategies to implement road safety interventions. PAHO promoted the launch of the Latin American Parliamentary Network for Road Safety in September 2019 in Paraguay, with the participation of parliamentarians from Bolivia, Brazil, Costa Rica, Honduras, Paraguay, and Peru, as well as representatives from the Central American Parliament and the Andean Parliament. PAHO serves as the network's technical secretariat.

j) A survey on violence against children was successfully completed in 28 Member States; data analysis is ongoing and will be published in a report in 2020. Regarding intimate partner violence (IPV) against women, a comparative analysis of prevalence estimates for 24 countries in the Americas was completed. Reported prevalence of physical and/or sexual IPV ranged from about one in seven ever-partnered women aged 15-49 (14%-17%) to more than half (58.5%).

k) Guyana and Haiti became the first two countries in the Region to undertake a Systematic Assessment of Rehabilitation Situation, a WHO tool for rehabilitation service strengthening. The assessment is the first step in a process to develop national strategic planning for comprehensive rehabilitation services.

Institutional strengthening for planning and monitoring of cancer control programs in Latin America

In various countries of the Region of the Americas, there has been a notable increase in the burden of cancer, which points to the need to develop evidence-based control plans. It is essential to have reliable information sources to serve as a basis for planning, monitoring, and evaluation of policy implementation. Vital statistics provide mortality information, and population-based cancer registries are the main mechanism for obtaining information on cancer incidence and survival in the population.

However, various challenges must be overcome in order to implement high-quality population-based cancer registries, such as sustainability, data quality, and capacity for analysis and production. Under the framework of Cooperation among Countries for Health Development (CCHD), PAHO is supporting a project that seeks to strengthen local capacities to improve the coverage and quality of population-based cancer registries in five countries: El Salvador, Guatemala, Panama, Paraguay, and Peru. Experts from Argentina and Colombia, as well as from the International Agency for Research on Cancer, are assisting the five countries with the development of enabling policy frameworks, data entry/management and surveillance capacities, and population-based cancer registries. With the support of PAHO/WHO, the transfer of good practices has been done through the national cancer institutes of Argentina and Colombia, which have delivered training workshops and on-site visits to the target countries.

Challenges

25. The following are the main challenges for Category 2:

a) Funding and high-level support for work on NCDs continues to lag behind that of other public health priorities. This lag persists even though NCDs are the leading cause of deaths and years lived with disability across the Region, as reported in Annex A under impact goal 5. Combating NCDs is a frequently stated national priority, driven in part by strong economic arguments.

b) Interference from the alcohol, tobacco, and ultra-processed food and beverage industries is delaying, weakening, or impeding policies, legislation, and regulatory measures intended to protect public health. This remains a major barrier to progress.

c) The limited capacity of the health system to prevent violence and respond to the needs of victims is hampering progress in this area. Violence disproportionately affects the most vulnerable populations, notably women and girls. Inadequate investment impedes the development of a coherent and unified response to violence across key sectors beyond health, including education, police, and justice.

d) Despite efforts to develop and strengthen the community-based mental health model in several countries, psychiatric hospitals still predominate and are associated with severe human rights violations. Inadequate mental health legislation is a continuing problem.

e) Although governments committed to reduce by half the number of deaths from road traffic crashes by 2020, road safety legislation and enforcement have not advanced. Furthermore, motorcycle use has increased, and with lack of regulation and legislation to safeguard these vulnerable road users, related mortality is increasing as well.

Enhanced capacity for mental health and psychosocial support in disaster management in the Caribbean

Following the devastating 2017 hurricanes, PAHO and the Caribbean Development Bank joined forces to enhance mental health and psychosocial support (MHPSS) in disaster management. In response to lessons learned from previous disaster responses, the project successfully:

- Established a roster of trained mental health professionals to provide services to countries in the event of a disaster.
- Launched a regional communication and awareness campaign, "Stronger Together" (https://www.paho.org/en/stronger-together-2020).
- Delivered an online self-learning course on Psychological First Aid (PFA), available on the Caribbean node of the PAHO Virtual Campus for Public Health.
- Assessed MHPSS needs and gaps in Anguilla, Antigua and Barbuda, Bahamas, Dominica, and Turks and Caicos, and developed a standard operating procedure for integrating MHPSS into national multi-hazard preparedness and response plans.

The project's innovative approaches and inter-programmatic partnerships have drawn global attention, including at the WHO 2019 Mental Health Forum, where the illustrated PFA booklet was showcased. In the context of the COVID-19 pandemic, PAHO is adapting the project to strengthen MHPSS responses to the current situation.

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

Key priorities

Promote health at key stages of life	Implement approaches based on gender equality, ethnicity, equity, and human rights	Address the social and environmental determinants of health

Main Achievements

26. The following are the main achievements for Category 3:

a) As noted above, there were marked reductions in infant, child, and maternal mortality during this period, including a decrease in absolute and relative inequalities with respect to infant mortality and maternal mortality. Maternal mortality reduction plans were updated in eight of 10 priority countries.

b) Over 30 countries are using the Perinatal Information System tool to obtain accurate information on obstetric events, with expanded use in the Caribbean during 2018-2019. Thirteen countries are monitoring congenital defects, and 250 professionals from 23 countries were trained in surveillance systems for these anomalies. In Suriname, 90 non-pneumatic anti-shock garments were provided to health facilities with deliveries and to educational institutes, and training was provided in emergency obstetric care. The Zero Maternal Deaths from Hemorrhage project continued to be implemented, with successful results in Brazil.

c) Youth participation in health was strengthened with the creation of the PAHO Youth for Health Group. This group spearheaded the I-Thrive campaign, designed to give young people a voice in defining what makes them thrive.

d) With Ecuador's ratification of the Inter-American Convention on Protecting the Human Rights of Older Persons and the approval of a specific law, eight countries have implemented the Convention in their national legislation.

e) The Plan of Action for Women's, Children's and Adolescents' Health 2018-2030 (Document CD56/8, Rev 1), the Strategy and Plan of Action on Health Promotion within the Context of the Sustainable Development Goals 2019-2030 (Document CD57/10), and the Strategy and Plan of Action on Ethnicity and Health 2019-2025 (Document CD57/13, Rev. 1) were approved and are being implemented,

"Better health and greater health equity will come when life chances and human potential are freed, to create the conditions for all people to achieve their highest possible level of health and to lead dignified lives."

- Report of the independent Commission on Equity and Health Inequalities in the Americas

reinforcing approaches that are essential to leaving no one behind. Participatory processes for the development of these documents have allowed for broad discussions with countries on paradigmatic changes in the model of care and the integration of health into other fields, within the frameworks of the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) and the SDGs.

f) The number of age-friendly communities in the Americas grew by more than 200 to a current total of over 600, more than in any other WHO region. The movement of mayors for healthy cities, municipalities, and communities was further consolidated as a platform for addressing social determinants of health and taking intersectoral action on priority public health issues.

Improved child and maternal health on the northern border of the Dominican Republic and Haiti

Between 2014 and 2016, Haitian women made up 44% of all women who gave birth at the Hospital Provincial in the border town of Dajabón, Dominican Republic. To address the health problems of pregnant women, the two neighboring countries embarked on a project under the framework of Cooperation among Countries for Health Development (CCHD), supported by PAHO, aimed at reducing maternal and neonatal mortality. The project's focus is on improving prevention, early detection, and adequate management of the main causes of death among pregnant women in health facilities and at the community level.

The initiative focuses on the northern portion of the Dominican-Haitian border, with local coordination and full participation of the regional and national health authorities of both countries in project implementation, supervision, and monitoring. It uses a three-tiered approach to promote the exchange of good practices at departmental level, in health facilities, and in communities. Binational networks that focus on adolescent and maternal health care for Haitian migrant women are under implementation. Joint meetings with community leaders and health workers ensure ownership of the project.

The project has improved the capacity of the health services to handle obstetric emergencies. It has also trained health and community workers, strengthened blood supply management, and implemented the Perinatal Information System.

g) The report of the PAHO independent Commission on Equity and Health Inequalities in the Americas was launched with a highly successful side event during the 57th Directing Council. PAHO also completed an analysis of the integration of health equity in national health policies and national development plans in 32 countries. With support from the Government of Canada, an integrated mechanism was developed that demonstrated significant examples of the ways in which PAHO is enhancing its capacity and activities to address four cross-cutting themes in countries.

h) Eleven countries signed the health commitments of the Climate Action Summit, and the Caribbean Action Plan on Health and Climate Change was launched during a high-level event in 2018. Ten cities committed to implement actions toward achieving the standards set in the WHO Air Quality Guidelines by 2030. Twenty-seven countries and subnational governments joined the BreatheLife campaign and are implementing actions to improve air quality and protect public health. The Central American Parliament approved a resolution to promote the development of national legislation for countries of the subregion and, with the support of PAHO, created an observatory of air quality within the Central America Integration System.

Challenges

27. The following are the main challenges for Category 3:

a) There are limited resources and institutional capacity within the health sector to address essential functions related to this category, such as environmental and occupational public health. The implementation of the Organization's priorities (including the new plans of action) will require creative intersectoral approaches.

b) Many countries have only recently begun to realize the implications of population aging for their health and economic systems. PAHO has seen an increasing demand for technical support in organizing systems to provide long-term care.

c) The Region does not have enough data in many key areas of work, including ethnic disparities and gender mainstreaming in health, as well as on emerging topics such as LGBT and masculinities. Information systems in countries are not sufficiently integrated to monitor and track progress on the health-related SDG indicators.

d) Although progress has been made in improving health across the Americas in recent decades, significant inequalities and inequities remain. There is no agreed, shared, inclusive, and interdisciplinary framework—neither within PASB nor in the countries—for work on equity in health that incorporates health systems approaches, intersectoral work on social and environmental determinants, and monitoring.

Combatting gender-based violence against women in Honduras

In Honduras, 383 deaths due to gender-based violence against women from 15 to 39 years of age were registered in 2018.

Through PAHO technical cooperation, and with the support of partners like Canada, 100 women from Yamaranguila, Intibucá, were trained on gender-based violence and women's empowerment. The intervention aims to reduce intra-family violence in the Lenca indigenous community of Yamaranguila. The comprehensive training applies an intercultural approach that seeks to strengthen women's self-esteem, human dignity, and leadership skills. The training builds an understanding of domestic and intra-family violence and of children's, adolescents', and women's rights, and also explains the available channels for reporting violence and seeking help.

Today Ana*, one of the participants in the training, describes herself as a healthy, empowered woman. She is a proud mother and grandmother and a leader in her community, who delivers workshops and tells her story so that other women too feel supported and empowered to break out of the cycle of violence.

* Name has been changed.

Category 4: Health Systems

Key priorities

Strengthen health systems based on primary care with a focus on health governance and financing toward progressive realization of universal health	**Organize people-centered, integrated service delivery and promote access to and rational use of health technologies**	**Strengthen health information and research systems, the integration of evidence, and transfer of knowledge and technologies**	**Develop human resources for health**

Main Achievements

28. The following are the main achievements for Category 4:

a) The High-Level Commission on Universal Health in the 21st Century: 40 Years of Alma-Ata was an interdisciplinary group of 17 regional experts. Following presentation of the Commission's report, the Director of PASB launched a Regional Compact on Primary Health Care for Universal Health, known as PHC 30-30-30.

b) Thirty-three countries implemented actions toward the progressive realization of universal health, including substantial health sector reforms, legislation changes, and/or definition of strategies, plans, and road maps. Of those, 26 countries included policy options on financing to make broader health sector reform more feasible and sustainable. As an example of these efforts, in 2019 El Salvador's National Assembly approved innovative legislation that provided the basis and tools to promote the integration of the segmented health system in the country.

c) To better respond to new data needs within the SDG agenda and the PHC 30-30-30 compact, PASB produced methodologies and quality estimates for key indicators of access barriers to health services, financial protection in health, and health spending statistics across 30 Member States. The financial protection statistics produced by PAHO were used in various regional and global reports.

d) Twenty-four countries developed their national capacity to implement the integrated health service delivery networks (IHSDN) framework, with a focus on strengthening the resolution capacity of the first level of care.

e) To support the reduction of maternal mortality, the Assessment of Essential

"We all have a solemn responsibility to ensure that today's declaration on primary health care enables every person, everywhere to exercise their fundamental right to health."

- Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, on the Declaration of Astana, 25 October 2018

Conditions tool was adapted as a means to identify opportunities for improvements in maternal care. Training was provided to professionals from 12 countries identified as priority countries for the reduction of maternal mortality, and the assessment was conducted in six countries.

f) PAHO launched the Regional Initiative for the Exchange of Information on Prices, Coverage and Economic Regulation of Health Technologies in order to improve access to and affordability of medicines and other health technologies. Thirteen countries now participate: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Honduras, Mexico, Panama, Paraguay, Peru, and Uruguay.

g) Thirty-four of 35 PAHO Member States have now signed agreements to use the PAHO Regional Revolving Fund for Strategic Public Health Supplies, with 17% growth in the procurement of essential medicines, diagnostic kits, and vector control supplies from 2018 to 2019. The Capital Account grew to US $20 million,[4] providing interest-free lines of credit for Member States during the biennium.

h) Member States moved forward with the adoption of the Global Benchmarking Tool, available in English, Spanish, and French, which strengthens regulatory systems for medicines and other health technologies. Self-assessments of regulatory capacities were completed in 2019 by Bolivia, Costa Rica, and Paraguay, and a joint assessment was performed by PAHO and WHO in Peru. The Caribbean Regulatory System is spurring regulatory reforms in CARICOM, speeding up access to quality medicines and monitoring quality of medicines on the market.

i) The coverage and quality of birth and death records has improved across the Region. This is the result of concerted Member State interventions in prioritizing vital statistics and investing in information systems for health (IS4H) that facilitate the collection of quality data. Information systems from 18 countries and territories have undergone assessments using the Organization's IS4H maturity assessment tool, and 25 Member States have established national reference centers or inter-institutional committees that manage vital and health statistics following PAHO guidelines.

j) Twenty-seven countries identified priorities, objectives, and indicators to measure their progress toward advancing the Plan of Action on Human Resources for Universal Access to Health and Universal Health Coverage (Document CSP29/10).

k) The Virtual Campus for Public Health continued to grow, with 87 self-learning courses available, reaching a total of 1,040,000 participants. Forty-two countries and territories continued to advance education strategies and programs for health personnel oriented toward public health and clinical management areas through the Virtual Campus or equivalent e-learning networks. Nineteen countries established fora for inter-professional education and collaborative practice in health.

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

Toward universal health for the Chaco Region

The Chaco territory is a cross-border area between Argentina, Bolivia, and Paraguay. In this region of 400,000 people, approximately 30% of the population belongs to indigenous communities that are dealing with many issues, including a lack of access to health services. Regrettably, women and children living in the Chaco have a higher probability of dying from preventable causes than those living in other regions.

Guided by the mandate to "leave no one behind," PAHO has implemented a project under its CCHD framework to design and strengthen health services that are culturally appropriate for indigenous and rural populations. The project seeks to eliminate barriers to accessing care, promote access to safe water and nutrition, and ensure emergency response to disasters.

In the Bolivian Chaco, the Tekove Katu School of Health supported partners to become promoters who facilitate access to water and sanitation, waste management, and hygiene within health centers and communities. In Paraguay, the project strengthened ties between indigenous midwives and health professionals, enabling them to work together toward safer deliveries through an intercultural approach and exchange of knowledge. The Chaco territory is now better positioned on the agendas of the three countries' ministries of health, raising the visibility of this border region's challenges, including the need for better data and information.

Challenges

29. The following are the main challenges for Category 4:

a) In light of the complex political and national contexts facing health systems, there is a need to design and implement comprehensive road maps to advance toward universal health. However, the limited capacity of national health authorities to steer, lead, and govern processes of transformation and strengthening, including dialogue with civil society, results in fragmented approaches that slow and impede efforts to increase equity and efficiency.

b) The review and strengthening of national health-related legislative and regulatory frameworks continues to require further efforts by Member States, with a view to achieving realization of the right to the highest attainable standard of health.

c) Public health expenditure has increased, but at a relatively slow pace. It has not been sufficient to replace out-of-pocket spending as a source of financing or to increase financial protection for households, a shortfall explained in large part by the increasing costs of medicines and health technologies.

d) There are continuing challenges with respect to data availability and the state of information systems, combined with limited capacity for monitoring health policies and reform processes in countries. Those countries that collect information on a regular basis still need to articulate their monitoring efforts with the policy-making process.

e) A number of barriers make it difficult to improve access to quality health services. They include fragmentation in addressing quality, with a predominance of vertical programs; an approach to access and coverage of health services that fails to emphasize quality; weaknesses in implementation and oversight of quality standards; a context that is unfavorable to a culture of quality; inadequate availability, capacity, and continuing education of human resources for health; limited access to medicines and other health technologies; and insufficient and inadequate financing.

f) Integrating pharmaceutical, blood, and radiological services within IHSDN continues to be a challenge that hinders not only access to services and products, but also the response capacity of the first level of care. The lack of proper pharmaceutical services at the first level of care complicates the organization of services and undermines access to medicines by the population.

g) Despite significant advances in the quality and coverage of health data, many countries display continuing weakness in their information systems for health. Information systems in many Member States are of variable coverage and quality, particularly in areas with significant inequalities and vulnerable populations. The resulting gaps have an impact on the targeting of health resources.

h) The transition to the latest revision of the International Classification of Diseases (ICD), from ICD-10 to ICD-11, will entail capacity building for individuals who are specialized in ICD coding, ranging from personnel within national statistics offices to the national health authorities. This transition requires significant investments and will take several years.

i) Funding for human resources for health continues to be insufficient to ensure the delivery of quality health services, particularly at the first level of care, and to meet the needs of remote underserved populations. Persistence of inequity at all levels, reduced retention rates in rural and neglected areas, precarious working conditions, suboptimal productivity, and poor performance are some of the challenges that countries are facing.

Improved blood transfusion services in Guyana

In Guyana, the blood transfusion service faced challenges around poor procurement systems and lack of structures and guidelines for quality governance, negatively affecting health service delivery. With support from the Hospital Garrahan Hemotherapy Center in Argentina and from PAHO, Guyana strengthened its blood transfusion system through exchanges focusing on improved management and on capacity building for health workers.

As a result of this collaboration, the national blood transfusion service has improved its operations in donor recruitment, blood processing, and distribution. Specific achievements through this initiative include the adoption of a strategic plan and a new national blood policy, creation of transfusion committees in the most important hospitals in the country, and gradual improvement of quality. The collaboration was instrumental in enabling the government of Guyana to create a specialized immunohematology laboratory with capacity for platelets pooling and to adopt standard operating procedures for all stages of the blood transfusion cycle.

Category 5: Health Emergencies

Key priorities

Reduce mortality, morbidity, and societal disruption resulting from emergencies and disasters	**Increase detection, management, and mitigation of high-threat pathogens**	**Strengthen health security through all-hazards risk reduction, preparedness, response, and early recovery activities**

Main Achievements

30. The following are the main achievements for Category 5:

a) A major effort for the Organization during the biennium was supporting the response to the Venezuelan situation and associated humanitarian problems within that country and neighboring countries (Brazil, Colombia, Ecuador, Guyana, Peru, and Trinidad and Tobago). While this situation brought many challenges, it also provided an opportunity to advance on many aspects of the program of work, particularly the control and prevention of epidemic- and pandemic-prone diseases, with an emphasis on vaccine-preventable diseases, as well as a wider agenda on mass migration and health. Ongoing emergency operations continued to prioritize the needs of populations in conditions of vulnerability within the context of protection of health, human rights, and culture.

b) Timely and appropriate response to all emergencies with potential health impacts was provided in 29 countries and territories within 48 hours of onset or request for support during 2018-2019.

c) No confirmed cases of cholera were reported in Haiti after January 2019, thanks to continuous support from PAHO to the Haitian government (epidemiology, surveillance, laboratory, infection prevention and control, resource mobilization, and vaccination). This represents a positive step toward the elimination of cholera from the island of Hispaniola.

d) PAHO maintained 24/7 coverage for urgent communications and issuance of alerts on public health threats. The average time between the estimated onset of public health threat events and the first receipt of information by WHO decreased from 33 days in 2018 to 20 days in 2019. This was facilitated by increased participation

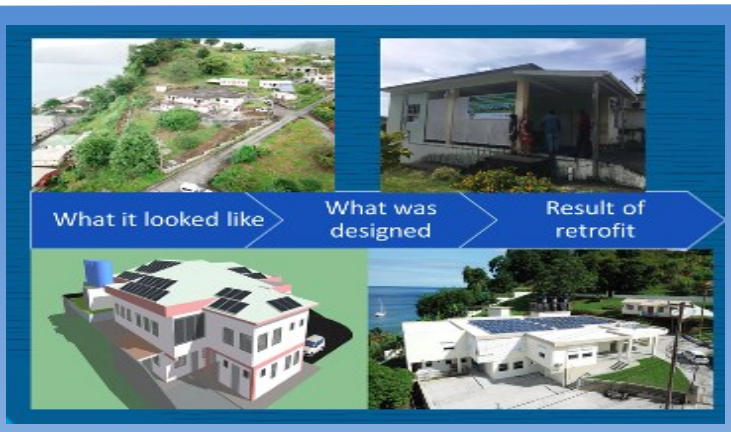
"PAHO has been working on disaster prevention and response for [over] 40 years, and this has enabled many countries in the Americas to be better prepared to face them. To save more lives, we need health centers with plans in place as well as better prepared communities."

- Dr. Carissa F. Etienne, PAHO Director, on an official visit to Belize in February 2019

and responsiveness on the part of the International Health Regulations (IHR) national focal points. One hundred percent of the events that represented acute public health events were risk-assessed in less than 72 hours.

e) Six Emergency Medical Teams (EMT) in the Americas are now certified by WHO, and a total of 39 countries and territories have introduced the EMT initiative. Eight Caribbean countries have at least two certified multisectoral response teams and 500 people trained for mass casualty management.

f) Four Caribbean countries now have 18 health facilities that have been upgraded to become "smart" facilities, with improved resilience to disasters and reduced impact on the environment (Dominica, Grenada, Saint Lucia, and Saint Vincent and the Grenadines). An additional 33 facilities are in various stages between design and retrofitting. Hospital safety was enhanced in Haiti, and 18 countries were trained in the updated Hospital Safety Index guidelines.



Caribbean leads the way to safer, greener health care facilities that can deliver care in disasters

The Caribbean region is vulnerable to natural hazards and climate change, which can cause significant disruption of health services and economic losses. With the support of the UK Department for International Development (DFID), the Smart Health Care Facilities in the Caribbean project offers seven countries the opportunity to better prepare their facilities for disasters (Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, and Saint Vincent and the Grenadines). The project builds on the PAHO Safe Hospitals Initiative and highlights the importance of having a sustainable and long-term vision for achieving a positive impact on health and climate change.

"Smart" health care facilities integrate disaster risk reduction, climate change adaptation, environmental management, and conservation strategies in one platform. According to the PAHO Plan of Action for Disaster Risk Reduction 2016-2021, 77% of hospitals in the Caribbean are in high-risk areas and require urgent remedial measures to protect lives during and after disasters.

