PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

# 52nd DIRECTING COUNCIL

**65th SESSION OF THE REGIONAL COMMITTEE**

*Washington, D.C., USA, 30 September-4 October 2013*

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*Provisional Agenda Item 4.2*

Off. Doc. 346 (Eng.)
1 September 2013
ORIGINAL: ENGLISH

## PAHO PROGRAM AND BUDGET 2014-2015*

* Note: This final version contains editorial changes and adjustments to the baselines as well as to the targets of the program area indicators. This note will be removed from the document at the time of its approval during the 52nd Directing Council.

**PAHO PROGRAM AND BUDGET 2014-2015**
**for the 52nd Directing Council**

## Introductory Note for the Directing Council

1. The presentation of Program and Budget 2014-2015 to the52nd Meeting of the Directing Council constitutes the third round of discussions with the Governing Bodies of the Pan American Health Organization (PAHO) within the proposed new PAHO planning framework. The document, along with the Strategic Plan 2014-2019, was discussed as a draft outline with the Member States Countries Consultative Group (CCG) in February 2013 and presented to the Seventh Session of the Subcommittee on Program, Budget, and Administration (SPBA7) in March. Additional sessions with the CCG were held in late April and updated for presentation to the 152nd Executive Committee. Final recommendations from the last CCG in July along with the feedback of the national consultations and the recommendations of the Executive Committee have been incorporated for the draft being presented to the 52nd Directing Council.

2. Both the PAHO Strategic Plan 2014-2019 and the PAHO Program and Budget 2014-2015 have been influenced by the Health Agenda for the Americas 2008-2017; the Country Cooperation Strategies (CCS); current resolutions, including plans and strategies; and the ongoing reform of the World Health Organization (WHO), particularly the WHO 12th General Programme of Work (GPW) 2014-2019 and the WHO Programme Budget 2014-2015. Consequently, and in light of PAHO's effort to maintain programmatic alignment with the WHO, the programmatic structure of both the PAHO Strategic Plan and the Program and Budget mirrors that of the WHO planning documents, with corresponding adjustments where regional specificity is needed.

3. The Program and Budget 2014-2015 is being presented for the consideration of Member States at a realistic level of US$ 563.1 million[*] in base programs. This represents an overall reduction of $50.3 million (8.2%) compared with the 2012-2013 approved budget of $613.4 million, as a result of the continued decline in Voluntary Contribution funding for the Region.

4. The Regular Budget portion of the total budget, which consists of Assessed Contributions from Member States plus Miscellaneous Income, is estimated at $279.1 million. This represents a reduction of $6 million compared to the 2012-2013 Regular Budget, as a result of the reduction in expected Miscellaneous Income.

5. With zero nominal growth in Assessed Contributions for 2014-2015, the Organization will be faced with absorbing an estimated 8.2% cost increase, or

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

approximately $21.4 million. This will challenge the Organization to follow a disciplined approach to cost reduction by seeking greater efficiencies and targeting priority-based reductions in programs in an institutionally responsible manner.

6. The Directing Council is invited to analyze the Program and Budget 2014-2015 and provide the Bureau with its comments, observations, and subsequent approval of the Program and Budget 2014-2015.

# PROGRAM AND BUDGET 2014-2015

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

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# Overview

## PAHO Program and Budget 2014-2015 in the Context of WHO Reform

1. The ongoing World Health Organization (WHO) reform process has significantly impacted both the structure and content of the WHO 12th General Programme of Work (GPW) and its associated Programme Budgets. Consequently, since the Pan American Health Organization (PAHO) maintains programmatic alignment with WHO for its own planning framework, these changes have influenced the PAHO Strategic Plan 2014-2019 (SP 2014-2019) and its Program and Budget 2014-2015 (PB 2014-2015).

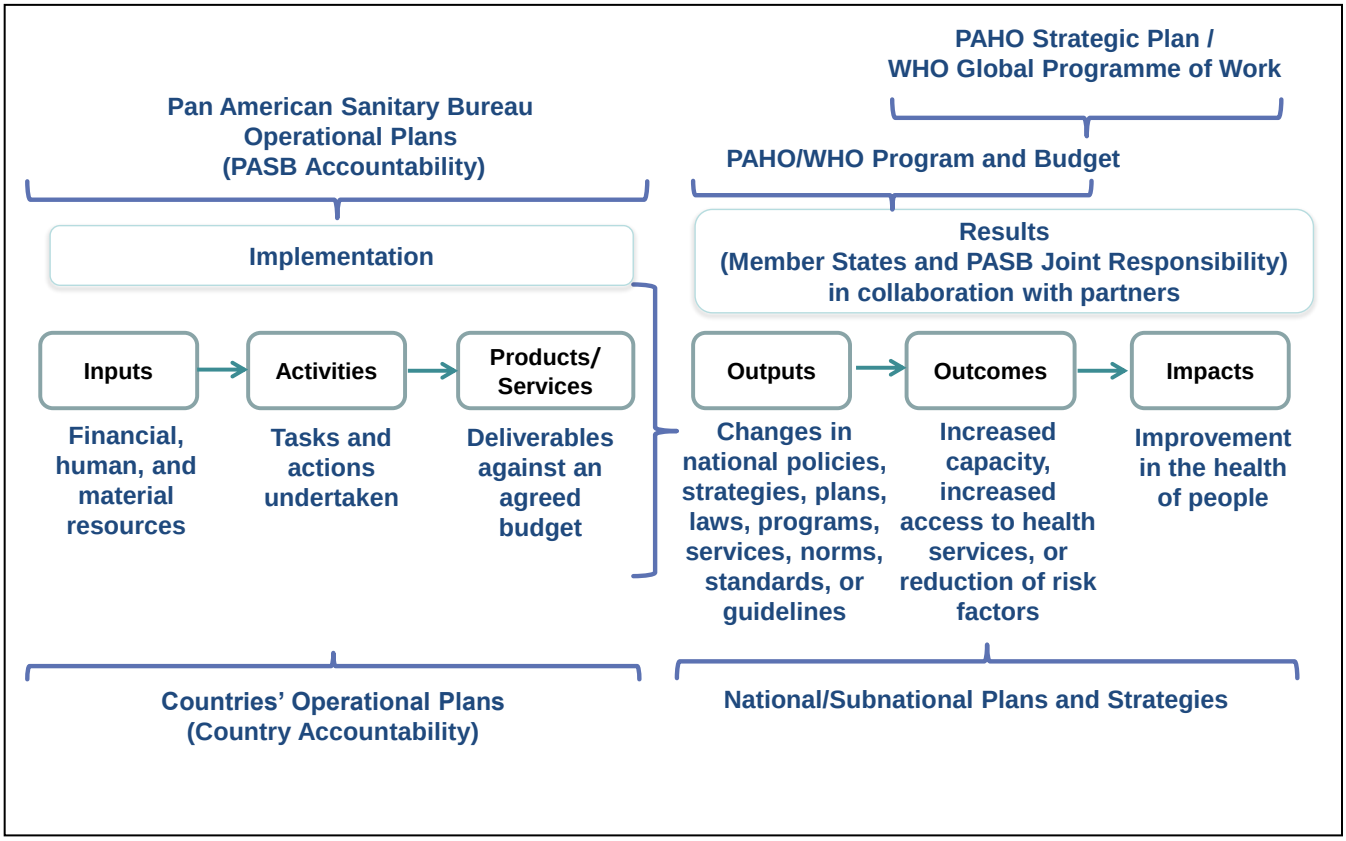
2. The PAHO Program and Budget 2014-2015 is the first to be developed under the new PAHO Strategic Plan 2014-2019. The PB 2014-2015 contains the same programmatic structure as the SP 2014-2019, namely categories, program areas, outcomes, and outcome indicators. In addition, the Program and Budget includes outputs and output indicators designed to articulate the contribution of the Pan American Sanitary Bureau (PASB) to the stated outcomes in the Strategic Plan. The expected achievements in the Program and Budget 2014-2015, in the form of outcome and output indicator targets, cover the two-year period ending on 31 December 2015.