Over 1,000 people have been trained, including health workers, technical stakeholders, users of health facilities, and media workers; 413 health facilities have been assessed for green and safety standards; 18 facilities have been retrofitted; and 48% of the retrofitting contracts (24 of 50 targeted facilities) have been awarded. The project has also been adapted by other donors and sectors (education) and is expected to end by May 2022.

g) Countries have improved the quality and extended the scope of their laboratory detection capacities to respond to emerging and reemerging viral pathogens in the Region. Three national laboratories (Bolivia, Dominican Republic, and Haiti) were designated by WHO as National Influenza Centers.

h) The average regional scores for 12 of 13 IHR core capacities are above the global average scores, according to States Parties Annual Reports submitted to the 72nd World Health Assembly. Furthermore, eight countries completed joint external evaluations, one of the three voluntary components of the IHR Monitoring and Evaluation Framework.

i) PASB has raised the level of financial and human resources available for health emergencies, particularly at country level. Over $70 million in voluntary contributions was mobilized for the category during 2018-2019.

Challenges

31. The following are the main challenges for Category 5:

a) Logistical and human resource capacity was strained when responding to multi-country emergencies. Obtaining accurate data from countries affected by the intensifying migratory flow has been difficult, especially data on the health situation of the migrant population and their main needs for emergency and long-term care.

b) The availability and systematic distribution of reagents and supplies for laboratory surveillance, confirmation, and timely detection of emerging viruses is insufficient, mainly because of the high cost of shipping and complex customs procedures that have led to loss of kits and panels. There are persistent gaps related to the implementation of surveillance systems for hospital-acquired infections due to lack of awareness and inadequate laboratory capacity. Countries also need to develop and/or update their policies on quality management and biosafety and biosecurity for laboratories.

c) The status of IHR core capacities is heterogeneous across subregions of the Americas. Countries need to shift their perceptions of the regulations from “an end in themselves” to a tool for strengthening the ability of health systems to perform essential public health functions. Member States require an appropriate national legal framework to support and enable implementation of their obligations and rights under the IHR.

d) Delays persist in processes for the revision of information disseminated through the IHR channels (postings on the Event Information Site). Countries also need to prioritize improvement, modernization, and automation of epidemiologic data collection mechanisms and data management structures.

e) Delays in meeting milestones for the Smart Hospitals project occurred due to the limited capacity of construction companies and the catastrophic impact of the

2017 hurricane season. The price of construction materials and services has also increased since the early stages of the project.

f) Ensuring financial sustainability and stability for the health emergencies program will remain a challenge, particularly in the context of prolonged large-scale emergencies that divert resource mobilization efforts away from base programs.

Toward the elimination of cholera in Haiti

Haiti marked a year free of confirmed cholera cases in January 2020. The outbreak that began in October 2010, affecting over 820,000 people and killing 9,792, has been controlled.

This major accomplishment was made possible by the joint efforts of Haiti, PAHO, and other partner agencies to address the root causes of cholera. Preventive activities focused on increased surveillance to detect and respond to possible outbreaks, the implementation of rapid diagnosis initiatives, and the execution of cholera vaccination programs. Primary health clinics were equipped with trained personnel, medicines, and supplies, enabling them to respond quickly and manage cases with appropriate rehydration and care. PAHO and the Ministry of Health worked together to implement the LaboMoto project, which used motorcycles to rapidly transport samples from treatment centers to laboratories. This initiative enabled testing and confirmation of suspected cases to increase from 21% in 2017 to 95% in 2019.

In order to receive validation from the World Health Organization for eliminating the disease, Haiti must maintain effective surveillance systems and remain cholera-free for two more years. Death from cholera is preventable using today's tools and mechanisms, and early detection and response to possible outbreaks must continue. However, to ensure that cholera is eliminated in the long term, there is an imperative need to accelerate investments in clean water and adequate sanitation in Haiti.

Category 6: Leadership, Governance, and Enabling Functions

Key priorities

Foster organizational leadership and governance	Implement the enabling functions of the Organization	Enhance strategic planning and resource coordination and mobilization

Main Achievements

32. The following are the main achievements for Category 6:

a) The two commissions established by PAHO—the High-Level Commission on Universal Health in the 21st Century: 40 Years of Alma-Ata, and the Commission on Equity and Health Inequalities in the Americas—presented their final reports, which facilitated the convening of high-level meetings with regional and global policymakers. This achievement consolidated the Organization's leadership role in defining country pathways for health policy and strategy formulation within a broader context of development.

b) The PAHO Strategic Plan 2020-2025 (SP20-25) was developed in close collaboration with Member States through the Strategic Plan Advisory Group (SPAG). It was fully endorsed by the Directing Council in September 2019, along with its first Program Budget 2020-2021 (PB20-21) and the new PAHO Budget Policy (Document CD57/5). The SP20-25 marked a significant step forward in the implementation of the Sustainable Health Agenda for the Americas 2018-2030.

c) Cooperation among Countries for Health Development allowed for optimized workflows, as well as better allocation of resources to strategic country-led initiatives. PAHO has supported the documentation of CCHD initiatives and the exchange of best practices and lessons learned in 31 countries, including all key countries and subregional organizations. In collaboration with the UN Office for South-South Cooperation (UNOSSC), PAHO has also contributed to the development of the UN System-wide South-South Cooperation Strategy, to be released in 2020.

"Our organization works continuously to reduce the burden of [NCDs] in alliance with other organizations and agencies within the Inter-American System. We advocate at the highest level of governments to enhance awareness of the severe impact of these diseases and for the implementation of policies and prevention."

- Dr. Carissa F. Etienne, PAHO Director, Annual Report 2018 presentation to the OAS

d) During the 2018-2019 biennium, PAHO mobilized a total of $261.5 million in PAHO voluntary contributions through 126 new agreements and 78 amendments to existing agreements.

e) PAHO developed a comprehensive anti-fraud and corruption policy.

Note: This photo is from the third meeting of the SPAG in April 2018. Not all SPAG representatives were present at the time the photo was taken.

Broad Member State participation in development of the new Strategic Plan 2020-2025

Every six years PAHO embarks upon a complex and intense process to set out its strategic direction for the following six years. Work on the PAHO Strategic Plan 2020-2025 swung into action in early 2018 with the formation of the Strategic Plan Advisory Group (SPAG). With a record-setting 21 countries participating, this group drew upon the Region's extensive experience in collective strategic planning.

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

The development process was iterative and rigorous. The end result represents the best collective thinking about where and how PAHO should concentrate its efforts through 2025, responding to the WHO 13th General Programme of Work, the SHAA2030, and the SDGs.

f) As in previous biennia, PASB received an unqualified audit opinion for the 2018 annual financial statements, exemplifying its consistent performance and commitment to transparency.

g) PAHO maintained and increased national and global media coverage and social media conversations on key public health issues, crises, campaigns, and events. Also, PAHO branding was renewed and made more engaging for digital platforms, campaigns, multimedia, and online content, as well as national, regional, and global events.

Challenges

33. The following are the main challenges for Category 6:

a) The political and economic situation in the Region affects public health infrastructure, public health goals, and the ability to maintain a critical mass of public health personnel, posing a technical and political challenge for PAHO. This has affected all levels of the Organization, with appreciable impacts on the technical cooperation provided by the PAHO/WHO Representative (PWR) Offices in PAHO key countries and countries in emergency situations, as well as by the multi-country offices in the Caribbean.

b) Significant delays in the receipt of assessed contributions from several Member States complicated the delivery of technical cooperation, particularly at country level.

c) Substantial variations in the interpretation and roll-out of UN reform at country level affected the PWR Offices and their implementation of political, strategic, and technical programs. The unique constitutional and legal status of PAHO requires special consideration as UN reform is implemented in the Region of the Americas. This has required ongoing guidance and support from the regional level, and close collaboration and coherence of approaches with the global level at WHO.

d) The complexity of planning, monitoring, and assessment processes and their overlapping timelines in PAHO and WHO continue to affect the ability of some Member States to provide their inputs on time.

e) The disparity between the approved funding for the Americas in the WHO Programme Budget and the funds ultimately received and budgeted continues to have an impact.

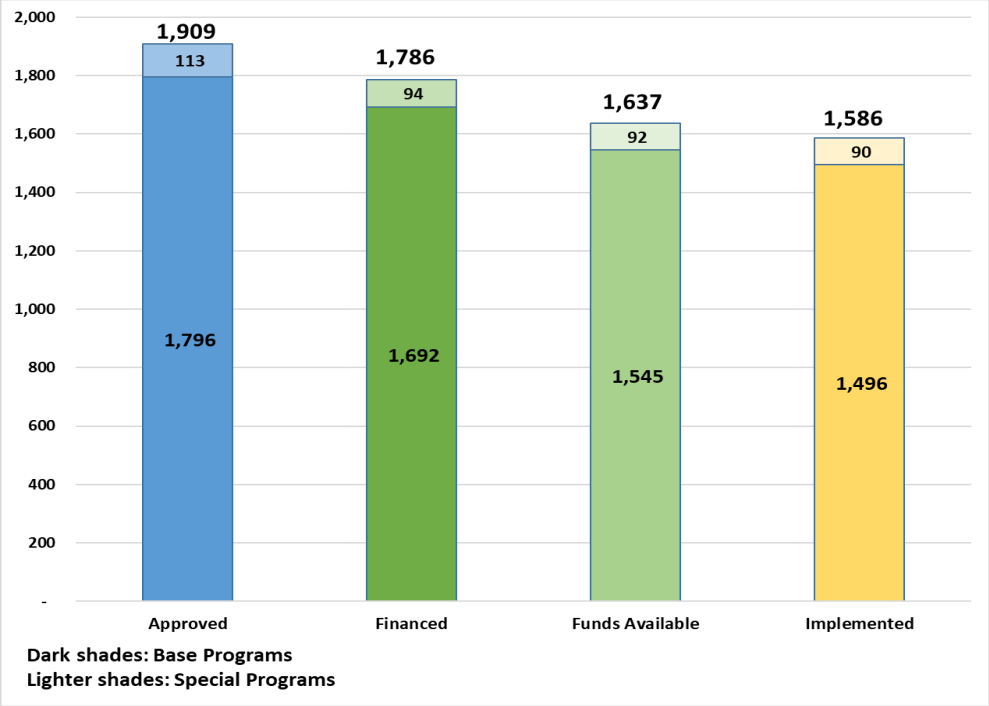
IV. Budget Implementation

34. This section analyzes implementation of the PAHO budget in two parts. The first part presents an overview of the financing levels reached by PAHO throughout the period of the PAHO Strategic Plan 2014-2019 and its corresponding three Program and Budgets (2014-2015, 2016-2017, and 2018-2019). The second part further analyzes the information related to PAHO Program and Budget 2018-2019 and compares approved budget levels with financing and implementation, as well as funding gaps, along with resource mobilization efforts during the period.[5]

Budget Overview for the Period of the PAHO Strategic Plan 2014-2019

35. To achieve the results of the Strategic Plan 2014-2019, the Organization estimated resource requirements of approximately $1.8 billion. During this period, PAHO adopted three Program and Budgets: PB14-15, PB16-17, and PB18-19. Figure 4 shows the levels approved, financed, available for implementation (also referred to as funds available), and implemented for the sum of the three PBs, identifying base and special programs.

Figure 4. PAHO Strategic Plan 2014-2019:
Overview of Budget, Financing, and Implementation
(US$ millions)



[5] Earlier biennia were described in more detail in previous end-of-biennium reports (Documents CD55/5 for 2014-2015 and CD56/5 for 2016-2017).

36. Considering all three Program and Budgets, Member States approved a total of $1.9 billion over the six years of the Strategic Plan: $1.8 billion for base programs and $0.1 billion for special programs. Of the total approved, 94% was financed ($1.7 billion for base programs, $0.1 billion for special programs); 86% was available for implementation ($1.5 billion for base programs, $0.1 billion for special programs); and 83% was implemented. Of the funds available for implementation, 97% were implemented over the six years.

37. As in WHO, the concepts of "financed" and "funds available for implementation" presume the following:

a) "Financed" refers to all income that the Organization considers in funding the Program and Budget, even when the corresponding "cash" has not been received in full, or when some of these funds are meant to be used in future biennia (for example, multi-year voluntary contributions).

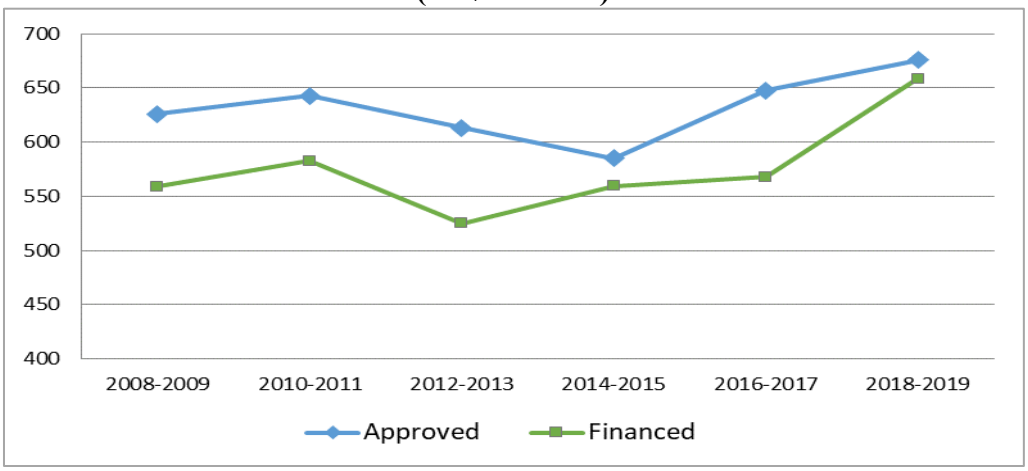
b) "Funds available for implementation" includes all types of funds that are distributed to entities and are ready for implementation in the respective biennium.

c) PAHO assessed contributions and miscellaneous revenue assume that quota payments due from Member States will be paid in full. Per historical practice, PAHO considers the full amount to be available at the beginning of the biennium and uses approved reserves while the cash arrives.

d) Similarly, the Organization may advance funds from existing reserves when voluntary contributions have been signed but funds have not been received. This makes them available and allows for timely implementation. The mechanism is only applied when doing so is considered low risk, particularly when there is a longstanding relationship with donors that have good payment records.

38. Figure 5 compares levels of approved budget and overall financing over the last six biennia, and Table 2 provides additional detail on the main sources of financing for PAHO for the period of the Strategic Plan. Financing reached its highest level in 2018-2019, mainly because of increases in two of its major sources: 39% for other sources (which includes voluntary contributions), and 9% for the WHO allocation to the Americas.

Figure 5. PAHO Program and Budgets: Approved and Overall Financing Trends (US$ millions)



39. In 2018-2019, PAHO budgeted for $214.3 million in assessed contributions and miscellaneous revenue (Table 2). However, from the perspective of cash received, as of 31 December 2019 the Organization was due to receive $88.9 million in assessed contributions from 2019 or earlier periods,[6] which required the use of reserves from other funds. Accordingly, PASB took several measures to address the cash shortage. More detailed information on the Organization's financial situation in 2019 is provided later in this report.

Table 2. Sources of Financing of Program and Budgets under PAHO Strategic Plan 2014-2019 (US$ millions)

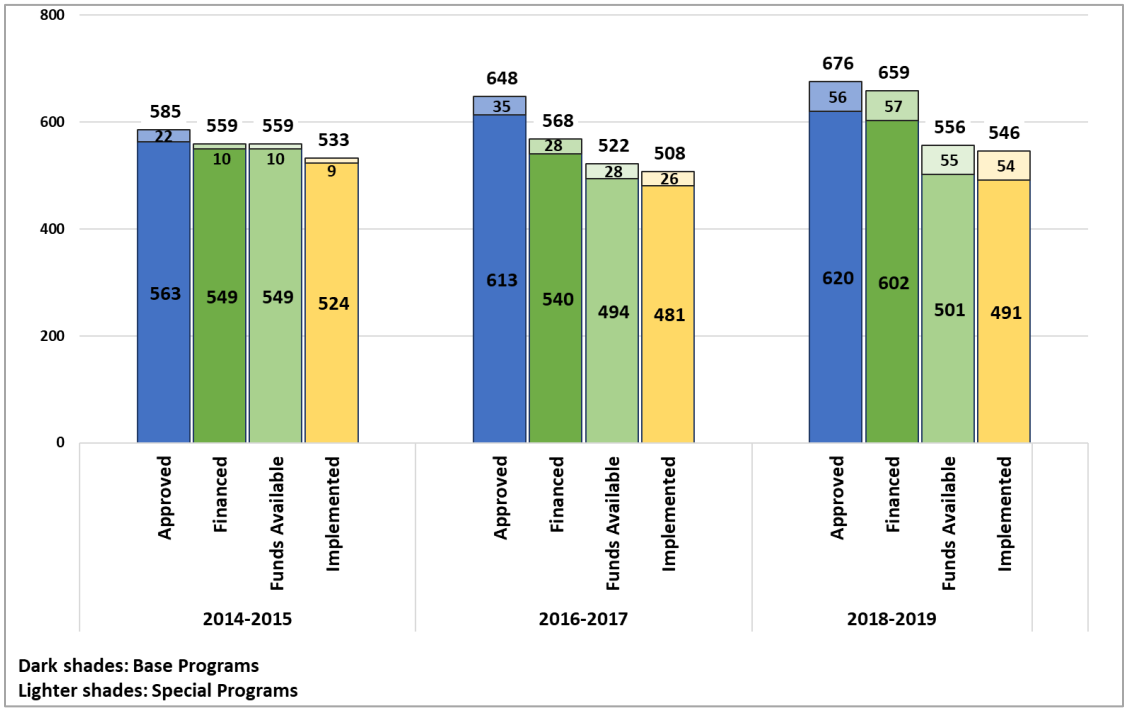
Source of Financing	2014-15 Financed	2016-17 Financed	2018-19 Financed	Total SP14-19
	(a)	(b)	(c)	(d) = (a)+(b)+(c)
PAHO assessed contributions and miscellaneous revenue	207.9	217.7	214.3	639.9
Other sources	203.6	209.0	290.1	702.7
WHO allocation to the Americas	147.1	141.0	154.3	442.4
TOTAL	558.6	567.7	658.7	1,785.0

Note: Amounts shown in this table for 2014-15 are based on financial statements of 2015 and on expense-related databases for 2014-2015. They differ from those in the end-of-biennium report for 2016-2017 (Document CD56/5, Add. I), which included amounts for base programs only.

[6] Overview of the Financial Report of the Director for 2019 (Document SPBA14/6).

40. Higher levels of approved budget have been accompanied by overall increased funding. For 2018-2019, PAHO had its highest-ever level of financing in budgetary terms (though not in cash terms, due to non-payment of assessed contribution quotas by some Member States). The total approved budget increased by 15% from 2014-2015 to 2018-2019, and financing increased by 18% (Figure 6).

Figure 6. PAHO Program and Budgets 2014-2015, 2016-2017, and 2018-2019: Overview of Budget, Financing, and Implementation (US$ millions)

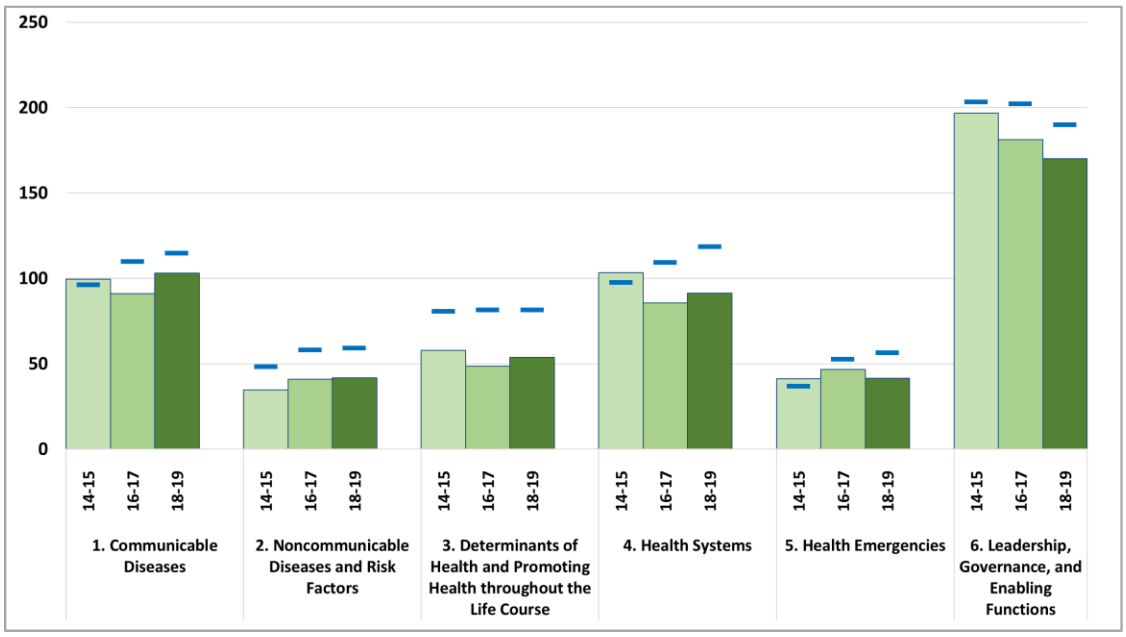


41. While overall levels of financing were adequate for the period of the Strategic Plan, there was a shift in funding available within the Program and Budgets from base programs toward special programs (Figure 6). Base programs show a decrease of $48 million, from $549 million in 2014-2015 to $501 million in 2018-2019. This was offset by an increase of $45 million in the special programs segment between the first and third biennia of the Strategic Plan. The reduction in base programs has had direct consequences for the ability of PAHO to implement its plans in a sustainable way. This was considered when proposing the PAHO Program Budget 2020-2021, which maintained the same level of funding for base programs ($620 million) as in 2018-2019.

42. Deeper analysis of the base programs by programmatic category also shows that absolute and relative levels of financing varied greatly across the technical programs. Figure 7 shows levels of approved budget and funds available for implementation by category and biennium. PB 2014-2015 had the highest availability of funds for base programs, as reflected in most of the categories. The following two biennia saw a reduction in availability of funding for most categories.

43. Two of the technical categories, Communicable Diseases (Category 1) and Health Systems (Category 4), were consistently better funded than other categories during the Strategic Plan period. They attracted the largest amount of voluntary contributions. In 2018-2019, antimicrobial resistance was moved from a specific output in Category 5 to become a program area in Category 1 (Program Area 1.6). Food safety also moved from Category 5 to Category 1, becoming Program Area 1.7. These account for some of the shifts in the respective budgets and funding of these categories. All financing directly related to Outbreak and Crisis Response is part of PAHO special programs and thus is not included in Figure 7.

Figure 7. PAHO Strategic Plan 2014-2019:
Budget and Funds Available by Biennium and Category
(base programs, US$ millions)



Note: Blue lines represent approved budget. Green bars represent funds available.

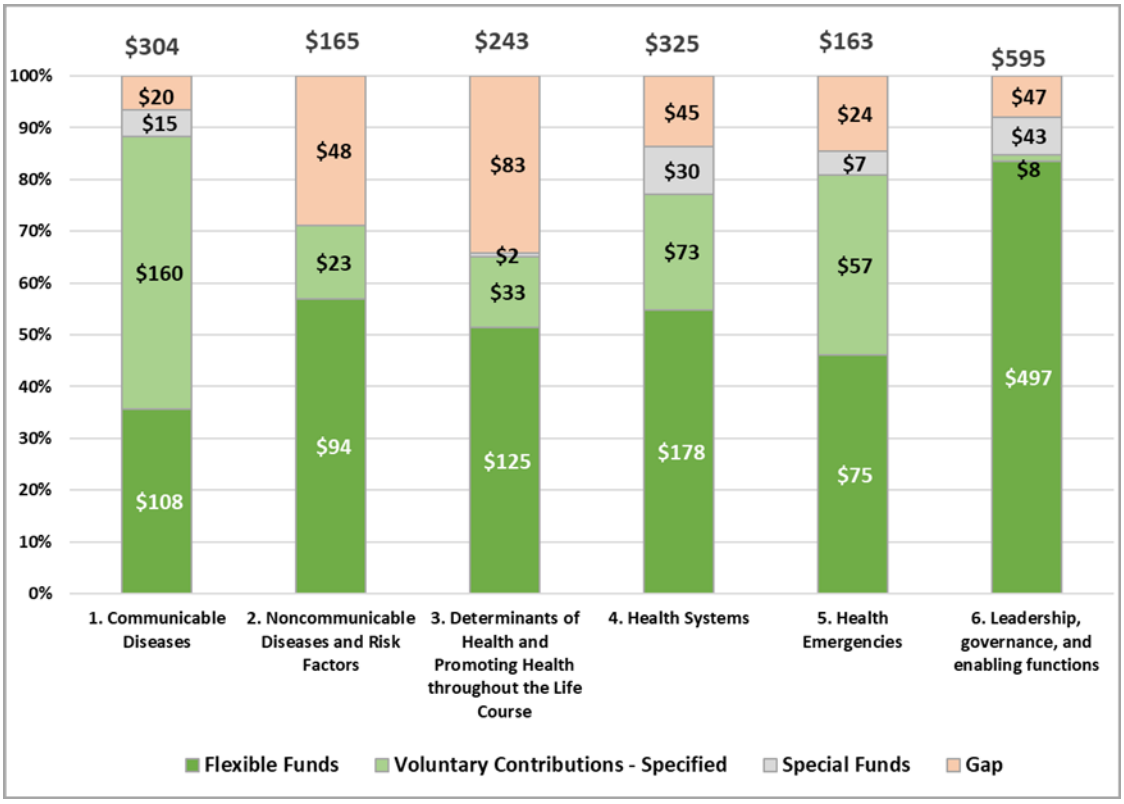
44. Noncommunicable Diseases and Risk Factors (Category 2), Determinants of Health and Promoting Health throughout the Life Course (Category 3), and Health Emergencies (Category 5) include some high-priority topics that are nonetheless not well funded by donors. Category 3 was the least well financed category throughout the Strategic Plan. While its budget space has remained somewhat stable, actual availability of resources decreased from $57.9 million in 2014-2015 to $53.6 million in 2018-2019.

45. Overall, Noncommunicable Diseases and Risk Factors (Category 2) shows a positive trend in budget space and funds availability. Although its budget level is modest in comparison to the mandate and burden of disease, during the period of the SP14-19 its financing levels increased from $34.8 million in 2014-2015 to $41.9 million in 2018-2019.

46. Finally, Leadership, Governance, and Enabling Functions (Category 6) has consistently been reduced in both budget space and funding over the last three biennia. This reflects deliberate reductions, increased efficiencies, and cost containment measures that have been introduced.

47. PAHO has traditionally used its flexible funds[7] to support program areas that face high financial gaps, to support public health gains in program areas that are not funded by voluntary contributions, and to support PAHO leadership, governance, and enabling functions. To illustrate this, Figure 8 presents a summary of approved budget levels for the SP14-19, available funds by main type of fund, and financial gaps by category.

Figure 8. PAHO Strategic Plan 2014-2019:
Funds Available for Implementation by Category and Main Fund Type
(US$ millions and percentages)



Note: Distribution by type of funds for 2014-2015 was estimated through distribution of expenses that occurred in that biennium.

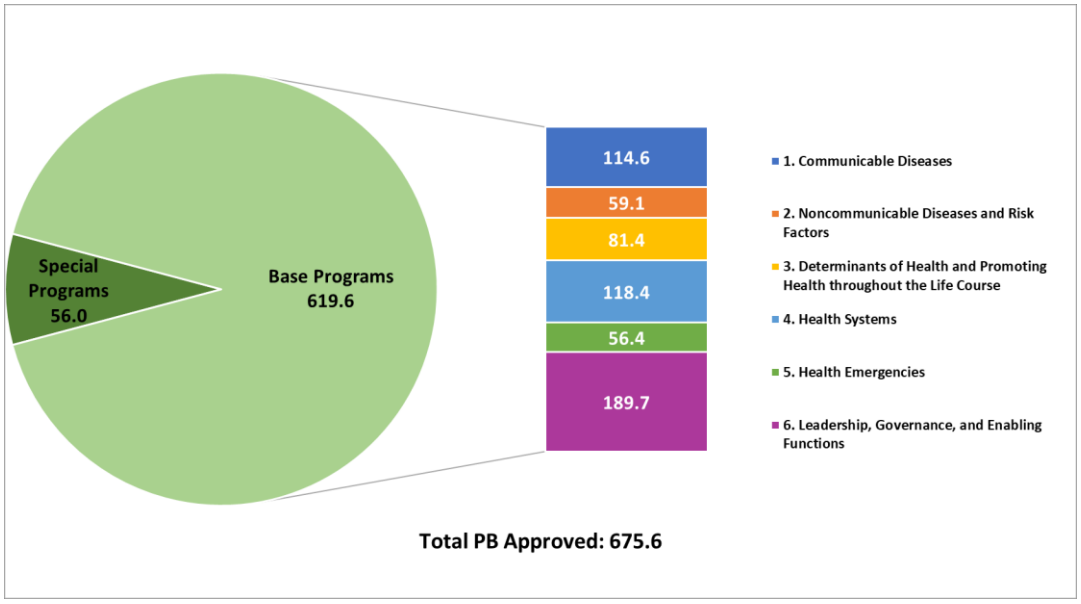
[7] As defined in the PAHO Budget Policy (Document CD57/5 [2019]), "flexible funds" mainly refers to PAHO and WHO assessed contributions, PAHO miscellaneous revenue, and revenue generated from special cost-recovery mechanisms such as project support costs for PAHO and WHO. Though more limited in nature, the WHO Core Voluntary Contributions Account is also considered flexible funds.

48. While each category is different in size, the vertical axis of Figure 8 shows the relative importance of each type of fund within a given category. Among the technical categories, Categories 2, 3, and 4 show the highest dependency on flexible funding; this demonstrates the organizational commitment to support these areas. In the case of Category 6, most financing comes from flexible funds, since this category includes functions that are normally not covered by voluntary contributions.

Implementation of the PAHO Program and Budget 2018-2019

49. The PAHO PB18-19 was structured in two segments: base programs and special programs. The total approved Program and Budget for 2018-2019 was $675.6 million; $619.6 million for base programs and $56 million for special programs (Figure 9). Base programs were divided in six categories and 33 program areas,[8] in line with the programmatic structure of the amended SP14-19 adopted at the 29th Pan American Sanitary Conference through Resolution CSP29.R5. The special programs segment included the Hemispheric Program for the Eradication of Foot-and-Mouth Disease, Smart Hospitals, Outbreak and Crisis Response, and polio eradication maintenance.

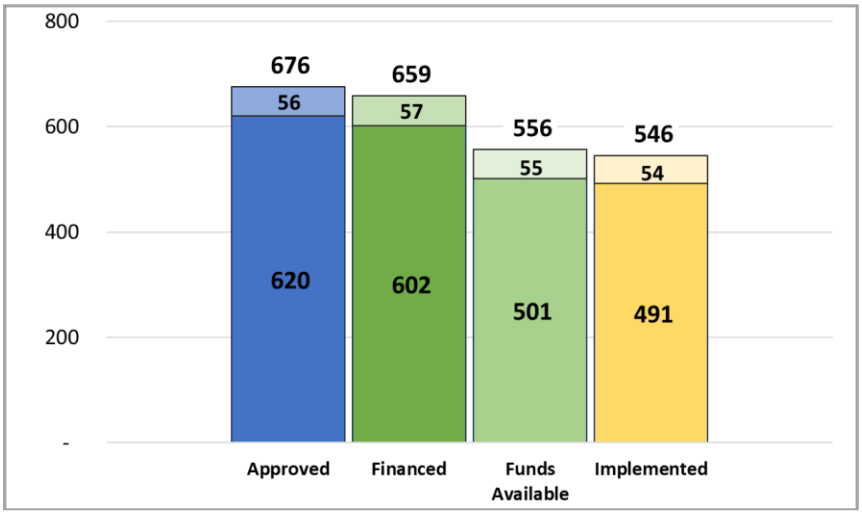
Figure 9. PAHO Approved Program and Budget 2018-2019 by Budget Segment and Category (US$ millions)



[8] Programmatically, Outbreak and Crisis Response is counted as another program area, though budgetarily this program area remains outside of base programs due to its high level of unpredictability.

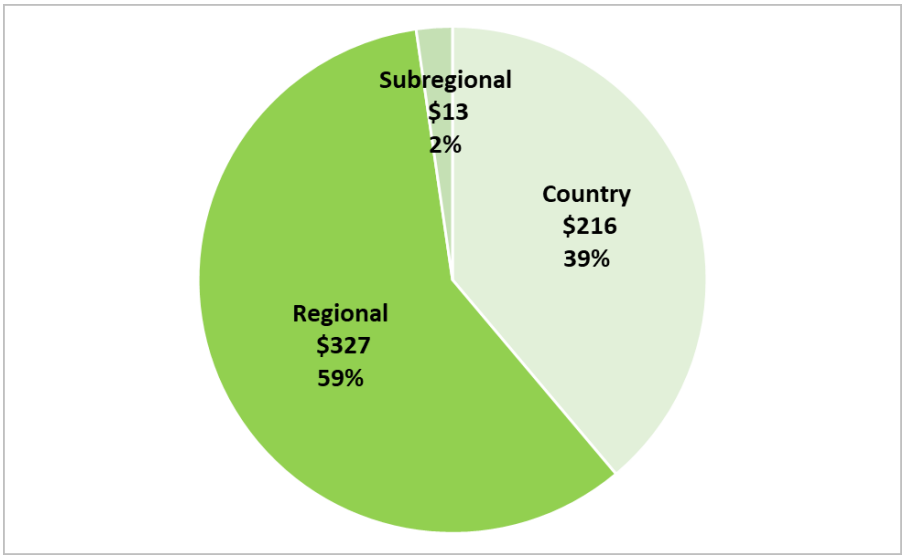
50. As shown in Figure 10, 97% of the Program and Budget was financed ($658.7 million) from a budgetary (not cash) perspective. This high level of budgetary financing is explained by the accounting for payment of PAHO assessed contributions 2018-2019 in full; inclusion of all voluntary contributions available in the 2018-2019 biennium (including those that were carried over into 2020); and, to a lesser degree, inclusion of other sources that were not to be fully spent during 2018-2019 (please refer to Table 2). A total of $556 million was available for implementation ($501 million in base programs and $55 million in special programs). This allowed PASB to close 2019 with implementation of $546 million ($491 million in base programs and $55 million in special programs), or 81% of the total approved budget.

Figure 10. PAHO Program and Budget 2018-2019: Overview of Budget, Financing and Implementation (US$ millions)



51. The distribution of funds available for implementation among the three functional levels of the Organization is presented in Figure 11. In 2018-2019, PASB allocated $229 million (41%) of its available resources at country and subregional levels. PASB is committed to maximizing the allocation of funds to country level while recognizing that an important number of technical and enabling functions that directly benefit the country level are administratively placed at regional level. With the adoption of the 2019 PAHO Budget Policy through Resolution CD57.R3, PASB will continue to strive to increase the allocation of funds to the country and subregional levels during the SP20-25.

**Figure 11. PAHO Program and Budget 2018-2019:
Funds Available by Functional Level
(US$ millions)**



Base Programs

52. Budgetary information for 2018-2019 by category and program area is presented in Table 3 and Figure 12. Disaggregation provides a better perspective on the financial realities within categories. Of the 33 program areas, 22 had funds available that exceeded 70% of their approved budget, but only 10 had over 90%. Eleven program areas had available funding that did not reach 70% of their approved budget. The five program areas with the lowest percentage of financing were 5.6, Disaster Risk Reduction and Special Projects (35%); 3.4, Social Determinants of Health (45%); 4.5, Human Resources for Health (50%); 2.3, Violence and Injuries (50%); and 1.7, Food Safety (55%).

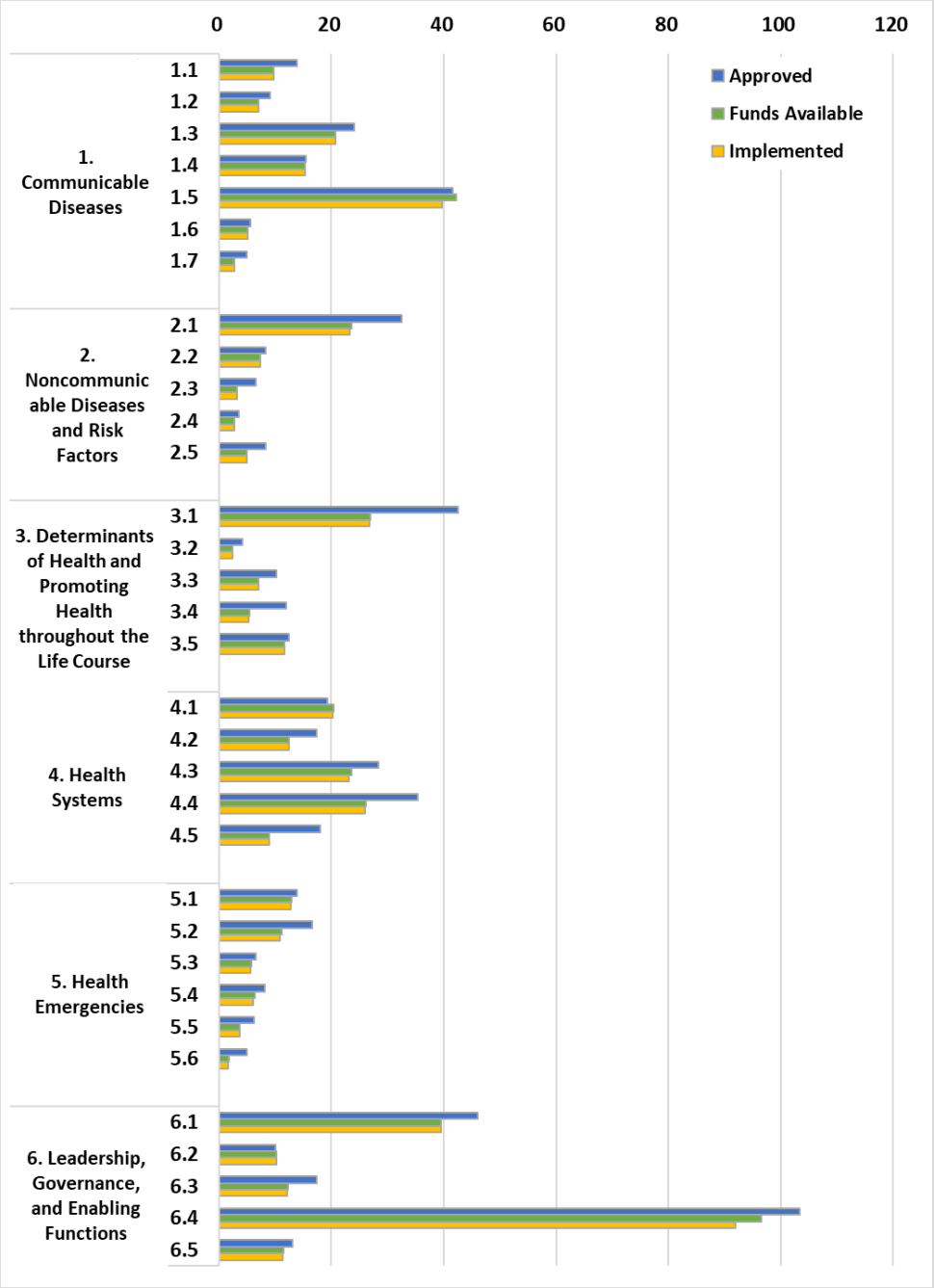
53. As expected, there was a direct correlation between funds available and implementation, as measured against approved budgets. Program areas that had high levels of funding had high levels of implementation. When implementation is measured against funds available, all program areas exceeded 94% implementation.

Table 3. PAHO Program and Budget 2018-2019: Approved, Available, and Implemented Funds, by Category and Program Area (US$ millions and percentages)

Category and Program Area	Approved 18-19 Budget	Available Funds	Implemented	Available Funds as % of Budget	Implemented as % of Budget	Implemented as % of Available Funds
1. Communicable Diseases	*114.6*	*102.9*	*100.1*	*90%*	*87%*	*97%*
1.1 HIV/AIDS, STIs, and viral hepatitis	13.8	9.7	9.7	71%	70%	99%
1.2 Tuberculosis	9.1	7.0	7.0	77%	77%	99%
1.3 Malaria and other vector-borne diseases	24.1	20.7	20.7	86%	86%	100%
1.4 Neglected, tropical, and zoonotic disease	15.4	15.4	15.3	100%	100%	100%
1.5 Vaccine-preventable diseases	41.6	42.3	39.6	102%	95%	94%
1.6 Antimicrobial resistance	5.6	5.0	5.0	90%	90%	100%
1.7 Food safety	5.0	2.8	2.8	55%	55%	100%
2. Noncommunicable Diseases and Risk Factors	*59.1*	*41.9*	*41.4*	*71%*	*70%*	*99%*
2.1 Noncommunicable diseases and risk factors	32.5	23.6	23.2	73%	72%	98%
2.2 Mental health and psychoactive substance use disorders	8.3	7.3	7.3	88%	88%	100%
2.3 Violence and injuries	6.5	3.2	3.2	50%	49%	100%
2.4 Disabilities and rehabilitation	3.5	2.7	2.7	78%	78%	100%
2.5 Nutrition	8.3	5.0	4.9	60%	60%	100%
3. Determinants of Health and Promoting Health throughout the Life Course	*81.4*	*53.6*	*53.3*	*66%*	*65%*	*99%*
3.1 Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health	42.6	27.0	26.8	63%	63%	99%
3.2 Aging and health	4.1	2.4	2.4	59%	59%	99%
3.3 Gender, equity, human rights, and ethnicity	10.2	7.1	7.0	69%	69%	100%
3.4 Social determinants of health	12.0	5.4	5.3	45%	44%	98%
3.5 Health and the environment	12.5	11.7	11.7	94%	94%	100%
4. Health Systems	*118.4*	*91.4*	*90.5*	*77%*	*76%*	*99%*
4.1 Health governance and financing; national health policies, strategies, and plans	19.3	20.4	20.3	106%	105%	100%
4.2 People-centered, integrated, quality health services	17.3	12.4	12.4	72%	71%	100%
4.3 Access to medical products and strengthening of regulatory capacity	28.4	23.5	23.1	83%	81%	98%
4.4 Health systems information and evidence	35.4	26.2	25.9	74%	73%	99%
4.5 Human resources for health	18.0	9.0	8.9	50%	49%	99%
5. Health Emergencies	*56.4*	*41.5*	*40.8*	*74%*	*72%*	*98%*
5.1 Infectious hazard management	13.8	12.9	12.7	93%	92%	99%
5.2 Country health emergency preparedness and the International Health Regulations (2005)	16.6	11.1	10.9	67%	66%	98%
5.3 Health emergency information and risk assessment	6.5	5.7	5.7	88%	87%	99%
5.4 Emergency operations	8.2	6.4	6.1	78%	75%	95%
5.5 Emergency core services	6.3	3.7	3.7	59%	59%	100%
5.6 Disaster risk reduction and special projects	5.0	1.7	1.7	35%	34%	97%

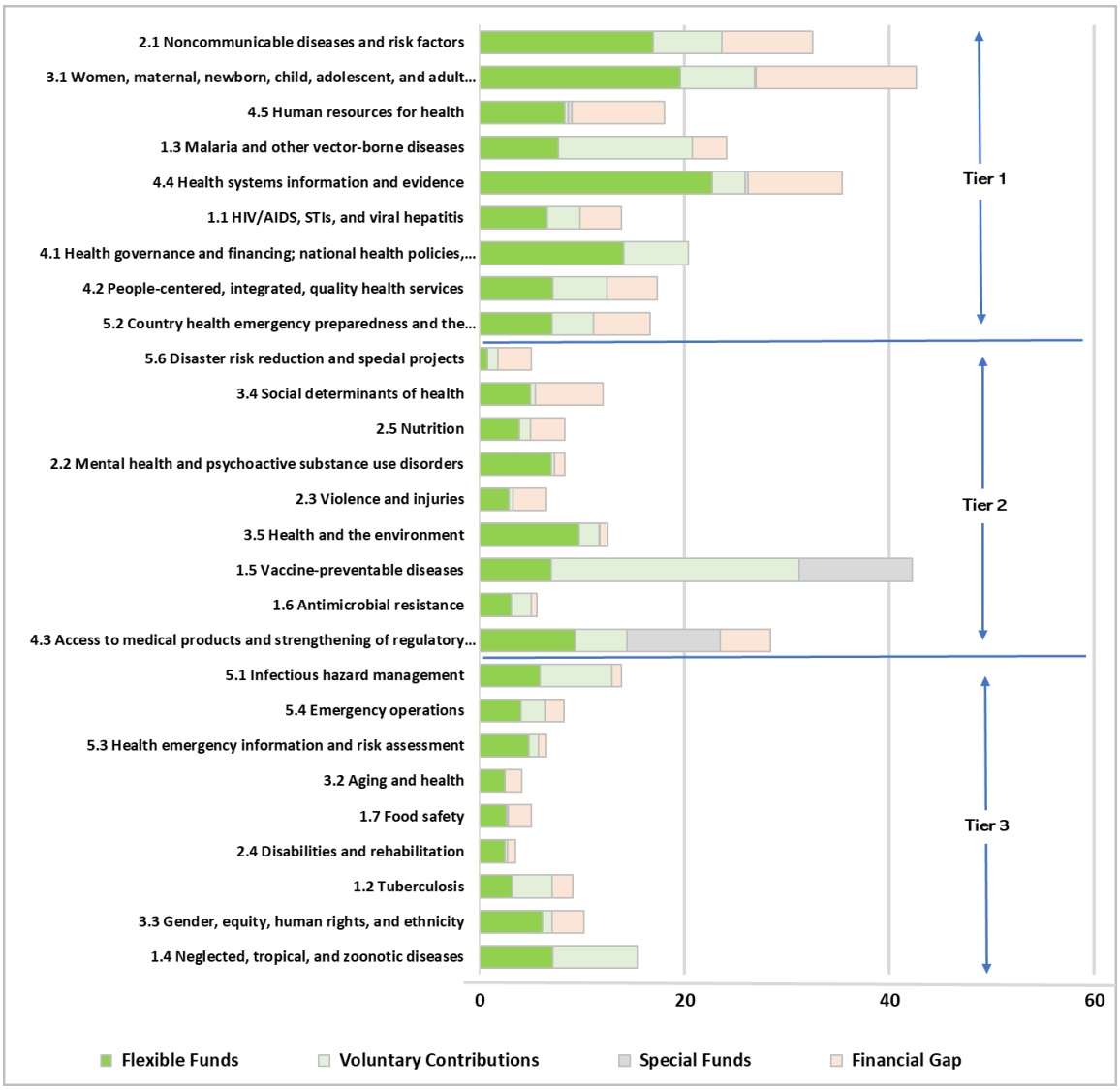
Category and Program Area	Approved 18-19 Budget	Available Funds	Implemented	Available Funds as % of Budget	Implemented as % of Budget	Implemented as % of Available Funds
6. Leadership, Governance, and Enabling Functions	*189.7*	*170.0*	*165.2*	*90%*	*87%*	*97%*
6.1 Leadership and governance	46.1	39.6	39.4	86%	86%	100%
6.2 Transparency, accountability, and risk management	10.0	10.3	10.2	103%	102%	99%
6.3 Strategic planning, resource coordinatior and reporting	17.3	12.2	12.2	71%	70%	100%
6.4 Management and administration	103.3	96.5	92.0	93%	89%	95%
6.5 Strategic communications	13.0	11.4	11.4	88%	88%	100%
BASE PROGRAMS - TOTAL	*619.6*	*501.4*	*491.3*	*81%*	*79%*	*98%*
SPECIFIC REGIONAL PROGRAMS AND RESPONSE TO EMERGENCIES	*56.0*	*55.0*	*54.5*	*98%*	*97%*	*99%*
Foot-and-mouth disease eradication prograr	9.0	9.1	9.1	101%	101%	100%
Smart hospitals	25.0	13.0	12.9	52%	52%	100%
Outbreak and crisis response	22.0	28.9	28.7	131%	131%	99%
Polio eradication maintenance	0.0	4.1	3.7	NA	NA	91%
PROGRAM AND BUDGET - TOTAL	*675.6*	*556.5*	*545.7*	*82%*	*81%*	*98%*

**Figure 12. PAHO Program and Budget 2018-2019:
Approved, Available, and Implemented Funds, by Category and Program Area
(US$ millions)**



54. Figure 13 presents the level of flexible funding for those program areas that were chosen as highest priorities for PAHO in 2018-2019. Program Areas 2.1 (Noncommunicable Diseases and Risk Factors), 3.1 (Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health), and 4.4 (Health Systems Information and Evidence) were in the top tier of prioritization and are the three program areas that received the highest amount of flexible funding. Still, given the reliance on flexible funding for many other program areas, the Organization has not been able to close financial gaps for all high-priority areas.