## Results-based Management Framework for Planning, Programming, and Budgeting

3. The implementation of a new results chain is a key element of the WHO reform and brings a greater level of clarity and coherence to the stated outcomes in the WHO GPW. The improved results chain has also been incorporated into the PAHO proposed planning framework and is reflected in the structure of both the Strategic Plan and the Program and Budget. The new results framework links the work of the PASB (outputs) to the health and development changes in the countries to which it contributes (outcomes and impact).

4. Figure 1 illustrates the new results chain for PAHO planning framework which is aligned with WHO's results chain.

**Figure 1. PAHO/WHO Results Chain**




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

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

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

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

9. The PASB **operational plans** include the following components:

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

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

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

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

11. **Risks and Assumptions:** The full results chain is predicated upon a number of risks and assumptions. They include the premise that resources and country collaboration are in place to ensure that interventions contribute to and achieve the outputs and outcomes as outlined in the Plan.

## Programmatic Priorities for PAHO's Technical Cooperation for 2014-2015

12. PAHO's general programmatic direction for the next six-year period has been extensively informed by the WHO reform dialogue. With a view to maintaining programmatic alignment with WHO, PAHO will use the same programmatic structure developed by WHO for the Strategic Plan 2014-2019 and Program and Budget 2014-2015.

13. The programmatic structure consists primarily of the six major categories of work and their program areas, as follows:

(a) *Communicable diseases:* Reducing the burden of communicable diseases, including HIV/AIDS, sexually transmitted infections, and viral hepatitis; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; and vaccine-preventable diseases.

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

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

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

(e) *Preparedness, surveillance, and response:* Reducing mortality, morbidity, and societal disruption resulting from epidemics, disasters, conflicts, and environmental and food-related emergencies by focusing on risk reduction, preparedness, response, and recovery activities that build resilience and use a multisectoral approach to contribute to health security.

(f) *Corporate services/enabling functions:* Fostering and implementing the organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of the Organization, enabling it to deliver effectively on its mandates.

14. The programmatic priorities highlighted for the 2014-2015 biennium will naturally fall within the six categories and related program areas in accordance with the programmatic prioritization framework of the Strategic Plan 2014-2019.

**Funding the Program and Budget**

15. PAHO uses a Results-based Management framework for the development of its biennial Program and Budget. The Program and Budget represents the estimated cost of

achieving the stated outputs under the responsibility of the Bureau that contribute toward attainment of the stated outcomes shared with the Member States, expressed through an integrated budget with multiple funding sources.

16. PAHO receives funding from two major types of resources: *(a)* Assessed Contributions, and *(b)* Voluntary Contributions. These, however, can be further delineated into six distinct funding streams, each with its own origin and characteristics, to show a full view of the funding dynamic of the Organization.

17. The six main sources of funding are as follows:

(a) *The PAHO Regular Budget*, which comprises Assessed Contributions from the PAHO Member States plus estimated Miscellaneous Income.

(b) *The AMRO share of the Regular Budget portion of the approved WHO budget*, which is the portion of the total WHO Regular Budget approved for the Region of the Americas.

(c) *PAHO Voluntary Contributions and special funds*, most of which are institutionally mobilized donor-based resources that are negotiated directly by PAHO and special funds such as the Master Capital Investment Fund, the Holding Account, and the IPSAS Surplus Account.

(d) *The AMRO share of WHO Voluntary Contributions*, derived from donor-based resources negotiated by WHO.

(e) *National Voluntary Contributions*, provided to the PASB for the implementation of national activities in the respective country. This source of funding is fairly unpredictable in nature, in terms of both the level that can be provided during a biennium, and the program areas that the monies address. Consequently, this funding source is shown separately and is not included in the presentation of the budget by base programs. Nevertheless, these funds are encouraged as a means of supplementing the Organization's resources in a given country for furthering the attainment of national priorities.

(f) *Outbreak, Crisis, and Response*, subject to emerging needs of the Region due to natural disasters or catastrophic events.

18. The funding sources described in letters *(a)* and *(b)* represent Assessed Contributions that are flexible in nature and support a program-based approach to funding the Organization's technical cooperation. The funding sources described in letters *(c)* and *(d)*, on the other hand, are predominantly earmarked, or project-based. Earmarked Voluntary Contributions continue to pose a challenge in terms of ensuring alignment between the Organization's planned activities and the actual resources mobilized. To the extent that the Organization can receive increased levels of non-earmarked Voluntary

Contributions, it will become more successful in achieving its intended programmatic targets.

19. The Program and Budget 2014-2015 (base programs) of $563.1 million represents an 8.2% decrease ($50.3 million) compared with the approved budget for 2012-2013. The budget builds on lessons learned from the 2010-2011 biennium assessment and the 2012-2013 midterm assessment, ongoing guidance from Member States, and public health trends. It is considered fiscally responsible, taking into account the global, regional, and country financial contexts. The budget figures presented for consideration by the Directing Council have been updated and reflect the results of the wider consultation with the Member States.