Figure 13. PAHO Program and Budget 2018-2019: Funds Available for Implementation by Program Area and Main Fund Type (US$ millions)



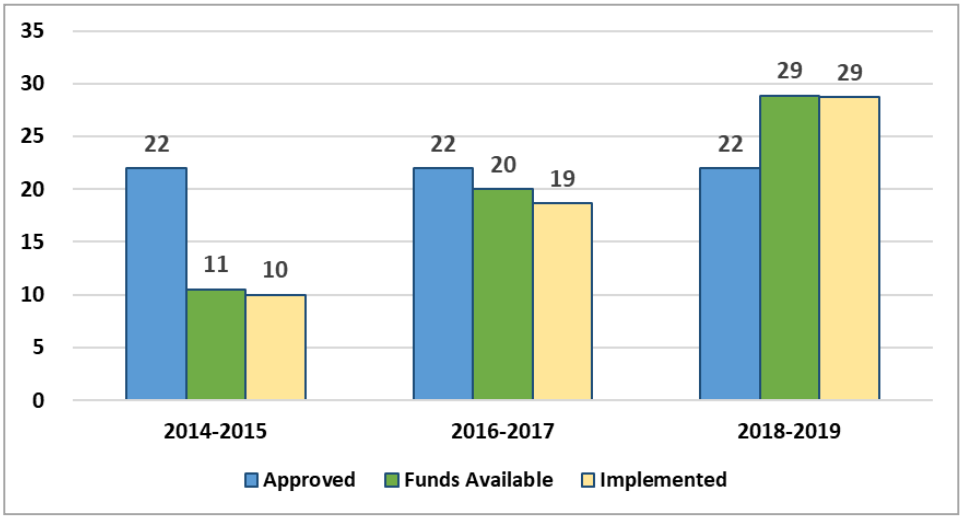
Special Programs

55. The special programs segment of the PB18-19 had an approved budget of $56 million, which was considered a placeholder, given the uncertainty about the needs and funding for this segment. Available funding and implementation were close to $55.0 million last biennium, with 52% of funding for Outbreak and Crisis Response, followed by 24% for the Smart Hospitals initiative, 16% for foot-and-mouth disease eradication, and 7% for polio eradication maintenance.

56. Figure 14 illustrates the available funding and implementation of the OCR component over the SP14-19 period. OCR had an approved budget (placeholder) of $22 million. In 2018-2019 a total of $29 million was awarded against the approved budget, and the funds were fully implemented. Most funds mobilized for OCR in 2018-2019 were in support of the PAHO response to maintaining an effective technical cooperation agenda in Venezuela and neighboring Member States related to the increased migration in South America and the Venezuela sociopolitical and economic situation. This event explains the increased amounts of OCR funds available in 2018-2019 compared to the previous two biennia.

57. Most OCR resources were directly implemented at the country level, and a significant proportion of the funds managed at regional level were also used to directly support country-level activities, including mobilization of experts and procurement of supplies and equipment for response operations. These funds provided the bulk of the Organization's resources to facilitate timely and appropriate deployment of experts and/or supplies to all 60 individual country emergency events meeting Grade 2 or Grade 3 criteria to which PASB provided support during 2014-2019.

Figure 14. Outbreak and Crisis Response: Overview of Budget, Funds Available, and Implementation (US$ millions)



Main Sources of Financing for 2018-2019

58. ***Assessed contributions and miscellaneous revenue*** constituted 33% of total financing expected to finance the Program and Budget (Table 2). Since assessed contributions are considered financial commitments from Member States, they are counted as "funds available" in full from the start of the biennium.

59. In 2019, PAHO suffered from an unexpected and unprecedented delay in payment of assessed contributions from several Member States. As of 31 December 2019, PAHO was still due to receive $88.9 million in assessed contributions from 2019 or earlier periods.[9] This forced PASB to establish a series of measures to slow down implementation, especially for the last six months of the biennium. By the time cost containment measures were put in place, PASB had (per usual practice) already made most of its approved funds available for implementation.

60. The cash flow situation that resulted from the balance due on assessed contributions was addressed in two main ways. First, PAHO established a series of internal cost containment measures, which included a slowdown in fixed-term hiring processes that were financed with flexible funds; a corporate freeze or reduction of short-term hires; postponement or cancellation of all non-essential activities, including for technical cooperation; review and reduction—where possible—of management-related costs; review of contractual agreements, e.g., insurance or telecommunications, to reduce costs; and use of other types of funds (such as voluntary contributions, when possible) to support technical cooperation activities. PAHO also tapped its Working Capital Fund, as well as other available unrestricted resources, to fulfill already committed obligations while it received additional payments. The financial situation had a real impact on the technical cooperation delivered toward the end of 2019; it also imposed reputational risk on the Organization due to postponement or cancellation of agreed commitments, and increased uncertainty for PASB staff.

61. As of June 2020, the PASB collection of assessed contributions has not improved considerably. The temporary measures set in place in 2019 to limit expenditures have therefore become stricter in 2020; allocation of resources for activities to the different PASB technical and administrative entities has been kept to a minimum, and filling of vacancies or new hiring has been limited. The effects of these measures are expected to be even more marked in PB20-21 implementation. More detailed information regarding assessed contribution receivables can be seen in the Financial Report of the Director and Report of the External Auditor for 2019 (*Official Document 360*).

62. Miscellaneous revenue corresponds to the interest earned during the biennium on the Organization's investments. For the 2018-2019 biennium, this amount was $27.5 million, resulting in a $7.5 million revenue surplus with respect to the originally estimated amount ($20 million) to be used in 2020-2021. The programming of the revenue

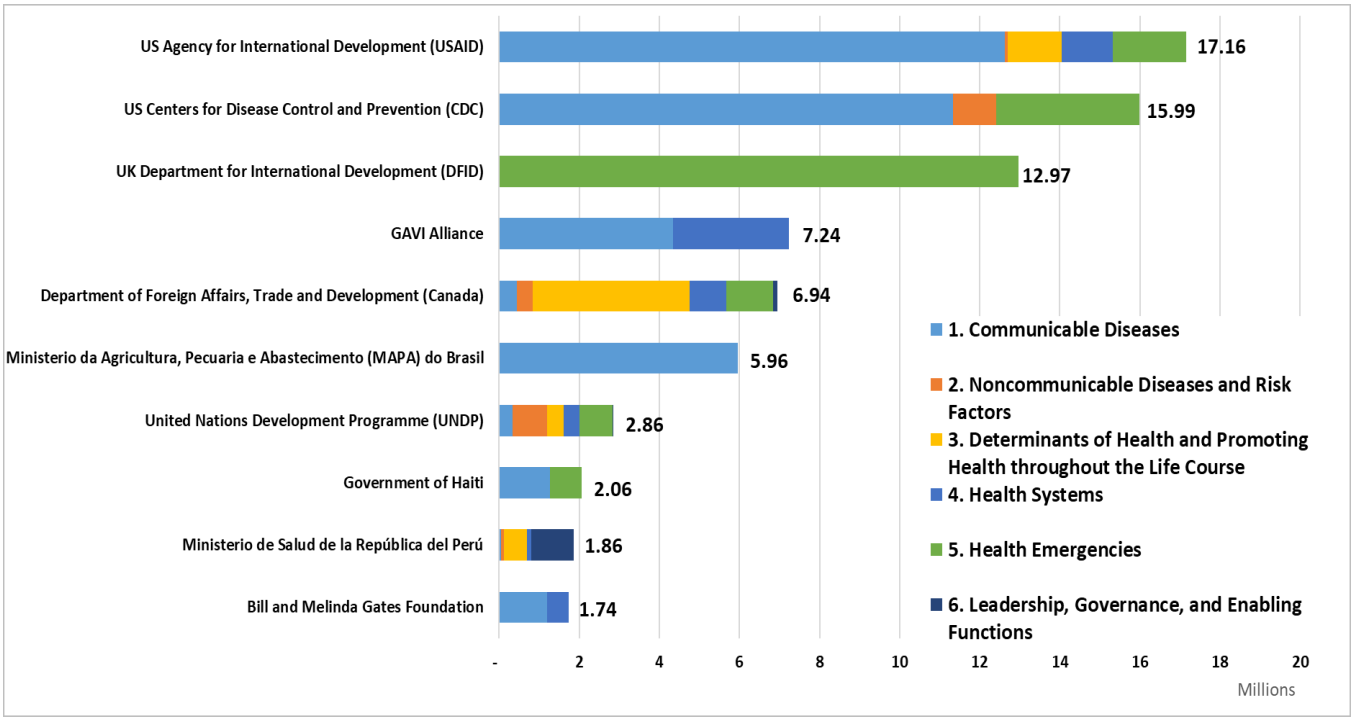
[9] Overview of the Financial Report of the Director for 2019 (Document SPBA14/6).

surplus for 2018-2019 is presented for consideration of Member States in a separate document, Programming of the Revenue Surplus (Document CD58/12).

63. ***Other sources of financing*** include, among others, PAHO voluntary contributions, revenue from program support costs, and any other income that finances the Program and Budget. Resource mobilization efforts yielded $153.1 million in PAHO voluntary contributions during 2018-2019, though some of these funds correspond to multi-year agreements that go beyond that biennium. Figure 15 shows the top 10 donors to PAHO during 2018-2019 and the programmatic categories to which these funds contributed during that period. It should be noted that 78% of all voluntary contributions available for implementation in 2018-2019 came from the top 10 donors to PAHO: 49% of these resources supported programs in Category 1, while 28% were directed to Category 5. Once again, PASB commends its partners for their trust and their commitment to support the Program and Budget, while it calls for improved flexibility of funds and strategic alignment with priorities as set out in the Organization's mandates.

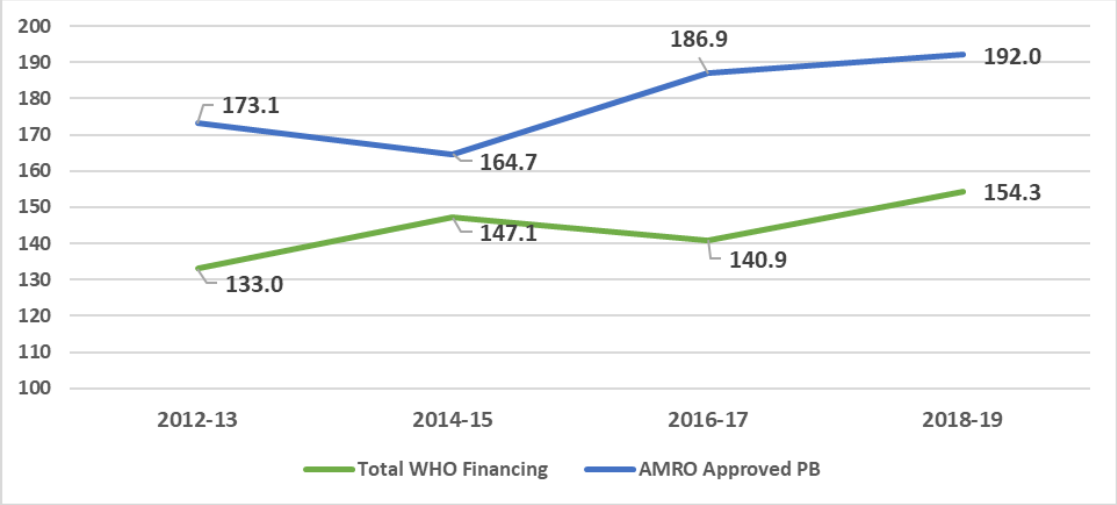
64. The remainder of the "other sources" component comprises PAHO revenue from program support costs, PAHO emergency funds, and all other PAHO special funds that finance the Program and Budget. These accounted for $137 million of available funds for base programs in 2018-2019. It is important to note that some of these funds were utilized to cover the assessed contribution shortage that PASB faced in 2019.

Figure 15. Top 10 Donors to PAHO Program and Budget 2018-2019 (US$ millions)



65. The ***WHO allocation to the Americas*** reached $154.3 million in 2018-2019, the highest level in the last four biennia (Figure 16). From this total, 67% or $103.2 million was flexible funds,[10] and $50.9 million was WHO voluntary contributions. Nonetheless, the financial gap between the WHO approved budget for the Region of the Americas (AMRO) and total levels of financing remained high, at 20%. The WHO Director-General is committed to strengthen the country level by decentralizing WHO financing, and the levels reached in 2018-2019 are a step in that direction. However, Member State advocacy is needed to include PAHO as part of the resource mobilization and further financial decentralization efforts.

Figure 16. WHO Approved Budget Levels and Financing for the Region of the Americas (AMRO) (US$ millions)



Note: "AMRO Approved PB" refers to fiscal space from the WHO Programme Budget that has been assigned to the Region of the Americas. It may or may not be fully funded.

66. ***Government-sponsored initiatives*** are also known as national voluntary contributions (NVCs). Although not part of the Program and Budget of the Organization, they are an important funding modality that complemented the financing of PAHO technical cooperation at country level during 2018-2019. NVCs are provided by national governments to finance specific in-country initiatives that are aligned with the existing technical mandates of PAHO. Similar to PB funds, NVCs are strictly managed following PAHO Financial Rules and Financial Regulations, are regularly audited, and are reported in financial reports. This funding modality is becoming increasingly important for technical cooperation in many countries that do not qualify for traditional voluntary contributions due to their level of economic development. The programmatic achievements to which NVCs contribute are reported as part of the Organization's overall results.

[10] Considers WHO Core Voluntary Contributions as part of the flexible fund allocation to the Americas.

67. Since NVCs depend greatly on alignment of national agendas with that of PAHO and on the availability of national resources, it is not easy to predict levels of funding from one biennium to the next. Table 4 lists the governments that used this modality of technical cooperation and financing in 2018-2019. NVCs do not follow PB timelines, and therefore amounts financed during 2018-2019 are frequently not intended to be fully implemented in that same period.

Table 4. National Voluntary Contributions to PAHO, Financed and Implemented during 2018-2019 (in US$)

Government	Financed in Biennium 2018-2019	Implementation
Brazil	205,213,129	109,791,250
Dominican Republic	25,514,146	15,024,133
Argentina	3,072,855	1,655,751
Costa Rica	2,343,966	739,001
Mexico	2,280,796	2,270,748
Panama	2,176,325	530,263
Colombia	1,370,750	1,279,441
Guatemala	614,592	142,894
Trinidad and Tobago	371,278	303,036
British Virgin Islands	313,352	148,627
Paraguay	104,028	43,389
Uruguay	92,946	88,700
Ecuador	52,810	52,810
Chile	13,085	13,083
Total NVCs 2018-2019	**243,534,058**	**132,083,127**

V. Risk Analysis

68. This section summarizes the main risks and mitigation actions with respect to the implementation of the PAHO Program and Budget 2018-2019.

69. Risk management was an integral part of the PAHO Strategic Plan 2014-2019. Program Area 6.2 was dedicated to efforts to increase transparency, accountability, and risk management, which are critical components of any well-functioning organization that implements results-based management. PAHO adopted a corporate risk management process in 2015 as part of its risk management framework, which has continued to mature and demonstrate its usefulness. It is important to highlight that as part of the accountability process, PASB has multiple mechanisms in place to ensure competent stewardship of funds and compliance with regulations and rules pertaining to financial and human resources. The risk management approach increases managerial capacity, leverages the resources and knowledge of operational staff to better inform Executive Management, and optimizes the achievement of results.

70. The risk register tool used by PAHO enables all entities to embed a systematic and consistent approach to identify, assess, and manage corporate risks across PASB, using a common risk language. Risk identification and monitoring and assessment are done regularly throughout PASB, using information from entities at Headquarters level, 27 PWR Offices, three subregional offices, and three specialized centers in the Region. The risk management process continues to mature, supported by an internal network of risk focal points who have access to training materials and guidance to build in-house capacity. Managers have a crucial role to play in ensuring that risk analysis is integrated into the managerial decision-making process. During the period of the Strategic Plan, the Enterprise Risk Management (ERM) program has been strengthened by adopting the lessons learned from previous biennia and increasing training to build internal risk management capacity.

71. As part of the governance of the ERM program, a risk management and compliance Standing Committee has been institutionalized to review the risk profiles, make recommendations and/or propose mitigation measures, and prioritize risks. At a corporate level, formal risk monitoring is conducted at least twice a year, and whenever a major change in the environment occurs. This is reported on a regular basis to Executive Management and to oversight bodies, such as the Audit Committee and the Internal Auditors.

72. In the context of PB18-19, using information gathered through the risk register, the Standing Committee and Executive Management identified and prioritized several risks according to the following criteria: programmatic impact, financial impact, reputational impact, and capacity to respond. The purpose of this process was to support the achievement of results as defined in the Strategic Plan. During the biennium, PASB managed several risk events, including delays in the receipt of assessed contributions from Member States. The assessed contributions from Member States constitute a significant proportion of the resources supporting the Program and Budget. Accordingly, these delays prevented the Organization from implementing the full program of work and forced

PASB to establish measures to slow down implementation during the last six months of the biennium.

73. The following table presents a summary of the prioritized risks and the respective mitigating actions taken. All of these risks have been systematically profiled, reviewed, and addressed, and were prioritized through the process outlined above.

Table 5. Main Risks and Mitigation Actions during 2018-2019

Risk	Risk Description	Summary of Risk Mitigation Actions
Limited availability and flexibility of financial resources	This limitation included untimely payment of assessed contributions by Member States and insufficient mobilization of voluntary contributions for the implementation of the SP and other mandates.	- Monitor collection of assessed contributions.[11] - Continue to explore mechanisms that will increase the timeliness of collection of assessed contributions. - Identify other resources and funding mechanisms available to the Organization. - Advocate at national level for financing for health. - Generate efficiencies in budgetary implementation. - Ensure that donor agreements are fully implemented in a timely manner. - Manage local currency bank balances to minimize exchange rate impact.
Limited ability to react to and plan for shifts in health priorities	This limitation included inability to forecast political changes and advocate to national authorities for health as a pillar of social and economic development, in line with the 2030 Agenda for Sustainable Development and the Sustainable Health Agenda for the Americas 2018-2030.	- Increase the role of PWRs and regional department directors in efforts to engage, advocate, and support high-level political dialogue to ensure commitment of Member States and partners, giving priority to health programs with a focus on health equity. - Promote regional cooperation among Member States, subregional integration mechanisms, UN entities, and nongovernmental organizations to coordinate approaches to health development. - Promote and adopt intersectoral and multisectoral approaches at national and subnational levels to address health conditions that are beyond the influence of the health sector. - Generate political and financial support for the Organization's core mandate to reduce health inequities, in line with the commitment to leave no one behind.

[11] Some measures were included in Resolution CD57.R1, Collection of Assessed Contributions, approved in 2019.

Risk	Risk Description	Summary of Risk Mitigation Actions
Impact of UN reform on PAHO mandate and governance[12]	UN reform has significant governance and managerial implications for WHO and PAHO, especially for the role of PWRs in terms of governance structure, joint funding, and planning, as well as delivery of country-level activities, including communications and resource mobilization.	- Ensure that national authorities and partners respect the constitutional status of PAHO. - Continue collaborating with WHO in its implementation of UN reform at country level. - Implement regional mandates as dictated by PAHO Member States, working directly with ministries of health and other ministries in carrying out technical cooperation activities (both PAHO and WHO) at country level. - Ensure common understanding that the sole accountability of PASB personnel at country level is to the PASB Director, and that PWRs are responsible for providing information to the UN Resident Coordinator on PAHO technical activities implemented with WHO funds at country level. - Evaluate the common UN business operations strategy as needed, on a case-by-case basis.
Delay in response to public health emergencies	This risk continues to be relevant for Member States and for PAHO operations and personnel security due to the unpredictability of natural disasters and outbreaks and the increasing scale of humanitarian crises.	- Monitor, anticipate, and prepare to mitigate the health consequences of emergencies and disasters, improving national preparedness, detection, response, and resilience. During the biennium several actions were taken and reported in relation to efforts by PAHO to maintain an effective technical cooperation agenda in Venezuela and neighboring Member States in response to the situation there. - Advocate for continuously strengthening and funding the first line of response for emergencies at the national level. - Monitor implementation of the International Health Regulations at national level.[13] - Ensure that PASB standard operating procedures are in place to organize support teams in cases of outbreaks, disasters, or other declared emergencies.
Cyber risk	A security breach of the PAHO information system may affect the integrity of data and availability of information for a significant period.	- Develop and implement a comprehensive information security program, including industry-standard technological tools. - Conduct training to raise staff awareness and compliance with information security procedures, including monitoring end-user devices, networks, and servers in order to flag or block suspicious activity.

[12] This risk was included during the biennium. See Report on Strategic Issues between PAHO and WHO (Document CD57/INF/1 [2019]).

[13] Implementation of the International Health Regulations (IHR) (Document CD57/INF/4 [2019]).

Risk	Risk Description	Summary of Risk Mitigation Actions
Potential for fraud and conflicts of interest	This risk is related to potential conflicts of interest in projects involving non-state actors and the threat to PAHO resources and credibility from fraud, corruption, and other types of misconduct.	- Develop and implement policy on the prevention of fraud and corruption, along with mandatory staff training to raise staff awareness and vigilance. - Strictly enforce policies related to engagement with non-state actors, procurement, and whistleblower protection. - Enhance investigative capacity. - Take decisive action in cases of fraud, corruption, and/or misconduct.
Weak and fragmented health information systems	This risk remains relevant because it affects the capability to monitor progress and make informed decisions for progress toward agreed health outcomes.	- Continue to advocate for investment in upgrading of integrated information systems for health with capacity to generate and analyze disaggregated health data for decision making and monitoring within the framework of the Plan of Action for Strengthening Information Systems for Health 2019-2023 (Document CD57/9, Rev. 1).[14] - Allocate significant resources to improve PASB technical cooperation in the area of information systems for health and strengthening data generation and analysis to improve health system management and support evidence-based decision making.

[14] Plan of Action for Strengthening Information Systems for Health 2019-2023 (Document CD57/9, Rev. 1 [2019]).

VI. Lessons Learned and Recommendations

74. This section summarizes the main lessons learned from the Strategic Plan 2014-2019 and Program and Budget 2018-2019 and outlines key recommendations for implementation of the health-related Sustainable Development Goals and the Sustainable Health Agenda for the Americas 2018-2030, as well as the PAHO Strategic Plan 2020-2025 and Program Budget 2020-2021.

Strengthen health systems in alignment with the Strategy for Universal Access to Health and Universal Health Coverage

75. With a view to supporting the goals of the PAHO Strategic Plan 2020-2025: Equity at the Heart of Health, there is continued need for high-level advocacy in countries to support the transformation of health systems toward the progressive achievement of universal access to health and universal health coverage. Communication at the highest level is required to advance commitments of the Political Declaration of the High-level Meeting on Universal Health Coverage, adopted by the United Nations General Assembly in 2019; regional and global mandates on universal health, primary health care, and health promotion; and recommendations of the report of the PAHO Commission on Universal Health in the 21st Century: 40 Years of Alma-Ata, as well as the report of the PAHO Commission on Equity and Health Inequalities in the Americas. PAHO remains well positioned to provide countries with the necessary technical, legal, and strategic support for health sector reform processes, in line with these mandates. The development and expansion of resilient and well-resourced health systems is key to the consolidation of health gains, response to disease outbreaks, health protection and promotion, and improved health and well-being for the Region's population.

76. The demand for technical support for the organization and development of integrated health services networks, including financing aspects, continues to increase. This requires expanded inter-country sharing of knowledge and experience, capacity building, and the mobilization of additional experts to address these needs in countries. There is growing recognition within countries that health services organization and delivery must focus on the needs of people and communities, be based on the primary health care strategy and the development of integrated health networks, and prioritize the recruitment and participation of a health workforce with local knowledge. Social participation and oversight of the availability and quality of services ensure the continuous adaptation of health services delivery based on needs.

Recommendations:

a) Provide the necessary technical, legal, and strategic support for health sector reform processes, with a view to enhanced capacities for health systems strengthening, aligned with global and regional mandates.

b) Continue to expand political and technical partnerships and embrace innovative approaches to technical cooperation in order to achieve lasting transformation of health systems.

c) Strengthen primary health care approaches through further and deeper integration with the community, and incorporate healthy settings (e.g., schools, urban areas, workplaces) and health promotion at the heart of the primary health care strategy.

Accelerate actions on key priorities in a context of limited resources through high-level advocacy and awareness raising, and by implementing both proven and innovative approaches to technical cooperation

77. As mentioned above, many of the topics that are high priorities for countries are nonetheless under-resourced. In order to effectively accelerate action, high-level advocacy is required, backed by intensified technical cooperation. For example, in the 10 countries that have been prioritized by PAHO for the reduction of maternal mortality, the presence of maternal health advisors allowed for continuous policy advocacy and the implementation of a set of key initiatives that contributed directly to the reduction of maternal mortality in those countries. Monthly monitoring of the situation using a more systematic approach allowed for an improved assessment of advances in technical cooperation and coordinated actions with national authorities. This remains a critical issue that requires commitment and adequate funding to reach sustainable results.

78. Raising awareness is also critical for programs with fewer resources. Evidence related to the economics of NCDs can provide a common language with which to engage ministries of health and finance. PAHO has used its convening power to disseminate the lessons learned from experiences with tobacco economics, and these lessons are also applicable to NCDs and their risk factors. Awareness is also important for the Organization's work with aging populations and its efforts to strengthen and use health-related law as an important tool to promote and protect the right of every person to the highest attainable standard of health.

79. Finally, PAHO can add value with the use of innovative approaches. HEARTS is a growing program that has generated many lessons on how to engage with primary care providers to change practice and improve hypertension control through investments in health system strengthening, partnerships, advocacy, and resource mobilization. In addition, countries are very eager for rehabilitation and disability-related tools. The WHO rehabilitation toolkit has been well received by many countries despite funding limitations.

Recommendations:

a) Engage in high-level meetings and other strategic opportunities for advocacy with political leadership as well as senior policy makers, including legislators and parliamentarians.

b) Plan and deploy PAHO communications to achieve more effective health advocacy, more sustained external relations, more successful resource mobilization, higher visibility, and an enhanced reputation in countries and among other stakeholders.

c) Continue to promote and support initiatives proven to be successful in addressing country priorities.

Strengthen country capacities in prevention, risk reduction, preparedness, surveillance, response, and early recovery in relation to all types of human health hazards that may result from emergencies or disasters

80. Difficult political and economic contexts affected the health situation in several countries and posed a technical and political challenge for PAHO. The Organization has continued its role as a powerful advocate at the highest level of government for building resilient public health infrastructures that can allow countries to withstand the stress resulting from disease outbreaks, natural disasters, and climate change events, as well as mass displacement of people across borders. In that context, the creation of alliances, relationships based on trust, and partnerships with national counterparts, nongovernmental organizations, and other UN agencies is critical to ensure uninterrupted response operations.

81. Even prior to the emergence of COVID-19, recurrent outbreaks of infectious diseases in the Region during 2014-2019 underscored the need to strengthen country core capacities under the International Health Regulations. The status of core capacities in countries across the Americas remains heterogeneous. A country-tailored approach, based on recognition that one size does not fit all, should be used to support and enhance the institutionalization of IHR core capacities in States Parties. Countries must also strengthen surveillance and laboratory preparedness and promote the exchange of information related to the IHR.

Recommendations:

a) Advocate for a resilient public health infrastructure at the highest level of government, and champion the Smart Hospitals initiative.

b) Provide conceptual guidance and technical cooperation to IHR States Parties to encourage and enable them to frame the core capacities as essential public health functions, to implement the IHR in national legislation, and to recognize the IHR as a tool for intersectoral public health preparedness.

c) Strengthen emerging pathogens laboratory networks to ensure a strong regional capacity for detection, alert, and response to new pathogens in accordance with the IHR.

d) Invest further in establishing robust communication bridges between technical and decision-making levels in the IHR States Parties.

e) Promote the incorporation of planning for the management of health emergencies, including epidemics, in risk management and disaster management systems.

Promote the generation, availability, and use of high-quality health information, analysis, and evidence, including vital and health statistics, to achieve greater impact on equity in health

82. Health analysis is a crucial function of the health sector, making it possible to ensure that policies and programs are evidence-based. The Region must continue to invest effort and resources to establish and strengthen capacities for health analytics and epidemiology, building on its accomplishments in producing Health in the Americas+, 2017 edition. Member States need to build capacities to conduct analyses based on disaggregated data, down to the municipal level where feasible. Critically, these reports should guide the prioritization of health issues and serve as the basis for policy and programs. Member States should also disseminate the findings of these reports with civil society and stakeholders to address key health issues in a holistic manner.

83. There is heightened interest and concern among countries to implement health inequality monitoring systems as a necessary starting point for efforts to better fulfill the health-related commitments of the SHAA2030 and the SDGs. PAHO has provided important technical support to help Member States measure and monitor inequalities, including at the subnational level. PASB ensures that existing data and evidence are factored into health equity analyses that can serve as a basis for strategies to address health program implementation issues. Member States are similarly investing in information systems for health that can capture data on the total population, including people in conditions of vulnerability, for whom data are not always collected. These measures contribute to ensuring that no one is left behind.

84. Member States increasingly recognize the need to set targets for the health-related SDG indicators. Country experiences with establishing targets have shown that this should be an inclusive process involving multiple stakeholders who work to build consensus and solidarity for the interventions needed to address identified health inequalities. Conceptual frameworks, core data sets, methodologies for collection, aggregated indices, and modeling constitute some of the challenges that both PASB and Member States will face in the development and reporting of indicators.

Recommendations:

a) Strengthen vital and health statistics to improve data quality as it relates to the completeness, accuracy, consistency, and accessibility.

b) Strengthen existing tracking tools to monitor indicators on a routine basis.

c) Carry out disaggregation of health data to ensure that no one is left behind.

d) Systematically review the impact of interventions on outcomes with respect to equity.

e) Build on best practices and lessons learned for measuring impact throughout the SP20-25.

f) Engage in high-level dialogue with WHO and the UN on the monitoring of health-related SDGs.

Address the determinants of health and risk factors through intersectoral action in line with the 2030 Agenda for Sustainable Development

85. The main factors that can prevent people from reaching their full health potential lie largely outside of the health sector. National health authorities must go beyond their comfort zones and engage with other sectors and partners in order to address risk factors and the determinants of health. For example, road safety and violence prevention are complex issues that require actions beyond the national health authorities. Stronger partnerships with social development ministries and other agencies are needed to have a meaningful impact.

86. These lessons recurred throughout the Strategic Plan 2014-2019 and the previous Plan and are now reflected clearly in the SP20-25, with several outcomes explicitly focused on improving country capacities in this area. Efforts to increase equity and accelerate progress to end avoidable deaths and disabilities require strong technical cooperation from PAHO to promote effective intersectoral action. A human rights-based approach with protective legal frameworks is fundamental to ensure fairness and equity in these efforts. In that regard, the 2030 Agenda and SHAA2030 can serve as important entry points and enablers.

Recommendation:

a) Work in a more intersectoral manner, in line with the 2030 Agenda, SHAA2030, and SP20-25, in order to address the determinants of health and risk factors that are the underlying causes of morbidity, mortality, and disability.

Ensure that PAHO remains relevant, authoritative, and transparent at the political and technical levels with Member States, partners, and stakeholders alike in an increasingly complex, pluralistic, and interconnected world

87. Close collaboration between PASB and Member States on the strategic planning and assessment processes continues to be a best practice to share with WHO and other UN agencies. When PASB has prepared strategic documents in full collaboration with Member States, the reception and possibilities for implementation have proven to be better than in the absence of such collaboration. Across the board, high-level collaborations with decision makers are critical to effectively implement the SP20-25 and achieve the SHAA2030 and SDG targets.

88. Evaluation assignments have provided impartial advice and recommendations for the development of the Organization’s projects, programs, plans, and strategies. During 2018-2019, PAHO implemented 20 evaluations at the different functional levels; all of them were conducted according to the United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation. The Final Evaluation of the Health Agenda for the Americas

provided important insights for the development of the SHAA2030. Recommendations set out in the Evaluation of the Regional Program Budget Policy were considered in the development of the new PAHO Budget Policy, the PAHO Strategic Plan 2020-2025, and the Program Budget 2020-2021. A streamlined process for the Revolving Fund was developed and implemented to facilitate provision of technical cooperation to Member States based on recommendations of the Revolving Fund Assessment.

89. Throughout the Strategic Plan period, PASB had to make continuous efforts to maintain the neutrality of PAHO and remind countries of its nonpartisan status. The Organization must remain impartial in order to continue advancing the public health agenda and helping countries promote and preserve health gains. The perception of PAHO as an impartial and neutral broker has been one of its greatest assets, one that must continue to be protected and upheld by all PAHO staff.

90. PAHO continues to pursue meaningful engagement that will allow it to have an impact on health-related issues taken up by the UN system. This requires the development of a structured process whereby PAHO effectively advocates and plays an influencing role at country and regional levels, together with WHO at the global level. The Organization's participation in preparatory processes for UN high-level meetings has resulted in the successful inclusion of the health perspective in final declarations and related documents.

Recommendations:

a) Advocate at the highest levels for implementation of the SHAA2030 and the SP20-25 as a means for the Region to advance toward the achievement of the 2030 Agenda.

b) Undertake regular analyses of the political and financial risks associated with a changing political and economic situation in the Region and develop specific strategies to mitigate negative impacts on health.

c) Promote a culture of evaluation in the Organization to enable PAHO to better manage and deliver its technical cooperation to Member States.

d) Continue safeguarding the role of PAHO as an impartial and neutral broker at all levels of the Organization.

e) Analyze the impact of UN reform on PAHO and its work, communicate with Member States on the implications, and issue related guidance for all levels of the Organization, consistent with WHO guidance, while respecting the constitution-specific rules, regulations, policies, and procedural structures of PAHO.

Expand partnerships in order to advance PAHO technical cooperation and reduce overlap, thereby contributing to greater efficiency

91. Throughout the SP14-19 period, dialogue and engagement with stakeholders and partners has progressed, which has allowed for improved delivery of technical cooperation. PAHO has spearheaded negotiations with new and existing partners. During 2018-2019,

an innovative three-year partnership on food safety was signed with Airbnb, the first agreement of its kind between PAHO and a global technology company. This initiative will allow PAHO to disseminate its food safety resources to Airbnb's large community of visitors and subscribers. The process for negotiation and approval of the cooperation agreement with Airbnb also provided lessons learned to guide mutually beneficial engagement with the private sector on matters related to public health.

92. Countries increasingly require more intense technical cooperation that is beyond the current capacity of PASB to deliver. Therefore, partnerships with PAHO/WHO Collaborating Centers, professional associations, and experts have helped extend the reach of PAHO technical cooperation. Involving the PAHO/WHO Collaborating Centers and other partners has facilitated laboratory capacity building and strengthened early detection and surveillance of emerging pathogens. Collaborating Centers have also proven to be critical partners for programs with limited resources, particularly those in Categories 2 and 3.

93. Member States and multilateral partners have expressed renewed commitment to strengthening information systems for health. The IS4H Initiative and the RELACSIS Network (Latin American and Caribbean Network to Strengthen Health Information Systems) have demonstrated the value of facilitating Member States' and partners' use of networks to foster South-South and triangular technical cooperation. This approach reduces costs, builds solidarity, and promotes sharing of successful practices within Latin America and the Caribbean. Regional networks are similarly complemented by inter-agency collaboration, particularly among the Economic Commission for Latin America and the Caribbean (ECLAC), the United Nations Population Fund (UNFPA), WHO, and the World Bank, to address vital and health statistics through a holistic approach. This collaboration has worked for birth and death records, which are managed by actors outside the health sector.

94. Subregional approaches backed by political commitment are also effective in implementing priorities: for example, promoting access to medicines and health technologies and strengthening legal and regulatory capacity. PAHO subregional offices have extended the scope and impact of the regional work with subregional mechanisms, including the subregional parliaments and parliamentarian networks. However, a more systematic approach to communication and coordination between regional and subregional offices is needed.

Recommendations:

a) Collaborate with new and existing partners for health, including traditional partners as well as those in the private sector.

b) Document successful partnerships and pilot programs in order to provide models for expanded partner collaborations.

Advance inter-programmatic work within PASB in order to deliver innovative, efficient, and effective approaches to technical cooperation

95. Inter-programmatic projects have proven to be important platforms for achieving better results on priority health topics. They can help find solutions for bottlenecks, establish resource-pooling mechanisms, and improve the delivery of integrated technical cooperation to countries. For example, assistive technologies such as wheelchairs and hearing aids are relevant across several domains, notably medicines and health technologies, disability and rehabilitation, and healthy aging; this topic therefore requires coordination and inter-programmatic work. Similarly, collaborative initiatives on physical activity, road safety, mental health, environmental health, health-related law, human rights, and surveillance have been evolving, and there is potential for improved collaboration in these areas.

Recommendations:

a) Expand inter-programmatic work on pilot projects that have proven to be innovative, efficient, and effective.

b) Develop operational mechanisms to facilitate the mainstreaming of inter-programmatic work in the work of PAHO.

Conclusions

96. The end-of-biennium assessment of PB18-19 and the final report on SP14-19 implementation show significant and steady progress toward the fulfillment of commitments jointly made between PAHO and its Member States. Under the theme "Championing Health: Sustainable Development and Equity," the SP14-19 catalyzed equitable health development throughout the Region. These achievements were made possible by the individual and collective actions of Member States, by ongoing PAHO collaboration with Member States and partners, and by the commitment of PASB staff across all levels of the Organization.

97. Moving forward, much remains to be done in order to fully attain the targets in the health-related SDGs and the SHAA2030. With the above lessons and recommendations in mind, and with a renewed sense of purpose, PAHO begins implementation of the new PAHO Strategic Plan 2020-2025. Its vision of "Equity at the Heart of Health" must be operationalized not only through the PAHO Program Budgets, but also through national health plans and policies, with PASB support for action at the country level. The lessons learned and experiences managing risks in the previous Strategic Plan can help us replicate successful interventions and prevent repetition of avoidable mistakes in the future.

Annexes

Annex A: Detailed Review of Impact Goals

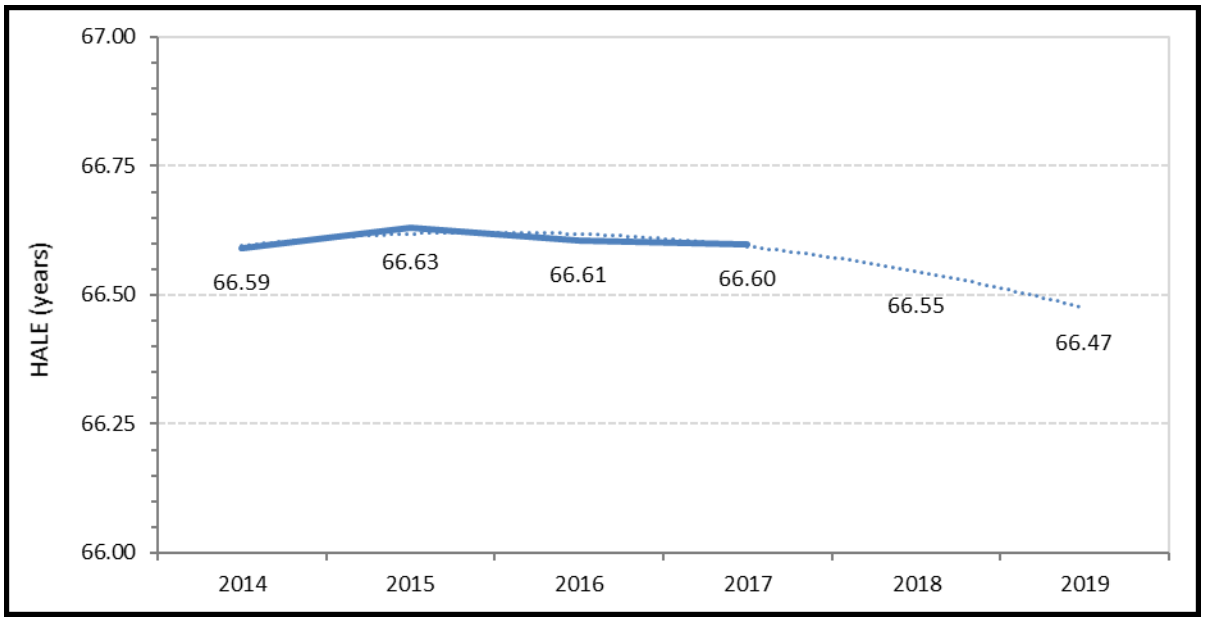
This annex presents detailed findings from the review of impact goals and the corresponding targets. A summary of this annex is available in Section III of the main report.

Goal 1: Improve health and well-being with equity

Target	Status (2019)
1.1 At least a 1.0% increase in Healthy Life Expectancy (HALE) for the Americas achieved by 2019, as compared to the baseline rate in 2014	**Not achieved** (0.2% decrease)

Analysis: The Healthy Life Expectancy (HALE) produced by the Institute for Health Metrics and Evaluation (IHME) for 2014 and a projection for 2019 were used, resulting in a regional HALE of 66.6 and 66.5 years in 2014 and 2019, respectively. This reflects a reduction of 0.2% between 2014 and 2019, which shows that the established target will not be achieved.

Figure A.1. Healthy Life Expectancy, the Americas, 2014-2019



Source: Calculated by PAHO using IHME Global Burden of Disease (GBD) 2017 estimates, http://ghdx.healthdata.org/gbd-results-tool.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

HALE is a measurement of population health that considers both mortality and morbidity, adjusting overall life expectancy by the number of years lived in less than perfect health. In other words, HALE combines life expectancy and the quality of life. It is used to compare the effectiveness of health service delivery practices, evaluate disparities, and

guide resource allocation. The HALE measurement is also used to demonstrate a marked reduction in health inequity gaps as measured by any of the following equity stratifiers: place of residence (rural/urban), race, ethnicity, occupation, gender, sex, age, education, and socioeconomic status using simple inequality measures (absolute inequality gradient and relative inequality gap). Since indicators such as HALE require information beyond mortality data, including morbidity and risk factors, countries agreed to use the HALE estimates computed by the IHME. This indicator is produced by the IHME at national level, but not by the health information systems of the countries.

Recommendations:

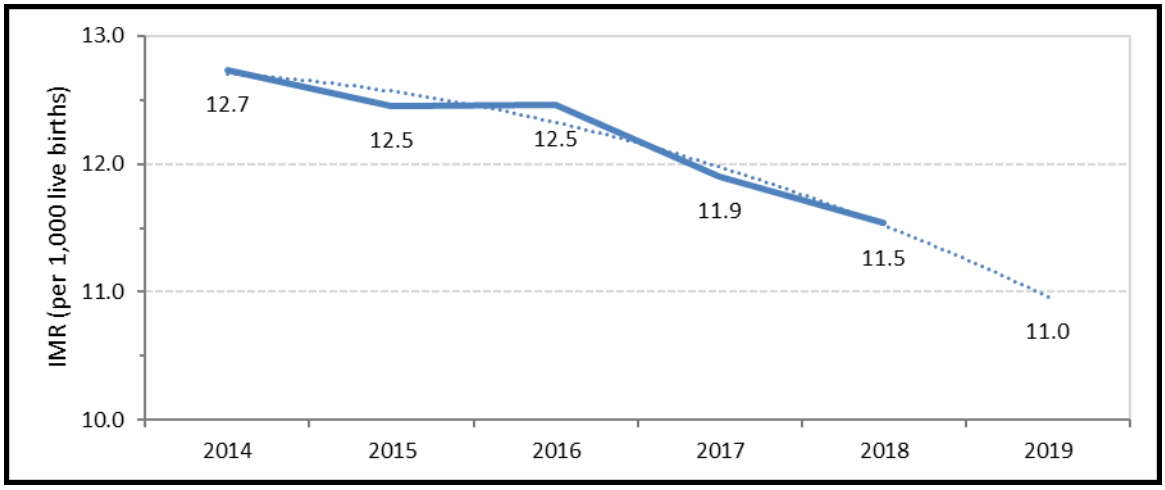
- Provide technical assistance to countries to build capacity for producing this indicator at national and subnational levels, so that countries are able to monitor national HALE and the social inequality associated with it. This is particularly important given the complexity of the indicator, which requires multiple inputs, as compared to simple indicators that are more straightforward to measure. Countries have the necessary data inputs to calculate this indicator.
- Work with countries to increase understanding of the HALE estimates that are produced internationally.