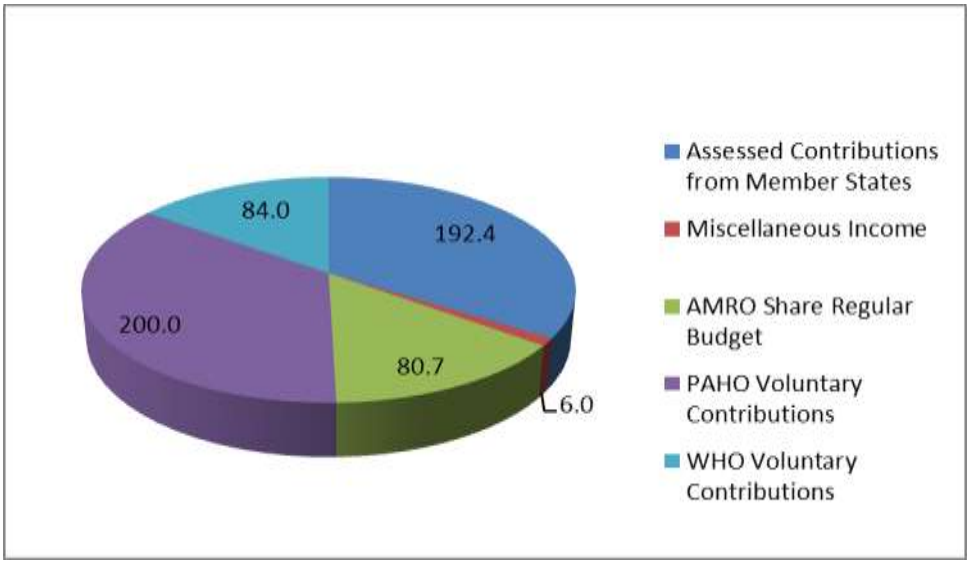
20. Table 1 shows the proposed financing of the 2014-2015 budget and compares the proposed figures with the approved 2012-2013 budget. In addition to the budget segment for base programs, the PB 2014-2015 includes segments for Outbreak and Crisis Response (OCR) and National Voluntary Contributions (NVC). Over the last two biennia OCR has been estimated at $22 million, and it is projected at the same level for the 2014-2015 biennium. With respect to NVCs, current trends show that these will reach or exceed $300 million in the 2012-2013 biennium. Hence, the proposed figures for NVC will mirror the level reached in the current biennium.

**Table 1. Total Budget by Funding Source**

| Regular Budget | 2012-2013 | 2014-2015 | Difference | % Change |
|---|---|---|---|---|
| PAHO Assessed Contributions | 192,400,000 | 192,400,000 | 0 | 0% |
| + PAHO Miscellaneous Income | 12,000,000 | 6,000,000 | (6,000,000) | −50.0% |
| **= Total PAHO Regular Budget** | **204,400,000** | **198,400,000** | (6,000,000) | **−2.9%** |
| + AMRO Assessed Contributions | 80,700,000 | 80,700,000 | 0 | 0% |
| **= Total Regular Budget (A)** | **285,100,000** | **279,100,000** | (6,000,000) | **−2.1%** |
| PAHO Voluntary Contributions | 248,300,000 | 200,000,000 | (48,300,000) | −19.5% |
| + WHO Voluntary Contributions | 80,000,000 | 84,000,000 | 4,000,000 | 5.0% |
| **= Total Voluntary Contributions (B)** | **328,300,000** | **284,000,000** | (44,300,000) | **−13.5%** |
| **Total Base Programs (C)** | **613,400,000** | **563,100,000** | (50,300,000) | **−8.2%** |
| + National Voluntary Contributions (D) | 300,000,000 | 300,000,000 | 0 | 0% |
| + Outbreak and Crisis Response (E) | 22,000,000 | 22,000,000 | 0 | 0% |
| **Estimated Other Sources (F) = (D+E)** | **322,000,000** | **322,000,000** | 0 | **0%** |
| | | | 0 | |
| **= Total Resource Requirements (G) = (C+F)** | **935,400,000** | **885,100,000** | (50,300,000) | **−5.4%** |

**Figure 2. Financing of the Program and Budget by Funding Source**

**(millions of US$)**




21. Details of each of the PB 2014-2015 funding sources are as follows:

(a) *PAHO Assessed Contributions:* During the 2014-2015 biennium, PAHO Assessed Contributions will remain unchanged compared to 2012-2013.

(b) *Miscellaneous Income:* The decrease of $6 million, from $12 million, corresponds to the expected reduction in interest income on PAHO investments as a result of the continued decline of U.S. market interest rates.

(c) *AMRO Regular Budget share:* This budget source refers to the portion of the WHO approved Regular Budget intended for the Region of the Americas. Based on documentation submitted to the 66th World Health Assembly (WHA66), this budget is based on the assumption that the AMRO share will remain at 2012-2013 levels ($80.7 million).

(d) *PAHO Voluntary Contributions:* This funding source is expected to have the largest reduction relative to 2012-2013. Given current and expected funding trends, a 20% reduction is anticipated.

(e) *WHO Voluntary Contributions:* Based on the documentation going forward to the WHA66, this budget source is expected to increase from $80 million to $84 million.

(f) *Total Resource Requirements:* Based on the proposed program and in light of the explanations above, the total resource requirement for the Program and Budget 2014-2015 is estimated at $563.1 million for base programs, an 8.2% decrease with respect to the 2012-2013 approved budget.

22. The budget of $563.1 million will require absorption of costs of approximately $21.4 million from the Regular Budget alone in order to remain at zero *real* growth. With zero nominal growth in Assessed Contributions, there is need for a disciplined approach to cost management to realize greater efficiencies. It is also necessary to identify priority-based reductions in programmatic implementation (sunsetting and re-profiling across the Organization).

23. At a time when further efficiencies and program reductions are being sought to counter real cost increases, it is worth noting that many corporate services and enabling functions (Category 6) keep increasing in cost and are mostly outside the control of the PASB. These are mainly staff-driven and operations-related costs. In addition, increased corporate accountability, risk prevention, and oversight mechanisms imposed on the Organization have contributed to higher management and administrative costs in general. Member States are kindly asked to take note of these circumstances and the limited flexibility that the Organization has in managing these significant costs at a moment of needed cost absorption.

**Implementation of the New PAHO Budget Policy**

24. The new PAHO Budget Policy builds upon the fundamental principles of equity and Pan American solidarity. It also introduces adjustments and new elements in response to the evaluation conducted of the previous policy and in light of the Organization's own lessons learned.

25. Following are the most salient changes reflected in the new Budget Policy:

(a) Needs-based objectivity was improved by including a measurement of inequalities within countries (i.e., Gini coefficient)

(b) Standards for country presence were established and will be protected to ensure that engagement between the Member States and PASB is adequately resourced for all countries.

(c) Results-based objectivity was added to guide resource distribution in order to assist in meeting the agreed programmatic targets of the Strategic Plan.

(d) Modeling logic and statistical techniques were improved to provide for more realistic and workable resource distribution results.

(e) Internal and external assessments will provide valuable input for future iterations of the policy.

26. The result is an improved strategic-managerial instrument that is critical for the effective and optimal distribution of resources in support of the Organization's work. PAHO resources are distributed among the three perspectives embedded within its Program and Budget: *(a)* the categories and program areas, *(b)* functional levels, and *(c)* organizational levels. PAHO will continuously strive—through both internal and external assessments—to achieve and maintain an optimal functional and organizational resource distribution scheme to generate the greatest level of impact in the countries while at the same time effectively responding to collective regional and subregional mandates.