Goal 2: Ensure a healthy start for newborns and infants

Target	Status (2019)
2.1 At least a 15% reduction in the regional Infant Mortality Rate (IMR) achieved by 2019	**Achieved** (13.9% reduction)
2.2 Relative inequality gap: at least 10% reduction	**Partially achieved** (8.3% reduction)
2.3 Absolute inequality gradient: at least 3 excess infant deaths averted per 1,000 live births	**Exceeded** (4.1 excess infant deaths averted)

Analysis: Using the infant mortality rate (IMR) produced by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) for countries of the Americas in 2014 and a projection of IMR for 2019, a regional IMR (weighted average) of 12.7 and 11.0 infant deaths per 1,000 live births has been estimated for 2014 and 2019, respectively. This shows a reduction of 13.9% for the regional IMR between 2014 and 2019. This indicates that the regional IMR target reduction of 15% is close to being reached.

Figure A.2. Infant Mortality Rate (IMR), the Americas, 2014-2019

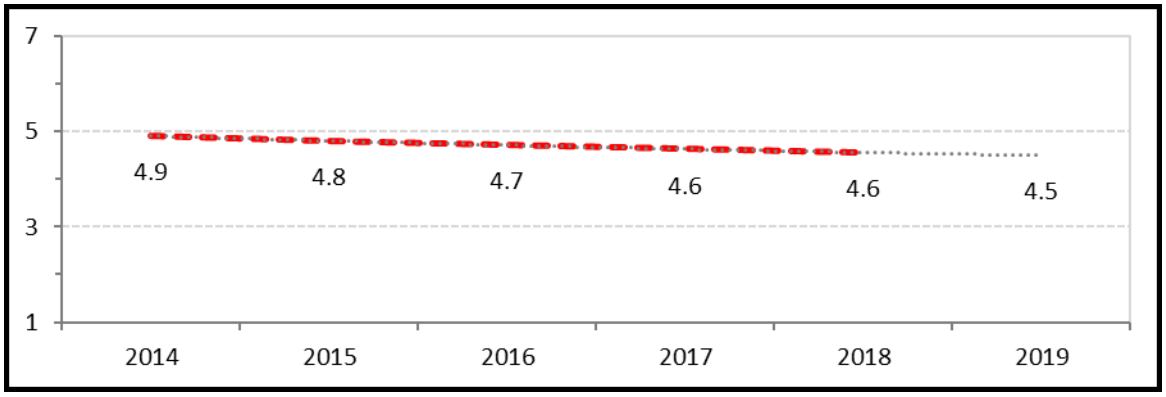


Source: Calculated by PAHO using data from UN IGME, 2019.

In terms of social inequalities in the IMR between countries, the absolute inequality (measured by the slope index of inequality) is 19.3 and 15.2 infant deaths per 1,000 live births in 2014 and 2019, respectively. Therefore, a reduction of 4.1 infant deaths per 1,000 live births between these two years is estimated. On the other hand, relative inequality (measured by the simple relative gap) is estimated at 4.9 and 4.5 in 2014 and 2019, respectively, which shows a reduction of 8.3% for this period. These results show that the

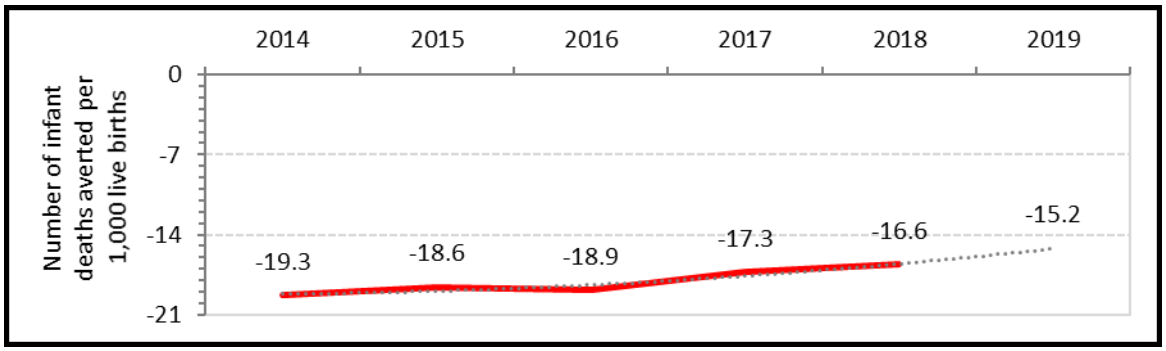
target for decreasing relative inequality is partially achieved and that the Region will exceed the target for decreasing absolute inequality.

Figure A.3. IMR, Trend in Relative Inequality Gap, 2014-2019



Source: Calculated by PAHO using data from UN IGME, 2019.
Note: A value closer to 1 indicates lesser inequality; a value further from 1 indicates greater inequality.

Figure A.4. IMR, Trend in Absolute Inequality Gradient, 2014-2019



Source: Calculated by PAHO using data from UN IGME, 2019.

Recommendations:

- Establish targets for reducing social inequalities within countries with respect to infant mortality, at least between subnational levels. This means that for each country, monitoring must track both the national IMR and social inequality estimates for this indicator within the country.
- Strengthen health information systems in countries in order to improve the quality of data, including IMR data at subnational level, particularly among populations with the highest degree of social vulnerability.

Goal 3: Ensure safe motherhood

Target	Status (2019)
3.1 At least an 11.0% reduction in the regional Maternal Mortality Ratio (MMR) achieved by 2019, compared to 2014	**Partially achieved** (9.4% reduction)
3.2 Relative inequality gap: at least 25% reduction	**Achieved** (24.4% reduction)
3.3 Absolute inequality gradient: at least 18 excess maternal deaths averted per 100,000 live births	**Exceeded** (31.1 excess maternal deaths averted)

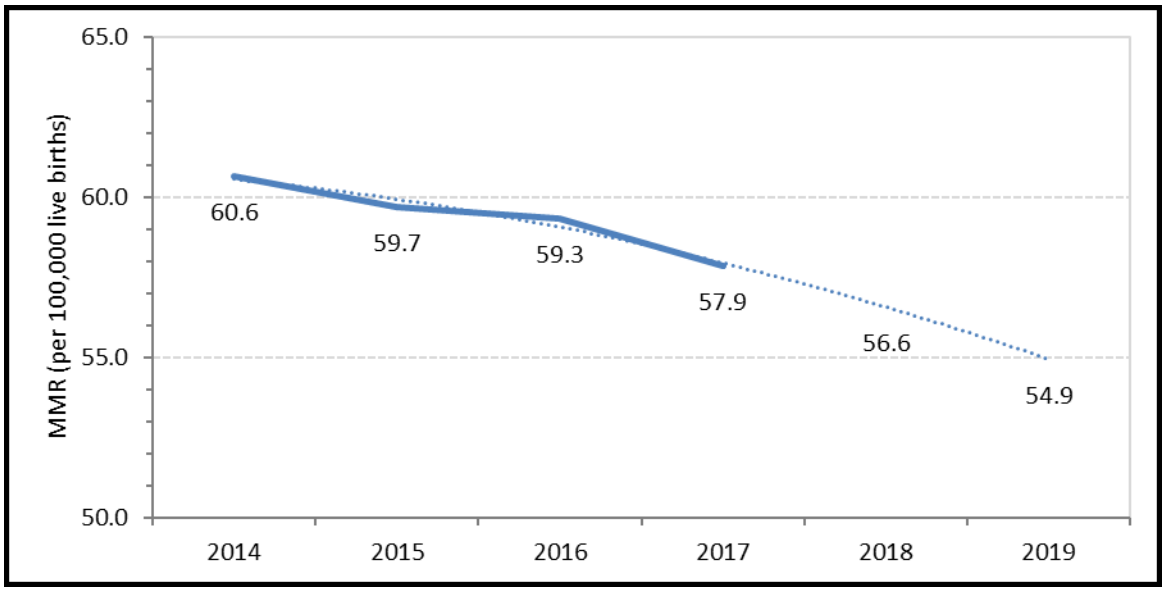
Analysis: According to the latest available maternal mortality ratio (MMR) estimates, the Region experienced a decrease from 60.6 maternal deaths per 100,000 live births in 2014 to 57.9 deaths per 100,000 in 2017. Estimates for the years after 2017 show that the MMR is projected to decrease further to 56.6 deaths per 100,000 live births in 2018 and 54.9 deaths per 100,000 in 2019. The projection is a 9.4% reduction for the 2014-2019 period, resulting in partial achievement of the target to reduce MMR by 11%.

It is important to note that the methodology of the United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG) for estimating MMR has changed in the most recent round of estimates, as all available data generated by countries have been considered at the time the estimates were produced. The overall regional MMR, based on the latest inter-agency estimates, is higher than in previous estimates. With respect to individual country MMR estimates, the figure is the same for some and lower for others.

Using the Health Needs Index *expanded* (HNI*e*) country gradient, a target was established to reduce maternal mortality by at least 18 excess maternal deaths per 100,000 live births. A 24.4% reduction in the relative inequality gap is projected for 2019; therefore, the target was nearly achieved. The absolute inequality gradient target is on track to be exceeded by 2019, based on the projected absolute reduction of 31.1 excess maternal deaths per 100,000 live births for the 2014-2019 period.

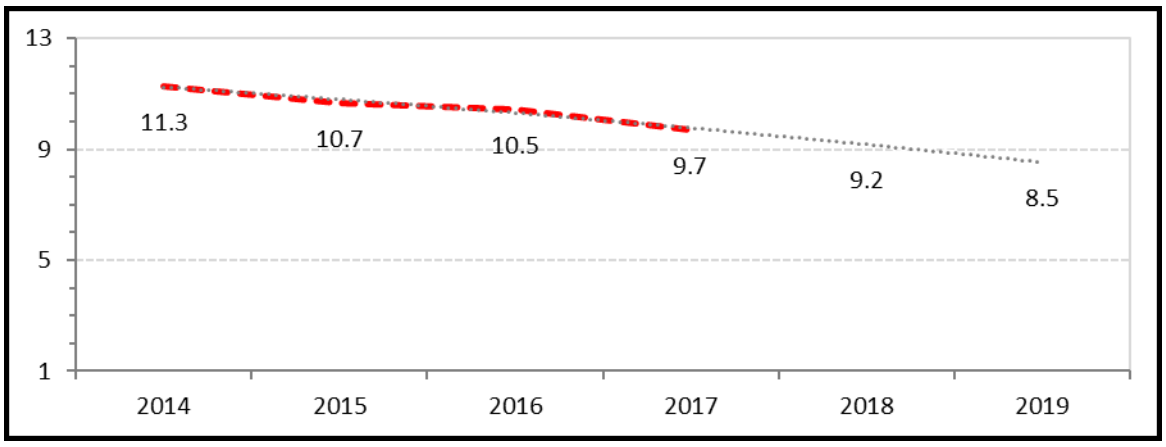
Notwithstanding these results, the analysis shows significant variations between and within countries, which suggests the need to boost efforts where they are needed most, particularly among the PAHO key countries. PAHO has been implementing targeted programs to reduce maternal mortality, such as the Zero Maternal Deaths from Hemorrhage project, which aims to improve the capacity to respond to obstetric emergencies (see the Brazil success story in Section III). Likewise, projects implemented in Colombia, Nicaragua, and Paraguay have focused on scaling up community models and best practices in an effort to reduce inequities in accessing quality health services. Particular emphasis is placed on women and children living in rural areas, and on indigenous and Afro-descendant groups.

Figure A.5. Maternal Mortality Ratio (MMR), the Americas, 2014-2019



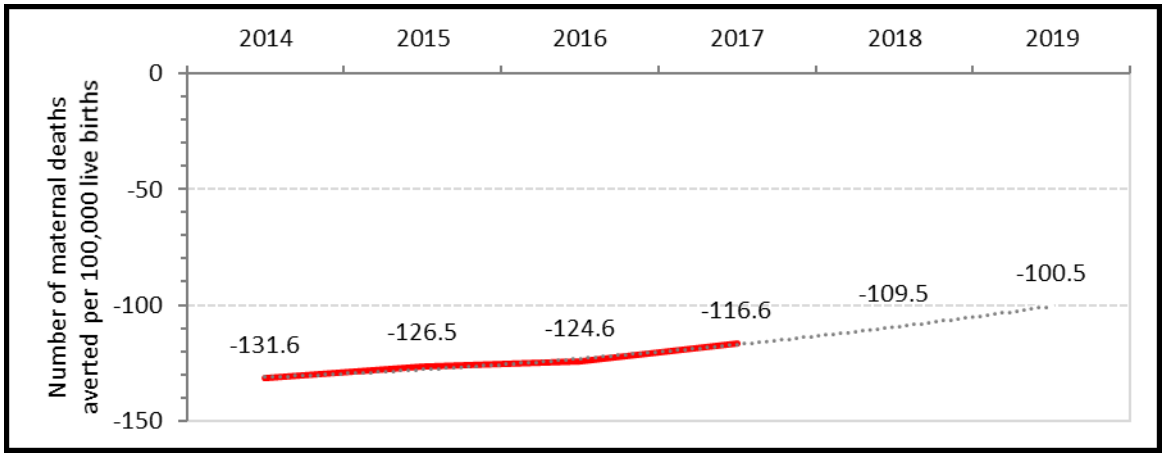
Sources: Calculated by PAHO using data from the MMEIG, 2019, https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/.
Data on live births from 2019 Revision of World Population Prospects. United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects 2019: Highlights (ST/ESA/SER.A/423), https://population.un.org/wpp//.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Figure A.6. MMR, Trend in Relative Inequality Gap, 2014-2019



Source: Calculated by PAHO using data from the MMEIG, 2019.
Note: A value closer to 1 indicates lesser inequality; a value further from 1 indicates greater inequality.

Figure A.7. MMR, Trend in Absolute Inequality Gradient, 2014-2019



Source: Calculated by PAHO using data from the MMEIG, 2019.

Recommendation:

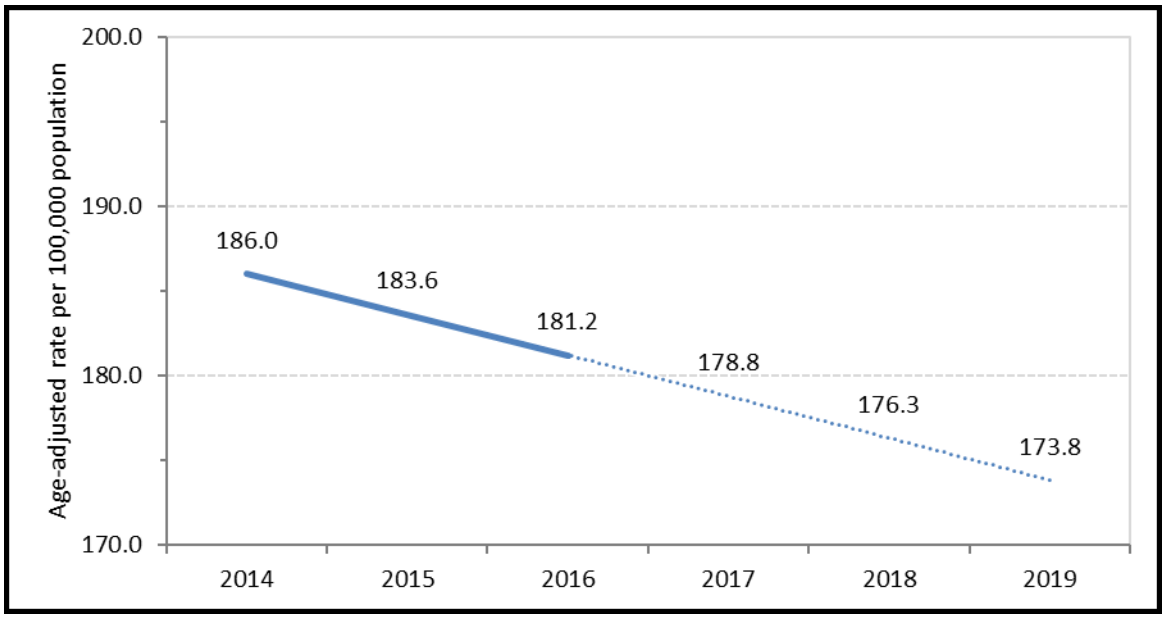
- Promote implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), the PAHO Plan of Action for Women's, Children's and Adolescents' Health 2018-2030, and the Every Woman, Every Child—Latin America and the Caribbean (EWEC-LAC) movement. These are important frameworks for the promotion and implementation of specific interventions aimed at improving the health of women, pregnant women, and newborns within the life course approach.

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

Target	Status (2019)
4.1 At least a 9% reduction in the regional rate of Mortality Amenable to Health Care (MAHR) achieved by 2019, compared to 2014	**Not achieved** (6.5% reduction)
4.2 Relative inequality gap: no more than 6% increase	**Exceeded** (14.8% reduction)
4.3 Absolute inequality gradient: at least 8 excess amenable deaths averted per 100,000 population	**Exceeded** (41.0 amenable deaths averted)

Analysis: Although the Region did not achieve the overall target, there has been a decrease in the rate of mortality amenable to health care (MAHR), from 186.0 deaths per 100,000 population in 2014 to a projection of 173.8 deaths per 100,000 in 2019. This represents achievement of over two-thirds of the target (i.e., a 6.5% absolute reduction compared to the targeted 9% reduction), indicating that the trend is favorable. The reduction in MAHR has been made possible by improved access to health care. While this gain seems to indicate that the regional efforts to progressively realize universal health are bearing fruit, countries still need to make greater progress on coverage and quality of care.

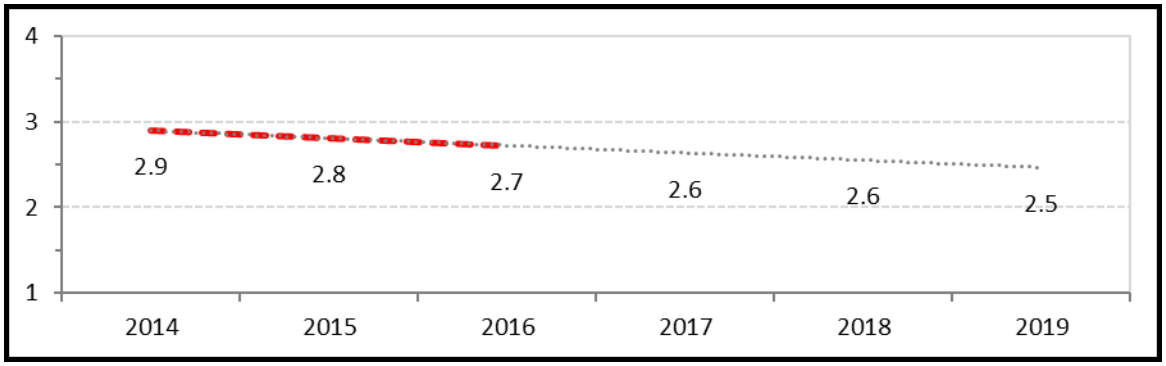
Figure A.8. Mortality Amenable to Health Care (MAHR), the Americas, 2014-2019



Sources: Calculated by PAHO using IHME GBD 2016 estimates, http://ghdx.healthdata.org/gbd-results-tool. Population data from 2019 Revision of World Population Prospects. United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects 2019: Highlights (ST/ESA/SER.A/423), https://population.un.org/wpp//.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

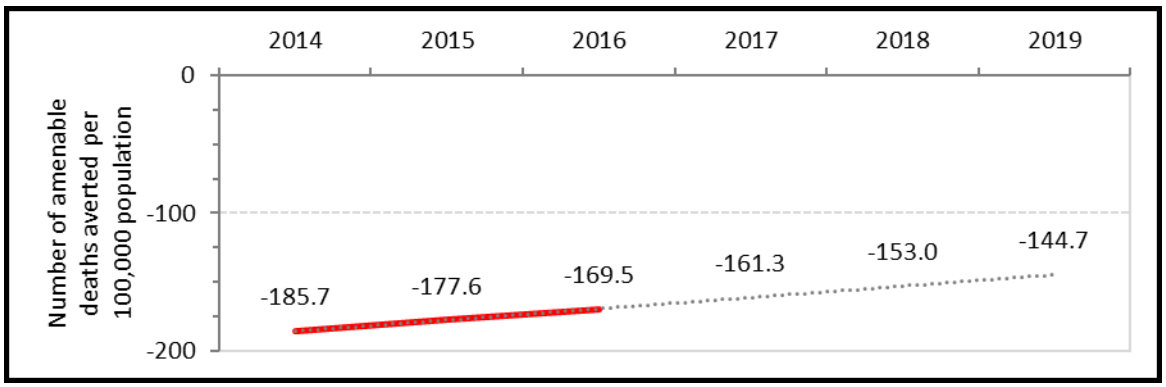
The assessment of this impact goal reveals another welcome trend: among countries in the Region, the risk of dying from poor quality of care due to social inequalities, in both absolute and relative terms, has been reduced in the 2014-2019 period. The Region exceeded its inequality reduction targets set for this goal, highlighting the relevance of equity considerations in the implementation of the Strategic Plan. The equity lens—as well as the quality lens—is essential in continuing to monitor the progressive realization of universal health through this critical indicator of the societal performance of health services.

Figure A.9. MAHR, Trend in Relative Inequality Gap, 2014-2019



Source: Calculated by PAHO using IHME GBD 2016 estimates.
Note: A value closer to 1 indicates lesser inequality; a value further from 1 indicates greater inequality.

Figure A.10. MAHR, Trend in Absolute Inequality Gradient, 2014-2019



Source: Calculated by PAHO using IHME GBD 2016 estimates.

Recommendation:

- Ensure careful revision and updating of the specific causes of death that are considered amenable to health care, given the mosaic of epidemiological profiles in the Region, and continue working to improve the completeness and quality of health information systems at national and subnational levels.