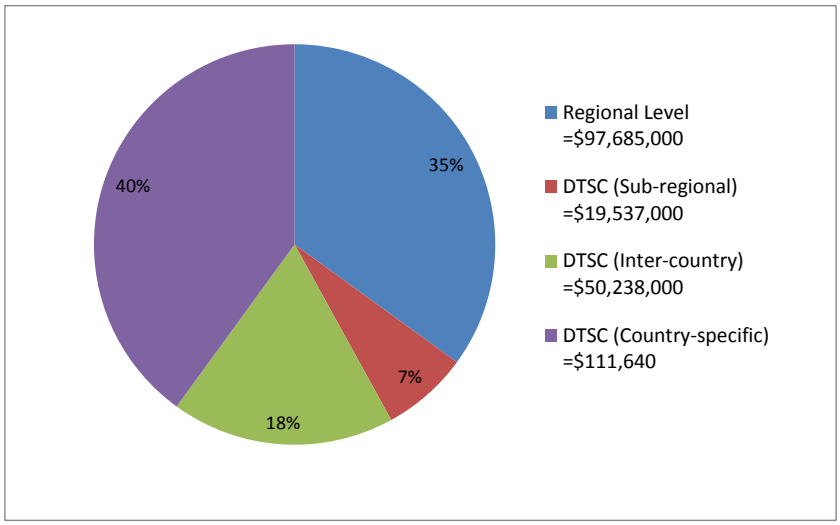
27. The distribution of resources among categories and program areas (Table 2) is typically the first step, as this is a collective expression by the PAHO Governing Bodies of the desired level of investment in the relative health needs of the Region. The funding levels of the categories and program areas set the tone for the Organization's work. The resources will then be distributed internally to the various functional and organizational levels in order to achieve the agreed mandates.

28. The distribution of resources at the functional level will be classified in two major categories: *(a)* direct technical support to countries (DTSC), and *(b)* regional. The first category, direct technical support to countries, will be divided into three types or levels: *(a)* country-specific, *(b)* intercountry, and *(c)* subregional. The initial allocation to the DTSC category will be the current 40% at the country level and will be increased by the amount of intercountry-level and subregional-level programming.

29. The distribution among the functional and organizational levels should be dynamic and responsive to the needs of the Organization. It should allow for budget ceiling adjustments throughout the planning process, taking into account new information and changes in the planning and budgeting environment, while maintaining the objective of improving results in the countries. This approach is considered to be at the heart of the country focus strategy. Over time, evaluation results should guide adjustments in the weighting of resources for these different approaches to the specific work of PAHO.

30. Figure 3 shows the PAHO functional-level structure and the distribution of resources across these levels. Direct technical support to countries totals 65% and includes the country-specific (40%), intercountry (18%), and subregional (7%) levels. The regional level totals 35%. The percentages are tentative and will be updated as the Organization moves forward with its operational planning.

**Figure 3. PAHO Functional-Level Structure**




31. Summary budget tables are provided at the end of each category. They show the Program and Budget 2014-2015 by category and program area.

32. The sections that follow illustrate the programmatic content of the Program and Budget in the new structure by category and program area.

## Budget by Program Area

33. The Program and Budget by category and program area reflects the planned investment required to carry out the two-year program of work. The budget shown for the 2014-2015 biennium is the result of a crosswalk from the former Strategic Objectives and Region-wide Expected Results to the new categories and program areas. The shifts in program areas from 2012-2013 to 2014-2015 take into account the results of the programmatic priorities stratification exercise conducted with Member States, as well as actual and expected funding trends. This stratification exercise grouped all program areas into three priority strata or tiers. The budget also applies a cap on increases in the budget assigned to program areas in tier 1 (20%) and tier 2 (10%), as a mechanism to balance the shifts as the Organization redirects its focus and reflects the decisions of Member States and the direction of technical cooperation for the biennium. At the same time, the reduction to budgets for program areas under tier 3 is also capped at 24%. Annex I provides details about the programmatic priority setting framework.

## Table 2. Budget Summary by Category and Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| **1** | **Communicable diseases** | | | |
| 1.1 | HIV/AIDS and STIs | 6,061,000 | 9,671,000 | 15,732,000 |
| 1.2 | Tuberculosis | 1,500,000 | 2,364,000 | 3,864,000 |
| 1.3 | Malaria and other vector-borne diseases (including dengue and Chagas) | 1,500,000 | 6,043,000 | 7,543,000 |
| 1.4 | Neglected, tropical, and zoonotic diseases | 6,983,000 | 4,497,000 | 11,480,000 |
| 1.5 | Vaccine-preventable diseases (including maintenance of polio eradication) | 5,100,000 | 43,093,000 | 48,193,000 |
| | ***Category 1 Subtotal*** | **21,144,000** | **65,668,000** | **86,812,000** |
| **2** | **Noncommunicable diseases and risk factors** | | | |
| 2.1 | Noncommunicable diseases and risk factors | 12,320,000 | 8,643,000 | 20,963,000 |
| 2.2 | Mental health and psychoactive substance use disorders | 2,344,000 | 915,000 | 3,259,000 |
| 2.3 | Violence and injuries | 1,500,000 | 6,085,000 | 7,585,000 |
| 2.4 | Disabilities and rehabilitation | 1,500,000 | 664,000 | 2,164,000 |
| 2.5 | Nutrition | 6,200,000 | 8,117,000 | 14,317,000 |
| | ***Category 2 Subtotal*** | **23,864,000** | **24,424,000** | **48,288,000** |
| **3** | **Determinants of health and promoting health throughout the life course** | | | |
| 3.1 | Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health | 13,680,000 | 29,059,000 | 42,739,000 |
| 3.2 | Aging and health | 1,500,000 | 181,000 | 1,681,000 |
| 3.3 | Gender, equity, human rights, and ethnicity | 4,759,000 | 3,851,000 | 8,610,000 |
| 3.4 | Social determinants of health | 9,352,000 | 2,203,000 | 11,555,000 |
| 3.5 | Health and the environment | 9,137,000 | 7,061,000 | 16,198,000 |
| | ***Category 3 Subtotal*** | **38,428,000** | **42,355,000** | **80,783,000** |
| **4** | **Health systems** | | | |

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| 4.1 | Health governance and financing; national health policies, strategies, and plans | 7,700,000 | 4,247,000 | 11,947,000 |
| 4.2 | People-centered, integrated, quality health services | 5,711,000 | 7,869,000 | 13,580,000 |
| 4.3 | Access to medical products and strengthening of regulatory capacity | 8,305,000 | 14,596,000 | 22,901,000 |
| 4.4 | Health systems information and evidence | 17,418,000 | 15,439,000 | 32,857,000 |
| 4.5 | Human resources for health | 9,900,000 | 6,289,000 | 16,189,000 |
| | ***Category 4 Subtotal*** | **49,034,000** | **48,440,000** | **97,474,000** |
| **5** | **Preparedness, surveillance, and response** | | | |
| 5.1 | Alert and response capacities (for IHR) | 5,520,000 | 4,334,000 | 9,854,000 |
| 5.2 | Epidemic- and pandemic-prone diseases | 3,720,000 | 4,296,000 | 8,016,000 |
| 5.3 | Emergency risk and crisis management | 6,050,000 | 12,930,000 | 18,980,000 |
| 5.4 | Food safety | 2,680,000 | 6,855,000 | 9,535,000 |
| 5.5 | Outbreak and crisis response | — | — | — |
| | ***Category 5 Subtotal*** | **17,970,000** | **28,415,000** | **46,385,000** |
| | **Subtotal (Categories 1 through 5)** | **150,440,000** | **209,302,000** | **359,742,000** |
| **6** | **Corporate services/enabling functions** | | | |
| 6.1 | Leadership and governance | 54,235,000 | 4,232,000 | 58,467,000 |
| 6.2 | Transparency, accountability, and risk management | 2,790,000 | 2,052,000 | 4,842,000 |
| 6.3 | Strategic planning, resource coordination, and reporting | 21,960,000 | 27,584,000 | 49,544,000 |
| 6.4 | Management and administration | 39,602,000 | 27,830,000 | 67,432,000 |
| | 6.4.1 Special project - PMIS | — | 10,000,000 | 10,000,000 |
| 6.5 | Strategic communications | 10,073,000 | 3,000,000 | 13,073,000 |
| | ***Category 6 Subtotal*** | **128,660,000** | **74,698,000** | **203,358,000** |
| | **Total (Categories 1 through 6)** | **279,100,000** | **284,000,000** | **563,100,000** |