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

Target	Status (2019)
5.1 At least a 9% reduction in the regional Premature NCD Mortality Rate (PNMR) achieved by 2019, compared to 2014	**Not achieved** (4.9% reduction)
5.2 Relative inequality gap: no more than 6% increase	**Not achieved** (10.6% increase)
5.3 Absolute inequality gradient: at least 18 excess premature deaths averted per 100,000 population	**Achieved** (18.3 premature deaths averted)

Analysis: Although the overall regional reduction for mortality due to noncommunicable diseases (NCDs) is observed at 4.9% and does not meet the target of 9.0%, the trend in the PAHO Regional Mortality Database shows a decrease in deaths. In contrast, data from IHME demonstrate a different trend, with an increase in deaths due to NCDs (data not shown). To gain a better understanding of the reasons for these differences, further investigation is under way between IHME and PAHO.

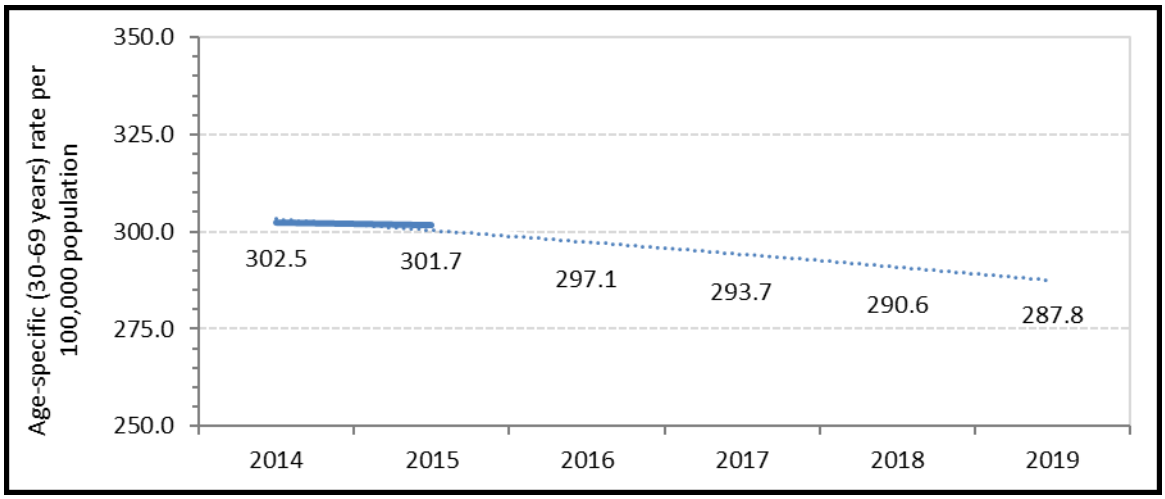
The relative risk of dying from NCDs has increased by 10.6% in the 2014-2019 period, so the target of no more than a 6% increase was not achieved. However, the absolute inequality gradient target was achieved, with 18.3 deaths per 100,000 population averted.

In 2016, NCDs (including cardiovascular diseases, cancer, diabetes, and others) accounted for 81% of all deaths.[15] The Region of the Americas faces a demographic and epidemiological transition as the median age of the population has increased over time to 33.5 years, and 12% of the population is age 65 years or older. Morbidity and mortality due to NCDs is ever-increasing and requires countries to implement interventions that are tailored to the challenges and risks of a population that is living to older ages than ever before. In addition to ensuring access to quality health care services, countries must advance their efforts in health promotion and prevention to address the main NCD risk factors, giving special attention to age, sex, ethnic groups, geography, and other socioeconomic factors.

Reducing NCD mortality requires political support and resource allocation for legislation that promotes multisectoral policies; regulations for risk factor reduction; health systems strengthening for the management of NCDs; and surveillance. Cardiovascular diseases, cancer, diabetes, chronic respiratory diseases, and other NCDs share the same major risk factors, namely tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity. Therefore, an integrated approach to the care of people at risk for, or living with, one or more NCDs is required to adequately address this public health matter.

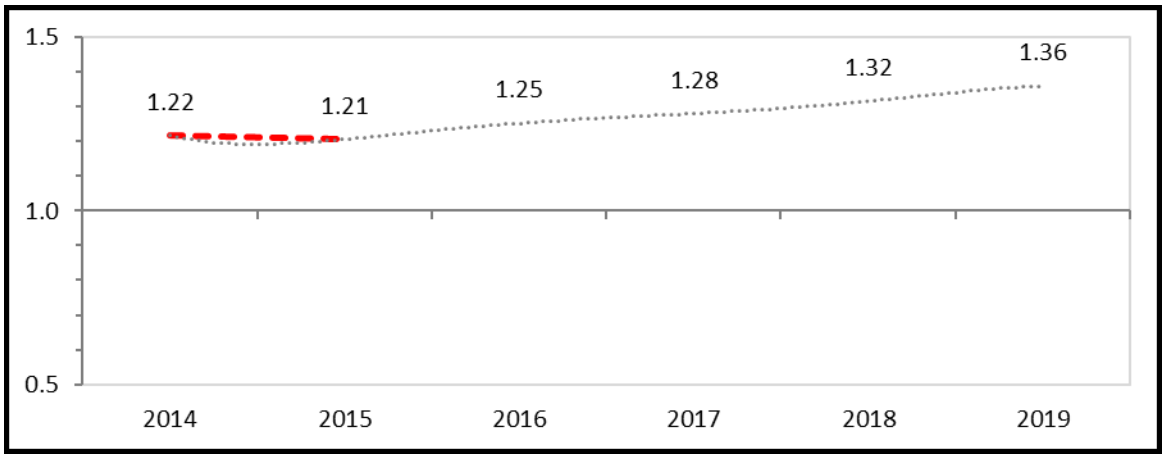
[15] Pan American Health Organization. Core Indicators 2019: Health Trends in the Americas. Washington, DC: PAHO; 2019.

Figure A.11. Premature Mortality Rate Due to Noncommunicable Diseases, the Americas, 2014-2019



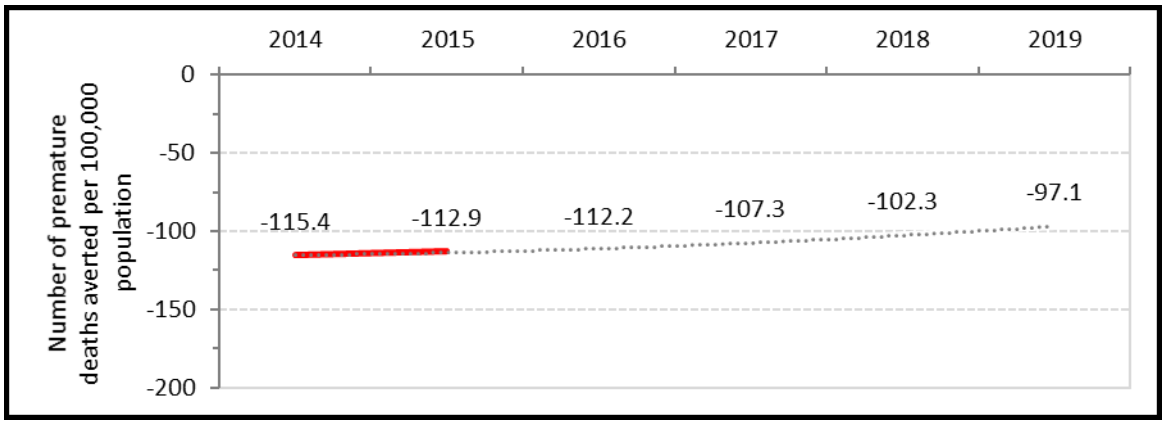
Source: Calculated using PAHO Regional Mortality Database 2018 (corrected).
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Figure A.12. NCD Premature Mortality, Trend in Relative Inequality Gap, 2014-2019



Source: Calculated using PAHO Regional Mortality Database 2018 (corrected).
Note: A value closer to 1 indicates lesser inequality; a value further from 1 indicates greater inequality.

Figure A.13. NCD Premature Mortality,
Trend in Absolute Inequality Gradient, 2014-2019



Source: Calculated using PAHO Regional Mortality Database 2018 (corrected).

Recommendations:

- Implement the WHO "NCD Best Buys," a comprehensive set of cost-effective policy and health service interventions to reduce tobacco use, to reduce harmful use of alcohol, to promote healthy diet, to promote physical activity, and to manage NCDs.
- As part of health system reform processes, integrate NCD prevention and control strategies to ensure availability of services, medicines and health technologies, and human resources for NCD prevention, screening, diagnosis, treatment, rehabilitation, and palliative care.
- Ensure high-level commitment to identify best practices tailored to target populations, and implement scalable solutions with strong legal support in a manner that effectively mitigates risk factors and that is focused on the entire life course.

Goal 6: Reduce mortality due to communicable diseases

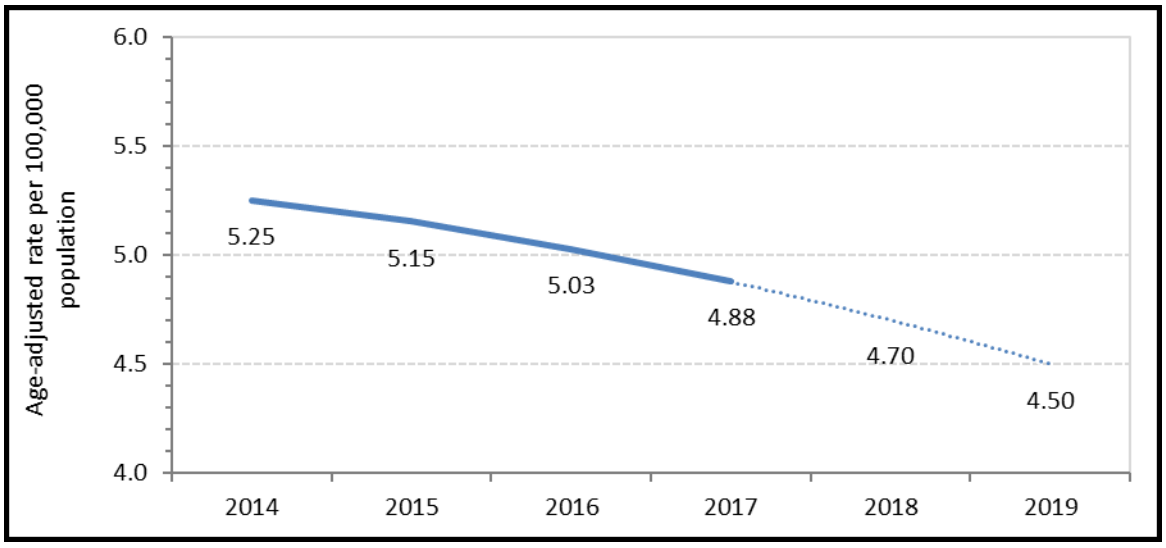
Target	Status (2019)
6.1 At least a 15% reduction in the mortality rate due to HIV/AIDS by 2019, compared to 2014	**Achieved** (14.3% reduction)
6.2 At least a 30% reduction in the case-fatality rate due to dengue achieved by 2019, compared to 2012	**Achieved** (30% reduction)
6.3 At least a 24% reduction in tuberculosis mortality rate achieved by 2019, compared to 2014	**Not achieved** (4.1% reduction)
6.4 At least a 75% reduction in the number of deaths due to malaria by 2019, compared to 2011	**Not achieved** (200% increase)

Analysis:

HIV/AIDS

The trend shows a decrease from 5.25 deaths per 100,000 population in 2014 to 4.88 deaths per 100,000 population in 2017. The projection is that the mortality rate will continue to decrease to 4.50 deaths per 100,000 population for 2019. Therefore, the projection represents a 14.3% reduction for the 2014-2019 period, which suggests that the target of a 15% reduction in the mortality rate due to HIV/AIDS has been nearly achieved.

Figure A.14. Mortality Rate Due to HIV/AIDS, the Americas, 2014-2019



Source: Calculated using IHME GBD 2017 estimates.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Throughout the SP14-19 period, PAHO continued to provide technical cooperation in promoting quality and comprehensive prevention, care, and integrated treatment services,

in line with the regional Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016-2021. These actions may have contributed to the projected decrease in the mortality rate. However, while the regional trend has been a decline in the burden and the number of deaths due to HIV/AIDS, the disease continues to have a greater impact among certain key populations than among others. The factors that have contributed to the successful regional trend in mortality, including increased access to diagnosis and medicines, are still lacking in many of these populations.

Dengue

In 2012, the regional case-fatality rate (CFR) was 0.07% of all dengue cases. Based on country reports submitted to PAHO, the rate was reduced to 0.049%, representing a 30% reduction. Therefore, the regional target to reduce the dengue CFR by 30% was achieved.

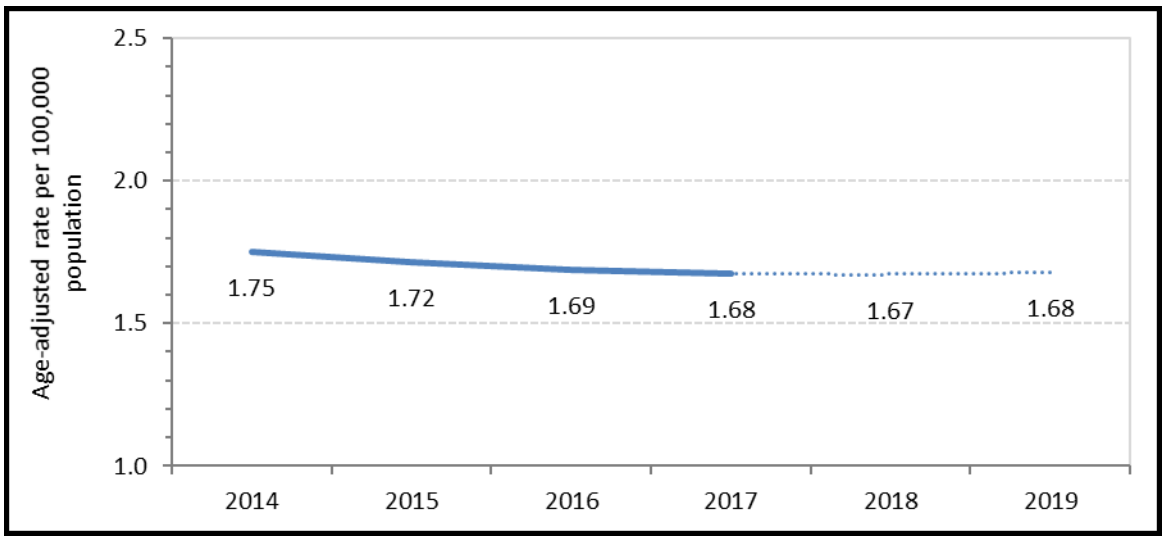
Notwithstanding the improvement in the CFR, intense arboviral disease transmission, especially dengue, was observed at the end of 2018 and during 2019. With more than 3 million cases, 2019 represented the year with the highest dengue case count ever recorded in the Americas. The epidemiologic profile of the disease is also shifting, as seasonal patterns are changing, and the disease burden is affecting younger populations to a greater extent than in previous periods. The decrease in the CFR may be attributed in part to the enhanced training on the early predictors of severe dengue disease provided for clinicians in primary health care settings.

Tuberculosis

The tuberculosis mortality rate shows a decrease from 1.75 deaths per 100,000 population in 2014 to 1.68 deaths per 100,000 population in 2017. The projection is that the rate remained steady through 2019, resulting in an overall 4.1% reduction in the TB mortality rate for the 2014-2019 period. This is well below the target reduction of 24%; therefore, the target was not achieved.

Overall, there has been slow implementation of the End TB Strategy, and of the commitments of the UN High-Level Meeting on Tuberculosis. Countries have also been slow to fully operationalize the latest WHO TB guidelines despite efforts by national TB programs. Intense coordination with different actors at various levels and a significant time investment are required. These factors have limited the progress toward national and regional targets.

Figure A.15. Tuberculosis Mortality Rate, the Americas, 2014-2019



Source: Calculated using IHME GBD 2017 estimates.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Malaria

There were 112 deaths due to malaria in 2011, compared to 336 deaths in 2018, based on country reports to PAHO. The massive increase in malaria transmission in Venezuela since 2015 has been associated with a significant increase in mortality in that country. The situation there continues to be critical, without substantial changes in the determinants of the epidemic and with structural gaps in the response.

With the exception of Venezuela, a 47% reduction in the number of deaths due to malaria was observed in the Region. Therefore, the Region was still below the target of a 75% reduction in malaria deaths in the 2014-2019 period.

Recommendations:

- Accelerate the implementation and increase coverage of HIV prevention, diagnosis, care and treatment services, in line with WHO recommendations and including innovative technologies and approaches, with full involvement of all actors, to achieve the international targets endorsed at the 2016 UN High-Level Meeting on Ending AIDS as a public health problem.
- Promote multi-disciplinary and integrated actions involving other sectors and the community in tackling arboviral diseases, including dengue.
- Accelerate the implementation of the End TB Strategy and the commitments made during the UN High-Level Meeting on Tuberculosis in 2018, with full involvement of all actors, to achieve the international targets toward eliminating TB as a public health problem.

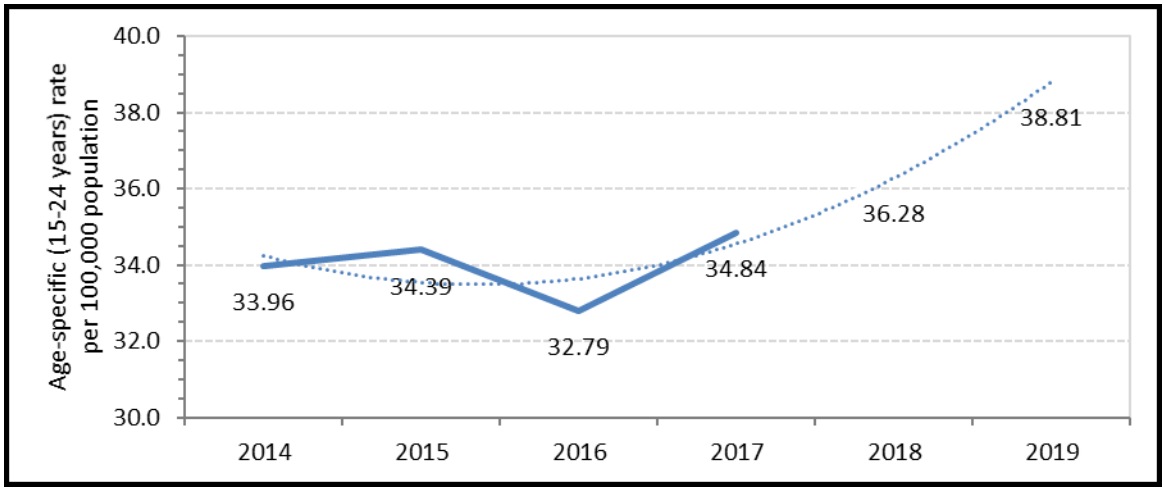
- Within the framework of the PAHO Disease Elimination Initiative, develop a model of inter-programmatic cooperation at country level that increases access to services among populations in conditions of vulnerability by addressing structural barriers to elimination.
- Promote inter-programmatic work at all levels to address health system strengthening and its response and progress toward elimination of priority communicable diseases.

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

Target	Status (2019)
7.1 At least a 6% reduction in the homicide rate achieved by 2019, compared to 2014	**Not achieved** (14.3% increase)
7.2 No increase in the suicide rate achieved by 2019, compared to 2014	**Exceeded** (1.9% reduction)
7.3 No increase in the mortality rate due to road traffic injuries by 2019, compared to 2014	**Exceeded** (4.1% reduction)

Analysis: All three indicators for this goal relate to acute health problems affecting the adolescent and young adult populations in the Americas, particularly the male segment of these populations. Contrary to the 6% target reduction for the homicide rate in these populations, the rate experienced a significant increase of 14.3% between 2014 and 2019. This may be related to a slowing of investments in interventions that apply a public health approach to violence. More broadly, this unwelcome trend may be linked to the persistently high levels of income, wealth, and social inequality in the Region, which often hits the male adolescent and young adult population particularly hard.

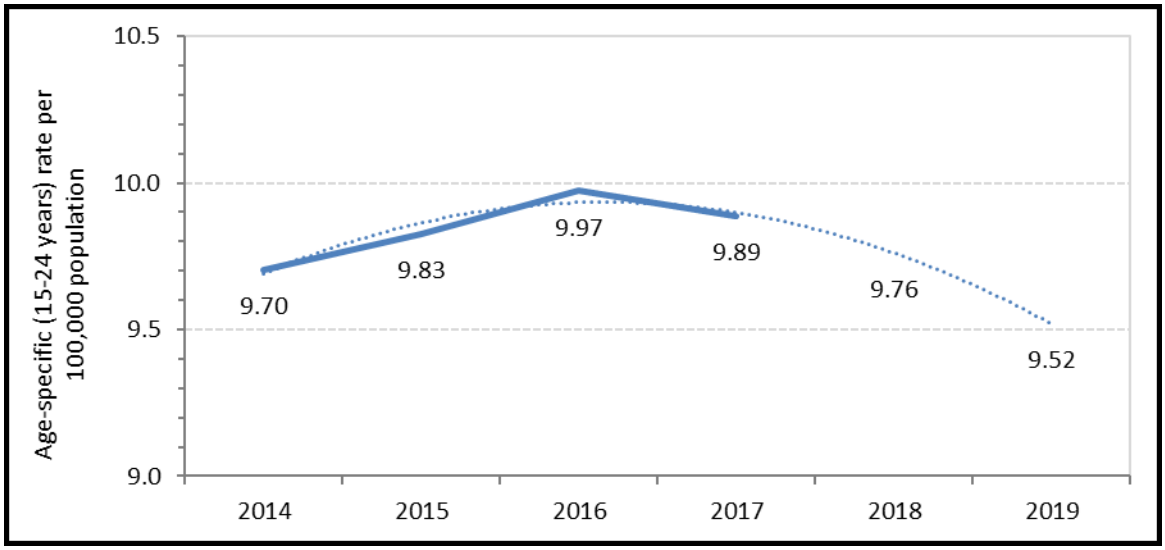
Figure A.16. Mortality Rate Due to Homicide (15-24 Years), the Americas, 2014-2019



Sources: Calculated by PAHO using IHME GBD 2016 estimates, http://ghdx.healthdata.org/gbd-results-tool. Population data from United Nations, Department of Economic and Social Affairs, Population Division, World Urbanization Prospects: The 2019 Revision, https://population.un.org/wpp/.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

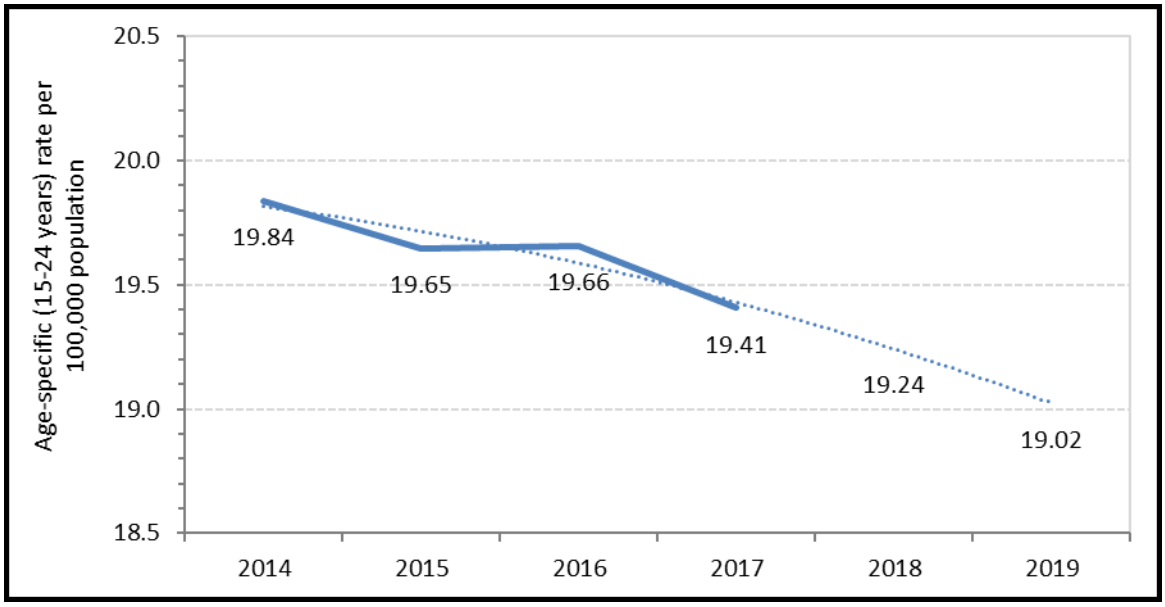
Mortality due to suicide decreased in the second half of the 2014-2019 period, after rising in the first half. As a result, the target of no increase was achieved, but there was only a small reduction in the risk of dying due to self-harm in the adolescent and young adult population. It may be that the same underlying determinants related to social inequality are at play in the Region. Meanwhile, the 4.1% reduction in the risk of dying due to road traffic injuries in adolescents and young adults may reflect the intensity of public health actions undertaken during the Decade of Action for Road Safety 2011-2020.