# Category 1 - Communicable Diseases

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

## Scope

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

## Priorities for PAHO Technical Cooperation for the Biennium

### 1.1 HIV/STIs

(a) Implement HIV-related strategies aligned with the four flagships: *(a)* strengthen and expand treatment programs; *(b)* eliminate mother-to-child transmission of HIV and congenital syphilis; *(c)* advocate for policy and priority setting and strengthen outreach to key populations; and *(d)* strengthen health information systems and the analysis and dissemination of information.

(b) Support countries in the development and updating of national strategic plans and guidelines for STI prevention and management.

(c) Support countries in the development of comprehensive national plans for the prevention and control of viral hepatitis, with emphasis on monitoring and surveillance.

### 1.2 Tuberculosis

(a) Improve country capacity in the use of rapid TB diagnostic tools, application of improved laboratory practices, delivery of care for multidrug-resistant tuberculosis (MDR-TB) patients, and integrated community-based management.

(b) Strengthen surveillance systems and increase access to quality first- and second-line drugs.

(c) Adapt TB-related emerging policies and technical guidelines to the national context.

### 1.3 Malaria and Other Vector-borne Diseases

(a) Strengthen efforts to prevent, control, and/or eliminate malaria in areas where it is endemic and prevent reintroduction in malaria free-areas.

(b) Strengthen national capacities in prevention, comprehensive surveillance, patient care, and early detection, preparedness, and control of outbreaks within the framework of the Integrated Management Strategy for Dengue Prevention and Control (IMS-Dengue) and the WHO Global Strategy 2012-2020.

(c) Sustain efforts to eliminate vector-borne Chagas disease and improve the identification, diagnosis, and treatment of infected patients.

### 1.4 Neglected, Tropical, and Zoonotic Diseases

(a) Expand preventive, innovative, and intensified disease management and increase access to essential medicines for neglected, tropical, and zoonotic diseases.

(b) Strengthen national capacity for disease surveillance and the timely monitoring of progress toward certification/verification of the elimination of select neglected, tropical, and zoonotic diseases.

(c) Implement sound strategies for the prevention, control, and elimination of human rabies transmitted by dogs.

(d) Establish and/or strengthen intersectoral coordination mechanisms for managing zoonotic risks, with special focus on marginalized and indigenous populations.

### 1.5 Vaccine-Preventable Diseases

(a) Strengthen national immunization programs to improve access of vulnerable populations to quality vaccination services and achieve >95% coverage in at-risk municipalities.

(b) Sustain efforts to keep the Region free of polio, measles, rubella, and congenital rubella syndrome, with particular emphasis on strengthening surveillance systems.

(c) Build country capacity to generate the necessary evidence to facilitate decision making on the introduction of new vaccines (e.g., rotavirus, pneumococcal conjugate, human papillomavirus), thus accelerating the reduction of morbidity and mortality related to vaccine-preventable diseases.

(d) Identify, secure, and rigorously monitor collections of wild-type polio viruses, destroy remaining stocks, or transfer collections from inadequately secured laboratories to a minimal number of facilities that meet internationally recognized standards for biosafety and biosecurity.

## Program Areas, Outcomes, and Outputs

### 1.1 HIV/AIDS and STIs

| Program Area: HIV/AIDS and STIs | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (Baseline +)** | **Target 2019[++]** |
| OCM 1.1 Increased access to key interventions for HIV and STI prevention and treatment | OCM 1.1.1 | Number of countries and territories that have 80% coverage of antiretroviral therapies (ART) in eligible populations* | 12 ARU, BER, BON, CUB, CUR, DSM, ECU, GUY, PER, SAB, STA, TRT | 21 ARG, CHI, DOR, ELS, HAI, NIC, SAV, TCA, VEN | 28 BAH, BRA, COL, COR, JAM, MEX, PAR |
| | OCM 1.1.2 | Number of countries and territories with at least 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission of HIV | 6 ARU, BER, BON, CUR, SAB, STA | 8 CUB, DOR | 25 ANU, BAR, BLZ, BRA, CAN, COL, CHI, DOM, ELS, GRA, GUY, MEX, PER, SAV, SCN, USA, VEN |
| | OCM 1.1.3 | Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women | 6 ARU, BER, BON, CUR, SAB, STA | 8 CUB, DOR | 24 ANU, BAR, BLZ, CAN, COL CHI, DOM, ELS, GRA, GUY, MEX, PER, SAV, SCN, USA, VEN |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables).

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables).

∗ Eligible populations as of mid-2013 are those HIV+ individuals who have a CD4 count of 350/ml or less. The definition of eligible populations may soon change in light of WHO's recommendation to initiate ART at the threshold of 500 CD4/ml.

| Program Area: HIV/AIDS and STIs | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline+)** |
| OPT 1.1.1<br>Implementation and monitoring of the regional HIV/STI strategy through technical cooperation at the regional and national levels | Number of countries and territories implementing the national HIV/STI strategies in accordance with the regional health sector strategy on HIV/STIs | 9<br>ARU, BER, CUR, DOM, DSM, JAM, SAB, STA, SCN | 28<br>ANG, BOL, BON, BVI, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, MON, PAR, PER, TRT, SUR, VEN |
| OPT 1.1.2<br>Adaptation and implementation of the most up-to-date norms and standards in preventing and treating pediatric and adult HIV infection, integrating HIV and other health programs, and reducing inequities | Number of countries and territories that have adopted/adapted the PAHO/WHO 2013 guidelines on the use of antiretroviral therapies (ART) for the treatment and prevention of HIV infection | 5<br>BER, CUR, DOM, JAM, SCN | 27<br>ARU, BAH, BAR, BOL, BON, COL, DOR, DSM, ECU, ELS, GUT, GUY, HAI, HON, MEX, PAR, PER, SAB, STA, TRT, SUR, VEN |
| OPT 1.1.3<br>Facilitation of development, implementation, and monitoring of national strategies for the prevention and control of sexually transmitted infections | Number of countries and territories that have updated their STI strategy based on global or regional recommendations | 6<br>ARG, BER, COL, CUR, DOM, JAM | 21<br>ARU, BAH, BON, CHI, CUB, DOR, DSM, ELS, GUY, SAB, STA, SCN, TRT, URU, VEN |
| OPT 1.1.4<br>Updating and implementation of national plans of action for the elimination of mother-to-child transmission of HIV and congenital syphilis | Number of countries and territories implementing a national plan of action for the elimination of mother-to-child transmission of HIV and congenital syphilis | 33<br>ANG, ANI, ANU, ARG, ARU, BLZ, BOL, BRA, BVI, CHI, COL, COR, CUB, DOM, DOR, ELS, GUT, GUY, HAI, HON, JAM, MEX, MON, NIC, PAN, PAR, PER, SAL, SAV, SCN, TCA, URU, VEN | 45<br>BAR, BER, BON, CAY, DSM, ECU, GRA, SAB, SUR, STA, TCA, TRT |