Figure A.17. Mortality Rate Due to Suicide (15-24 Years), the Americas, 2014-2019



Sources: Calculated by PAHO using IHME GBD 2016 estimates, http://ghdx.healthdata.org/gbd-results-tool. Population data from United Nations, Department of Economic and Social Affairs, Population Division, World Urbanization Prospects: The 2019 Revision, https://population.un.org/wpp/.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Figure A.18. Mortality Rate Due to Road Traffic Injuries (15-24 Years), the Americas, 2014-2019



Sources: Calculated by PAHO using IHME GBD 2016 estimates, http://ghdx.healthdata.org/gbd-results-tool. Population data from United Nations, Department of Economic and Social Affairs, Population Division, World Urbanization Prospects: The 2019 Revision, https://population.un.org/wpp/.
Note: Vertical axis has been rescaled to facilitate visualization of trends.

Recommendations:

- Address mortality due to violence, suicides, and road traffic injuries among adolescents and young adults by promoting an intersectoral approach and supportive legislation. Emphasis should be given to the importance of these issues as they affect men.
- Undertake actions to tackle underlying social and health inequities and the social determinants of health that contribute to these causes of death.

Goal 8: Eliminate priority communicable diseases in the Region

Target	Status (2019)
8.1 Elimination of MTCT in 10 countries	**Partially achieved** (7 of 10 countries)
8.2 Elimination of onchocerciasis in 4 countries	**Achieved** (4 countries)
8.3 Elimination of Chagas transmission in 21 endemic countries	**Partially achieved** (15 countries)
8.4 Elimination of malaria in at least 3 of 7 endemic countries in the pre-elimination phase	**Achieved** (3 of 7 countries in the pre-elimination phase)
8.5 Zero human cases of dog-transmitted rabies in 35 Member States	**Partially achieved** (33 Member States)

Analysis:

Elimination of mother-to-child transmission

As of 2019, seven countries and territories (Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis) were validated by WHO as having eliminated mother-to-child transmission (EMTCT) of HIV and syphilis; this was short of the target of 10 countries. Two applicant territories were not recommended by the Regional Committee to move forward. Some difficulties in the process of validating countries included natural disasters in the Caribbean, other competing public health priorities, and the frequent updates to the global requirements for validation, making the process more cumbersome for countries. Currently, two countries are in the process of validation and two more are expected in 2020 to submit the official request to begin the validation process. Therefore, the target is considered partially achieved.

Onchocerciasis

As of 2019, four countries had eliminated onchocerciasis, thus fully achieving the target of four countries. WHO verified onchocerciasis elimination in Ecuador (2014), Mexico (2015), and Guatemala (2016); Colombia had been previously verified in 2013. The main strategy to achieve elimination was mass drug administration, that is, the periodic (two times a year) administration of ivermectin (Mectizan), with a minimum coverage of 85% in each treatment round over a period of 10 to 12 years. This was accompanied by health education and social mobilization programs. The partnership between country programs, the Onchocerciasis Elimination Program for the Americas, and PAHO has been key to success. Moving forward, only one focus remains in the Region, on the border between Venezuela and Brazil.

Chagas

As of 2019, 15 endemic countries had successfully eliminated Chagas transmission. This fell short of the target of 21 countries; thus, the target was partially achieved. During the time period of the Strategic Plan, new evidence was collected to conclude that Guyana, French Guiana, Panama, and Suriname (previously target countries) have sylvatic transmission of Chagas disease, and therefore there is no reason to pursue interruption of transmission as a public health goal in those countries. Ecuador and Venezuela have progressed very little since 2014.

Malaria

As of 2019, three countries that had previously been in the pre-elimination phase had successfully eliminated malaria, achieving the target. Paraguay and Argentina were certified as malaria-free countries in 2018 and 2019, respectively. By the end of 2019, El Salvador completed three years without local transmission, a situation that will be certified by WHO in 2020; this will allow El Salvador to be considered officially as a malaria-free country. In addition, Belize had no indigenous transmission of malaria during 2019. The country must complete three consecutive years without indigenous cases to be technically considered as malaria-free and apply for WHO certification.

Countries that have recently eliminated malaria need to ensure that their health systems have the capacities to detect, diagnose, investigate, and respond to the occurrence of new imported or indigenous cases, while other endemic countries should continue to make progress in reducing cases on the way to elimination. At the same time, the increase in malaria transmission in some countries and the intense dynamics of population movements and other social determinants, such as gold mining, are important challenges for the elimination of malaria in the Region.

Human Cases of Dog-Transmitted Rabies

As of 2019, 33 of 35 Member States had registered zero human cases of dog-transmitted rabies. During 2018, 13 cases were registered (across Bolivia, Dominican Republic, and Haiti), and during 2019 only three cases were registered (Bolivia and Haiti). The Region has not achieved the goal of zero cases of human rabies transmitted by dogs, but significant improvements occurred in the countries where the disease has not yet been eliminated. In Haiti, an important dog vaccination campaign was launched in 2019 with the support of the World Bank. It is paramount that countries, donors, and international organizations join efforts to end dog-mediated human rabies in the Americas. Bolivia, the Dominican Republic, and Haiti need to prioritize actions for the elimination of this fatal disease as part of their health agendas.

Recommendations:

Elimination of mother-to-child transmission

- Take the opportunity provided by the new framework for EMTCT of HIV, syphilis, Chagas disease, and hepatitis B (EMTCT Plus) to establish validation criteria that lead to continuous assessment and improvement in the quality of maternal and child health services.
- Ensure reliable diagnostics through the implementation of external quality assessment of national laboratory networks, not only for HIV and syphilis, but for all other infectious diseases in the context of the PAHO Disease Elimination Initiative.

Neglected Infectious Diseases

- Strengthen political commitment at the highest level and increase human, logistical, and financial resources to control and eliminate neglected infectious diseases (NID), including post-elimination surveillance.
- Develop intersectoral synergies to address the social and environmental determinants of NID (water, sanitation, housing, education, hygiene, environment, work, etc.) within the framework of the 2030 Agenda, Health in All Policies, and the PAHO Disease Elimination Initiative.
- Create capacities to address the control and elimination of NID in an inter-programmatic way, providing affected people and communities with comprehensive care, so that no one is left behind.

Malaria

- Implement additional actions to prevent the reestablishment of transmission in countries that have recently eliminated malaria.
- Maintain actions and continue to promote technical platforms, collaboration among multiple actors, and initiatives to support achievement of the 2025 targets.
- Join efforts around a new Regional Malaria Elimination Plan 2021-2025, which PAHO will prepare during 2020.

Human Cases of Dog-Transmitted Rabies

- Reinforce surveillance and prevention actions and, whenever necessary, ensure access to post-exposure prophylaxis (PEP).

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

Target	Status (2019)
9.1 At least 70% of emergencies in which the crude mortality rate returns to accepted baseline (pre-disaster levels) within three months	**Achieved** (100%)

Analysis:

Between 2014 and 2019, there were 60 individual country emergency events that met the Grade 2 or Grade 3 criteria as indicated in the technical specifications for Target 9.1. PASB fully implemented the performance standards of the WHO Emergency Response Framework (ERF) in response to these emergencies.

Of the 60 events, 16 were considered for this assessment (Table 1); the others were excluded due to the indicator criteria or non-availability of data. The underlying cause of death[16] that was observed at the time of 10 of the 16 events did not show any reasonable causal relationship with those events. In nine of these 10 events, no deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred. In the remaining six events, the crude mortality rate returned to pre-disaster levels within three months. Based on the 16 events that were assessed, this indicator can be considered as achieved, since mortality for six events returned to baseline levels within three months, and nine did not record any deaths from exposure to forces of nature in the country's mortality database for the year in which the event occurred.

Important lessons were identified during all events, and certain internal response mechanisms were reviewed and updated as a result. PASB also capitalized on response activities to integrate planned mitigation and preparedness-type interventions in technical cooperation with the affected countries. This strategy was particularly effective during the various operations to strengthen laboratory capacity and increase immunization coverage in response to outbreaks. Innovation and investment in new technologies have also proven key to overcome difficulties in information management and activity implementation in the context of high-complexity emergency operations, such as the response to the Venezuela situation.

A key enabling factor in results related to this goal was the effort by PASB to capitalize on new and existing partnerships and alliances and to establish networks and working groups. These include the Inter American Humanitarian Health Assistance Network (IHHAN), as defined in the PAHO Plan of Action for the Coordination of Humanitarian Assistance, adopted through Resolution CD53.R9, as well as the Regional EMT Group of the

[16] As defined in volume 2 of the ICD-10 (2016), the underlying cause of death is "(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury."

Americas. This allowed PAHO to engage with key national stakeholders in leadership positions who can in turn stimulate engagement at the national level.

An important risk that impacted several health response operations during the period and constrained operations within the health sector was political instability and deterioration in the security situation of some countries.

Methodological challenges affecting this impact indicator include limited availability of timely vital statistics data as well as the need to ensure full alignment with the WHO 13th General Programme of Work (GPW13) and the SDG indicators. Accordingly, PAHO has adopted a revised impact indicator related to deaths from disasters and emergencies for SP20-25. It is aligned with the GPW13 Results Framework and SDG indicator 13.1.1, both of which calculate the mortality rate attributed to disasters per 100,000 population.

Recommendation:

- Monitor the revised indicator related to deaths from disasters and emergencies.

Table A.1. Emergency and Disaster Events Considered in the Assessment of Goal 9

Country	Event	Date	Comments
Puerto Rico	Hurricane Maria	20 Sep 2017	The mortality database did not include month of occurrence.
Cuba	Hurricane Irma	8 Sep 2017	The September mortality crude rate was lower than the August and October rates. Four provinces included information on the specific cause of death in September. The rate in July, August, October, and November was 0 because there were no deaths due to cataclysmic storm (ICD-10 code X37).
Mexico	Earthquake	7-9 Sep 2017	The September mortality crude rate was lower than the August rate. Eight states show deaths due to specific cause of death (victim of earthquake) in September. The rates in July, August, October, and November were 0, except for Distrito Federal (Mexico City) with 0.05 per 100,000 mortality rate in October.
Anguilla Antigua and Barbuda	Hurricane Irma	6 Sep 2017	No deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred.
Costa Rica	Hurricane Otto	24 Nov 2016	The November mortality crude rate was lower than the December rate and slightly higher than the September rate. Two provinces show deaths due to specific cause of death that are higher in November, compared with the September-October period when the death rate was 0, and December, when the rate was also 0.
Cuba	Hurricane Matthew	4 Oct 2016	No deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred.

Country	Event	Date	Comments
Belize	Hurricane Earl	4 Aug 2016	No deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred.
Ecuador	Earthquake	16 Apr 2016	Manabi province mortality rate (victim of earthquake) was higher in April than in May, June, and July.
Dominica	Tropical Storm Erika	16 Aug 2015	The August mortality crude rate was higher than the September and October rates. There were 9 deaths where other specific causes of death were listed (victims of avalanche, landslide and other earth movements, ICD-10 code X36, and exposure to other unspecified forces of nature, ICD-10 code X39).
Paraguay	Floods	1 Apr 2015	No deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred.
Chile	Floods and landslides	1 Mar 2015	Three regions show deaths due to specific cause of death (victim of avalanche, landslide and other earth movements) in March, and the specific rate was higher than in April, May, and June.
Paraguay	Floods	1 May 2014	Only one death (victim of cataclysmic storm).
Dominica	Christmas trough floods	24 Dec 2013	No deaths from exposure to forces of nature were recorded in the country's mortality database for the year in which the event occurred.
Saint Lucia			
Saint Vincent and the Grenadines			

Annex B: End-of-Biennium Assessment Process and Methodology

1. This section briefly describes the components and methodology of the end-of-biennium assessment process.

Assessment of Impact Goals

2. The Strategic Plan 2014-2019 established nine impact goals with 26 targets and indicators to measure progress at regional level. To establish and refine the impact 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 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 the updated estimates produced by inter-agency groups. 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, in turn 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 indicators are monitored using the PAHO Regional Mortality Database and other existing sources of information, including data reported by countries 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.[17] The overall assessment of the targets considered the integrated quantitative and qualitative analysis of their corresponding indicators, using the rating criteria below.

- **Exceeded:** 2019 target has been reached and exceeded, meaning that the change between the baseline year and 2019 was over 100% of the target change.
- **Achieved:** 2019 target has been reached or almost reached, meaning that the change between the baseline year and 2019 was between 90% and 100% of the target change.
- **Partially achieved:** 2019 target has not been reached. However, the change between the baseline year and 2019 was between 75% and 89% of the target change.

[17] 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

- **Not achieved:** 2019 target has not been reached. Moreover, the change between the baseline year and 2019 was less than 75% of the target change.

Assessment of Outcome and Output Indicators

6. The other key element of the end-of-biennium assessment is the assessment of the outcome and output indicators defined with Member States for the SP 2014-2019 and the PB 2018-2019.[18] All have defined baselines and targets, as well as technical specifications, which provide standard definitions and measurement criteria to guide the assessment.

7. For the 2014-2015 and 2016-2017 assessments, the process followed the mandates of Member States (Resolutions CD52.R8, CD53.R3, and CD54.R16), in which Member States and PASB committed to joint accountability and transparency. However, due to the difficulties of conducting the joint assessment of outcome and output indicators at a time when countries are responding to COVID-19, the results in this report do not include information from the joint assessment. In that regard, indicators were assessed based on information available to PASB, following the rating criteria below. Individual national health authorities may complete the joint assessment as they are able in order to reflect the country assessment of the indicators and document the results to inform future planning.

Criteria for Rating Outcome and Output Indicators at Regional Level

- **Exceeded:** 2019 target has been reached and exceeded, meaning that the change between the baseline year and 2019 was over 100% of the target change.
- **Achieved:** 2019 target has been reached or almost reached, meaning that the change between the baseline year and 2019 was between 90% and 100% of the target change.
- **Partially achieved:** 2019 target has not been reached. However, the change between the baseline year and 2019 was between 1% and 89% of the target change.
- **Not achieved:** 2019 target has not been reached. Moreover, the change between the baseline year and 2019 was 0% of the target change or less.

[18] For this report, the outcome indicators that were assessed were the revised set that was approved in the amended Strategic Plan at the 29th Pan American Sanitary Conference in September 2017, which became effective in 2018.

Annex C: Glossary of Programmatic and Budgetary Terms

This annex provides definitions of key terms presented in this document.

AMRO approved Program and Budget: Fiscal space from the WHO Programme Budget that has been assigned to the Region of the Americas. It may or may not be fully funded.

Approved Program and Budget: Estimated resource requirements that have been approved by Member States for a specific budgetary period. The total approved amounts are allocated across the main Program and Budget segments (base programs and special programs). For base programs, the budget is also allocated across the current programmatic categories (corresponding to the SP14-19 framework).

Assessed contributions (PAHO assessed contributions): One of the main sources of financing of the Program and Budget. The Pan American Sanitary Conference or the Directing Council adopt the total Program and Budget and the amount of the assessments, determined in accordance with PAHO Financial Regulation 4.3, for the budgetary period. After the PASC or Directing Council has adopted the Program and Budget, the Director informs Member States of their commitments with respect to contributions for the budgetary period. Assessed contributions and budgeted miscellaneous revenue shall be made available for implementation on the first day of the budgetary period to which they relate.

Base programs: The larger of the two main budget segments that make up the PAHO Program and Budget. It includes the main programmatic framework agreed upon in the PAHO Strategic Plan. In 2018-2019 base programs were organized in six categories and 33 program areas, as adopted by the 29th Pan American Sanitary Conference.

Budget: Fiscal space for planning purposes. The PAHO budget, whether assigned to the whole Organization or to programmatic or organizational elements, is unfunded fiscal space that requires actual financing. The image of an empty bucket can be useful in visualizing the concept: the bucket is only filled once actual funds are received and assigned to the budget bucket in order to be committed (also known as obligated) and expensed. Synonyms: budget space, budget allocation, (budget) ceiling, budget envelope.

Categories: Strategic areas of focus that were used to guide implementation of the Strategic Plan 2014-2019. SP14-19 was organized into six categories. The concept of categories was discontinued for SP20-25.

Financing: All income that the Organization considers in funding the Program and Budget, even when the corresponding "cash" has not been received in full, or when some of these funds are meant to be used in future biennia (for example, multi-year voluntary contributions). It assumes that all financial commitments from Member States and donors (that is, PAHO assessed contributions and signed voluntary contributions) will be fully honored.

Flexible funds: PAHO and WHO assessed contributions, PAHO miscellaneous revenue, and revenue generated from special cost recovery mechanisms such as project support costs

for PAHO and WHO. Though more limited in nature, the WHO Core Voluntary Contributions Account is also considered flexible funds.

Funding gap: Difference between the budget and actual funding for the Organization (or a sub-element thereof). The gap is normally addressed through resource mobilization. Synonyms: financing gap, unfunded budget.

Funds available: Funds that have been distributed to entities and are ready in their workplans for implementation. This includes all flexible funds, as well as the subset of voluntary contributions and other sources of income that can be utilized in the respective biennium.

General Programme of Work (GPW): World Health Organization official document that sets out the strategic direction of WHO, outlines how it will proceed with program implementation, and provides a framework to measure progress. The 12th GPW covered the period 2014-2019 in alignment with the PAHO SP14-19. It covered three WHO Programme Budgets: PB14-15, PB16-17, and PB18-19. The 13th GPW covers the period 2019-2023 and WHO PB20-21 and PB22-23, but it also influenced implementation during PB18-19 through resource allocation within the existing authority of the WHO Director-General.

Government-sponsored initiatives: Funds provided by national governments to finance specific in-country initiatives that are aligned with the existing mandates of PAHO; also known as national voluntary contributions (NVCs). Typically, NVCs are provided as part of national technical cooperation agreements. Since most of these contributions are planned, implemented, and reported at national level, they fall outside the governance of the PAHO Program and Budget, although they are strictly managed following PAHO financial rules and regulations and are subject to accounting in financial reports. The programmatic results of national technical cooperation agreements are reported as part of the strategic achievements of the Organization. The level of NVCs has fluctuated greatly in recent years, making it difficult to predict the exact level of this funding modality for 2020-2021.

Impact: Sustainable changes in the health of populations, to which the work of PAHO Member States, PASB, and other partners will contribute.

Implementation: Funds committed for activities, goods and services, and staff costs that were fully received, completed, or expensed by the last day of the biennium.

Miscellaneous revenue: Investment revenue earned on the funds administered by the Organization, investment fees associated with the portfolios, net currency exchange gains and losses, savings on prior period obligations, and other revenue.

National voluntary contributions: See “government-sponsored initiatives”.

Other sources of financing (other sources): Voluntary contributions that are mobilized directly by PAHO, as well as other special funds that finance the PB.

Other special funds (special funds): Revenue from program support costs related to voluntary contributions, as well as any other authorized income that finances the Program Budget, such as revenue generated from sales and services and revenue from services

charges on procurement funds, or any other special fund that has been authorized by Governing Bodies. The Voluntary Contributions – Emergency Preparedness and Disaster Relief Fund is also included in this component.

Outcome: Collective or individual changes in the factors that affect the health of populations, to which the work of Member States and PASB will contribute.

Output: Changes in national systems, services, and tools derived from the collaboration between PASB and Member States, and for which they are jointly responsible.

Program and Budget (PB): PAHO official document that sets out the corporate results and targets for the Organization agreed by Member States for a period of two years. It presents the budget that PASB will require in order to support Member States in achieving the maximum impact in health. It follows the programmatic framework agreed upon in the PAHO Strategic Plan. Starting in the 2020-2025 Strategic Plan period, the document is referred to as the "Program Budget" without the "and".

Program area: Priorities for the Organization that were identified by Member States as part of the development of the WHO 12th GPW 2014-2019. For SP14-19, each outcome was equivalent to one program area. The concept of program areas was discontinued for SP20-25.

Special programs**:** The second of the two main budget segments that make up the PAHO Program and Budget. It fully depends on voluntary contributions. For PB18-19, this budget segment included components related to foot-and-mouth disease eradication, Outbreak and Crisis Response, the Smart Hospitals initiative, and polio eradication maintenance.

Strategic Plan (SP): PAHO official document that sets out the Organization's strategic direction, based on the collective priorities of its Member States, for a period of six years. For the Strategic Plan 2014-2019, PAHO adopted three Program and Budgets: PB14-15, PB16-17, and PB18-19.

Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030): The highest-level strategic planning and policy framework for health in the Americas. It represents the health sector's response to commitments adopted by the PAHO Member States in the 2030 Agenda for Sustainable Development, together with unfinished business from the Millennium Development Goals and the Health Agenda for the Americas 2008-2017. It also looks ahead to emerging and future public health challenges in the Region. The SHAA2030 is implemented through the PAHO strategic plans and strategies, as well as through subregional and national health plans.

Voluntary contributions: Donations and bequests, either in cash or in kind, that can be used by the Organization to finance the Program and Budget. Any conditions that may be attached to them must be consistent with the objectives and policies of the Organization.

WHO allocation to the Americas: A dual budgetary and financing concept. As a budgetary term, it refers to fiscal space in the WHO PB that has been assigned to the Region of the Americas, as approved by Member States during the World Health Assembly. As a financing term, it refers to actual funds received from WHO to finance the WHO component of the PAHO PB.

WHO financing: Actual funds received from WHO to finance the WHO component of the PAHO PB. WHO financing consists of either WHO flexible funds or WHO voluntary contributions. In the last few biennia, the amount of WHO financing has been less than the WHO budget allocated for the Region of the Americas.

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