## 1.2 Tuberculosis

| Program Area: Tuberculosis | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 1.2<br>Increased number of tuberculosis patients successfully diagnosed and treated | OCM 1.2.1 | Cumulative number of TB bacteriologically confirmed patients successfully treated in programs that have adopted the WHO-recommended strategy since 1995 | 1.34 million | 2.05 million | 2.3 million |
| | OCM 1.2.2 | Annual number of tuberculosis patients with confirmed or presumptive MDR-TB, including rifampicin-resistant cases, placed on MDR-TB treatment worldwide | 3,473 | 3,975 | 4,410 |
| | OCM 1.2.3 | Percentage of new TB patients diagnosed in relation to WHO estimated cases from 1995 to 2011 | 81% | 86% | 90% |

| Program Area: Tuberculosis | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 1.2.1<br>Countries enabled to implement new diagnostic approaches and tools to strengthen TB diagnosis | Number of countries and territories implementing WHO-recommended rapid diagnostic for TB | 13<br>ARG, ARU, BER, BRA, COL, CUR, ECU, ELS, GUT, HAI, JAM, MEX, PER | 28<br>BAH, BOL, BON, BVI, CHI, COR, DOR, DSM, GUY, HON, NIC, PAR, TRT, URU, VEN |
| OPT 1.2.2<br>Policy guidance and technical guidelines updated to strengthen country capacity for early diagnosis and treatment of MDR-TB patients | Number of countries and territories implementing WHO guidelines for early diagnosis and treatment of MDR-TB | 16<br>BER, BRA, COL, CUR, DOM, DOR, ECU, ELS, GUT, HAI, HON, JAM, MEX, PAR, PER, VEN | 28<br>ARG, BAH, BAR, BOL, BON, CHI, COR, CUB, DSM, GUY, NIC, TRT |
| OPT 1.2.3<br>Policy guidance and technical guidelines updated to strengthen country capacity for early diagnosis and treatment of TB-HIV patients | Number of countries and territories implementing WHO guidelines for early diagnosis and treatment of TB-HIV | 23<br>ARG, BER, BOL, BRA, COL, COR, CUR, DOM, DOR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAR, PER, TRT, SUR, VEN | 36<br>ARU, BAH, BAR, BON, CHI, DOM, DSM, ECU, GRA, PAN, SAV, SAL, STA |

## 1.3 Malaria and Other Vector-borne Diseases

| Program Area: Malaria and Other Vector-borne Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 1.3 Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases | OCM 1.3.1 | Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (based on PAHO/WHO recommendations) | 85% | 90% | 95% |
| | OCM 1.3.2 | Number of countries and territories with installed capacity to eliminate malaria | 10 ARG, ARU, BER, COR, CUR, ECU, ELS, JAM, MEX, PAR | 18 BLZ, DSM, ECU, GUT, GUY, NIC, PAN, VEN | 23 BOL, DOR, COL, HAI, HON |
| | OCM 1.3.3 | Number of countries and territories with installed capacity for the management of all dengue cases | 14 BAH, BER, BON, BRA, CUR, COL, ELS, JAM, GUY, MEX, SAB, STA, TRT, VEN | 22 ARG, ARU, DSM, DOR, PAN, PER, PUR, SCN | 30 BOL, COR, DOM, ECU, GUT, HON, NIC, PAR |
| | OCM 1.3.4 | Number of countries and territories where the entire endemic territory or territorial unit has a domestic infestation index (by the main triatomine vector species or by the substitute vector, as the case may be) of less than or equal to 1% | 15 ARG, ARU, BER, BLZ, BOL, BRA, CHI, COR, GUT, HON, MEX, NIC, PAR, PER, URU | 26 BON, CUR, DSM, ECU, ELS, COL, GUY, PAN, SAB, STA, TCA | 31 FRG, JAM, SCN, SUR, VEN |

| Program Area: Malaria and Other Vector-borne Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015** |
| OPT 1.3.1<br>Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy, and monitoring and surveillance | Number of malaria- endemic countries and territories in which an assessment of malaria trends is being undertaken using routine surveillance systems | 19<br>ARU, BLZ, BOL, BRA, COL, COR, CUR, DOR, ECU, ELS, GUT, GUY, HON, MEX, NIC, PAN, PER, SUR, VEN | 24<br>FRG, GUA, HAI, MAR, PAR |
| OPT 1.3.2<br>Updated policy recommendations and strategic and technical guidelines on vector control diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection, and response | Number of malaria-endemic countries and territories that are applying malaria strategies to move toward elimination based on WHO criteria | 8<br>ARG, COR, COL, DOR, ECU, ELS, MEX, PAR | 16<br>BLZ, GUY, GUT, HON, NIC, PAN, PER, VEN |
| OPT 1.3.3<br>Implementation of the new PAHO/WHO dengue classification to improve diagnosis and treatment within the framework of IMS-Dengue and the WHO Global Strategy for 2012-2020 | Number of countries and territories implementing PAHO/WHO-recommended strategies to improve comprehensive dengue epidemiological surveillance and patient management | 16<br>ARG, ARU, BOL, BON, COL, DSM, DOR, CUR, GUT, HON, JAM, MEX, PAN, PER, VEN, VER | 31<br>BAR, BRA, COR, CUR, DOM, ECU, ELS, GUY, NIC, MON, PAR, SAB, SAV, STA, SCN |
| OPT 1.3.4<br>Implementation of the Strategy and Plan of Action for Chagas Disease Prevention, Control and Care | Numbers of countries and territories that have established integrated control programs for Chagas in the endemic territorial units where the transmission is domiciliary | 15<br>ARG, BOL, BLZ, BRA, CHI, COL, COR, ELS, GUT, HON, MEX, NIC, PAR, PER, URU | 21<br>ARU, ECU, GUY, FRG, SUR, VEN |
| OPT 1.3.5<br>Endemic countries enabled to strengthen their coverage and quality of care for patients infected with Trypanosoma cruzi | Number of endemic countries and territories implementing national plans of action to expand coverage and quality of care for patients infected with Trypanosoma cruzi | 11<br>ARG, ARU, BOL, COR, ECU, GUT, HON, MEX, NIC, PAN, URU | 23<br>BAH, BLZ, BRA, CHI, COL, ELS, FRG, GUY, PAR, PER, SUR, VEN |

## 1.4 Neglected, Tropical, and Zoonotic Diseases

| Program Area: Neglected, Tropical, and Zoonotic Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 1.4<br>Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control and/or elimination of neglected, tropical, and zoonotic diseases | OCM 1.4.1 | Number of countries and territories with annual increases in diagnosed cases and etiological treatment as a result of an increase in the quality and coverage of medical attention for human leishmaniasis | 3<br>CUR, DOR, MEX | 11<br>ARU, BRA, COL, GUY NIC, PAN, VEN, TCA | 19<br>ARG, BOL, COR, ELS, GUT, HON, PAR, PER |
| | OCM 1.4.2 | Number of endemic countries and territories with high burden of leprosy that have reduced by 35% the rate of new cases with grade-2 disabilities per 100,000 population as compared to their own baseline 2012 data | 0 | 3<br>COL, CUB, MEX | 10<br>ARG, BOL, BRA, DOR, ECU, PAR, VEN |
| | OCM 1.4.3 | Number of endemic countries and territories having achieved the recommended target coverage of population at risk of lymphatic filariasis | 4<br>ARU, HAI, DOR, SCN | 4<br>- | 6<br>BRA, GUY |
| | OCM 1.4.4 | Number of endemic countries and territories having achieved the recommended target coverage of population at risk of onchocerciasis | 5<br>ARU, BRA, DOR, MEX, SCN | 6<br>COL | 7<br>VEN |
| | OCM 1.4.5 | Number of endemic countries and territories having achieved the recommended target coverage of population at risk of trachoma | 3<br>ARU, MEX, SCN | 5<br>GUT, VEN | 8<br>BRA, COL, DOR |
| | OCM 1.4.6 | Number of endemic countries and territories having achieved the recommended target coverage of population at risk of schistosomiasis | 3<br>ARU, BRA, SCN | 4<br>CUR | 5<br>VEN |

| Program Area: Neglected, Tropical, and Zoonotic Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| | OCM 1.4.7 | Number of endemic countries and territories having achieved the recommended target coverage of population at risk of soil-transmitted helminthes | 8<br>ARU, BLZ, GUY, HAI, MEX, NIC, TRT, SCN | 13<br>DOM, DOR, ELS, GUY, HON | 20<br>BRA, BOL, COL, ECU, PAR, PER, VEN |
| | OCM 1.4.8 | Number of countries and territories with established capacity and effectiveness processes to eliminate human rabies transmitted by dogs | 31<br>ANI, ARG, ARU, BAH, BAR, BER, BLZ, CAN, CHI, COL, COR, CUB, CUR, DOM, ECU, ELS, GRA, HAI, JAM, MEX, NIC, PAN, PAR, SCN, SAL, SAV, SUR, TRT, USA, URU, VEN | 35<br>BRA, HON, PER, GUY | 38<br>BOL, GUT, DOR |

| Program Area: Neglected, Tropical, and Zoonotic Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 1.4.1<br>Implementation and monitoring of the WHO Roadmap for neglected infectious diseases (NIDs) through the Regional NID Plan | Number of endemic countries and territories implementing a national or subnational plan, program, or strategy to reduce the burden of priority NIDs according to their epidemiological status | 8<br>ARG, ARU, BRA, GUY, HAI, HON, MEX, SUR | 17<br>BAH, BON, COL, ELS, CUR, NIC, PAR, PER, VEN |
| OPT 1.4.2<br>Endemic countries enabled to establish integrated surveillance of leishmaniasis in human population | Number of endemic countries and territories that have integrated surveillance of human leishmaniasis | 3<br>ARG, ARU, COL | 13<br>BAH, BRA, COL, CUR, ELS, GUY, NIC, PAN, PER, VEN |
| OPT 1.4.3<br>Implementation of the PAHO/WHO Plan of Action for the Elimination of Leprosy | Number of endemic countries and territories applying PAHO/WHO-recommended strategies for elimination of leprosy as a public health problem at the first subnational administrative level | 20<br>ARU, COL, COR, CUB, CUR, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PER, SAL, SUR, TRT, URU | 26<br>ARG, BAH, BOL, DOR, PAR, VEN |

| Program Area: Neglected, Tropical, and Zoonotic Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 1.4.4<br>Countries enabled to implement plans of action for the prevention, surveillance, control, and elimination of rabies | Number of countries and territories implementing the plans of action to strengthen rabies prevention, prophylaxis, surveillance, control, and elimination | 30<br>ANI, ARG, ARU, BAH, BAR, BER, BLZ, CAN, COR, COL , CHI, CUB, DOM, ECU, ELS, GRA, GUY, JAM, MEX, NIC, PAN, PAR, SCN, SAL, SAV, SUR, TRT, USA, URU, VEN | 39<br>BOL, BRA, CUR, DOR, GUT, HAI, HON, PER, STA |
| OPT 1.4.5<br>Countries enabled to implement plans of action for strengthening zoonotic disease prevention, surveillance, and control programs | Number of countries and territories implementing plans of action to strengthen zoonosis prevention, surveillance, and control programs according to international standards | 6<br>ARG, ARU, CAN, USA, SCN, VEN | 19<br>BER, BON, BRA, COL, CUR, ECU, ELS, GUY, MEX, PAN, PAR, PER, TRT |

## 1.5 Vaccine-Preventable Diseases

| Program Area: Vaccine-Preventable Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 1.5<br>Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases | OCM 1.5.1 | Regional average coverage with three doses of diphtheria, tetanus, and pertussis-containing vaccine | 92% | 93% | 94% |
| | OCM 1.5.2 | Number of countries and territories with reestablishment of endemic transmission of measles and rubella virus | 0 | 0 | 0 |
| | OCM 1.5.3 | Number of countries and territories that have introduced one or more new vaccines | 34<br>ARG, ARU, BAH, BAR, BER, BOL, BON, BRA, CAN, CAY, CHI, COL, COR, CUR, DOR, ECU, ELS, FRG, GUA, GUT, GUY, HON, MAR, MEX, NIC, PAN, PAR, PER, TRT, SAB, STA, URU, USA, VEN | 41<br>ANU, BLZ, CUB, DSM, HAI, JAM, SUR | 51<br>ANI, BVI, DOM, GRA, MON, PUR, SAL, SAV, SCN, TCA |

| Program Area: Vaccine-Preventable Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| | OCM 1.5.4 | Number of countries and territories reporting cases of paralysis due to wild or circulating vaccine-derived poliovirus (cVDPV) in the preceding six months | 0 | 0 | 0 |

| Program Area: Vaccine-preventable Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 1.5.1<br>Implementation of the of the Global Vaccine Action Plan as part of the Decade of Vaccines Collaboration to reach unvaccinated and undervaccinated populations | Number of countries and territories with immunization coverage >95% that are implementing strategies within their national immunization plans to reach unvaccinated and undervaccinated populations | 19<br>ARG, ARU, BER, BOL, COL, CUR, DSM, DOM, DOR, ELS, GUT, GUY, HAI, PAR, PER, SAB, SCN, STA, VEN | 26<br>BAR, CHI, COR, JAM, PAN, SUR, TRT |
| OPT 1.5.2<br>Implementation of the Plan of Action to Maintain the Americas Free of Measles, Rubella, and Congenital Rubella Syndrome | Number of countries and territories implementing the Plan of Action to for Maintaing Measles, Rubella, and Congenital Rubella Syndrome Elimination in the Region of the Americas | 6<br>ARU, BAH, BER, JAM, SAB, SCN | 42<br>ANI, ARG, BAR, BLZ, BOL, BRA, BVI, CAN, CHI, COL, COR, CUB, CUR, DSM, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SAL, SAV, STA, SUR, TRT, URU, USA, VEN |
| OPT 1.5.3<br>Countries enabled to generate evidence on the introduction of new vaccines | Number of countries and territories generating evidence to support decisions on the introduction of new vaccines | 12<br>ARG, BER, BOL, CUR, COL, ELS, JAM, NIC, PER, SAB, STA, TRT | 19<br>ARU, DOM, GUT, GUY, HON, SCN, VEN |
| OPT 1.5.4<br>Maintenance of regional surveillance systems for the monitoring of acute flaccid paralysis (AFP) | Number of countries and territories with a surveillance system upgraded to the Integrated Surveillance Information System for Vaccine-preventable Diseases (ISIS) or creating bridges to the centralized immunization database and the WHO database | 18<br>ARG, BAH, BRA, COR, CUR, COL, DSM, GUT, HAI, HON, JAM, MEX, NIC, PAN, PAR, URU, SCN, VEN | 29<br>ARU, BOL, BON, CHI, DOM, DOR, ELS, GUY, PER, STA, TRT |

| Program Area: Vaccine-preventable Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 1.5.5<br>Countries enabled to implement new algorithms for the isolation and intratypic differentiation of poliovirus with improved performance indicators | Number of countries and territories implementing the new diagnostic algorithms at the national or subnational level | 7<br>ARG, ARU, BRA, COL, JAM, PER, TRT | 15<br>BON, CHI, CUB, GUY, MEX, SAB, STA, VEN |
| OPT 1.5.6<br>Processes established for long-term poliovirus risk management, including containment of all residual poliovirus and the certification of polio eradication in the Region | Number of countries and territories implementing Phase II of the Polio Containment Action Plan | 5<br>ARU, DOM, JAM, PER, SAB | 38<br>ANI, ARG, BAH, BAR, BLZ, BOL, BRA, CAN, CHI, COL, COR, CUB, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, SAL, SAV, SCN, STA, SUR, TRT, USA, URU, VEN |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | **Regular Budget** | **Other Sources** | **Total** |
| **1** | **Communicable diseases** | | | |
| 1.1 | HIV/AIDS and STIs | 6,061,000 | 9,671,000 | 15,732,000 |
| 1.2 | Tuberculosis | 1,500,000 | 2,364,000 | 3,864,000 |
| 1.3 | Malaria and other vector-borne diseases (including dengue and Chagas) | 1,500,000 | 6,043,000 | 7,543,000 |
| 1.4 | Neglected, tropical, and zoonotic diseases | 6,983,000 | 4,497,000 | 11,480,000 |
| 1.5 | Vaccine-preventable diseases (including maintenance of polio eradication) | 5,100,000 | 43,093,000 | 48,193,000 |
| | ***Category 1 Subtotal*** | **21,144,000** | **65,668,000** | **86,812,000** |

## Category 2 - Noncommunicable Diseases

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

### Scope

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

### Priorities for PAHO Technical Cooperation for the Biennium

#### 2.1 Noncommunicable Diseases and Risk Factors

(a) Strengthen national capacities for implementing evidence-based and cost-effective NCD and risk factor policies, programs, and services for primary prevention, screening, early detection, diagnosis, and treatment.

(b) Improve country capacity for surveillance and monitoring of NCDs and risk factors to support reporting on progress toward global and regional commitments on NCDs and risk factors.

#### 2.2 Mental Health and Psychoactive Substance Use Disorders

(a) Strengthen national capacity in the area of mental health and substance use to provide responsive treatment and care and social welfare in community-based services.

(b) Protect and promote the human rights of people with mental health conditions against human rights violations and gender-based discrimination.

### 2.3 Violence and Injuries

(a) Support countries and territories in implementing evidence-based policies and programs for preventing violence and injuries, with focus on road safety and violence against women, children, and youth.

(b) Improve the quality and use of data on violence and injuries for evidence-based policies and programming.

### 2.4 Disabilities and Rehabilitation

(a) Support governments in providing access for people with disabilities to all key services; invest in programming to meet specific identified needs of people with disabilities; and adopt a national disability strategy and plan of action.

(b) Support the development of national eye, ear, and oral health policies, plans, and programs, and strengthen service delivery as part of wider health system capacity building.

### 2.5 Nutrition

(a) Strengthen the evidence base for effective nutrition interventions and the development and evaluation of policies, regulations, and programs; provide the leadership, necessary practical knowledge, and capacities required in order to scale up actions; and promote multisectoral approaches involving key actors such as ministries of education, agriculture, and the environment.

## Program Areas, Outcomes, and Outputs

### 2.1 Noncommunicable Diseases and Risk Factors

| Program Area: Noncommunicable Diseases and Risk Factors | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| OCM 2.1<br>Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors | OCM 2.1.1 | Reduce harmful use of alcohol, as appropriate within the national context* | 8.67 liters/person/ year (2003-2005) | To be determined based on WHO alcohol report 2014 | 7.8 liters/person/year (10% reduction) |
| | OCM 2.1.2 | Prevalence of current tobacco use (15+ years of age) | 21% (2010) | 19% | 17% (to achieve the global target of 30% reduction by 2025) |
| | OCM 2.1.3 | Prevalence of insufficient physical activity | 60% (under review) | 58% | 55% (to achieve the global target of 10% relative reduction) |
| | OCM 2.1.4 | Percentage of persons with controlled hypertension** (<140/90 mmHg) | 15% | 25% | 35% |
| | OCM 2.1.5 | Prevalence of raised blood glucose/diabetes | 18.8% | 18.8% | 18.8% (same level, to contribute to the global target to halt the rise in diabetes and obesity by 2025) |
| | OCM 2.1.6 | Number of countries and territories with a halt in the rise of obesity at current national levels | 3 BER, JAM, MEX | 4 TCA | 11 COR, COL, PER, DOR, SCN, TRT, VEN |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables)

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables).

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

** By measuring the percentage of persons with controlled hypertension, countries will be able to address in a comprehensive manner the first and most prevalent risk factor for NCDs in the Region. Hypertension is a cause of premature mortality from stroke, of cardiovascular diseases, and of disability caused by chronic kidney disease. By using this indicator, the Region will also be able to report to WHO's indicator regarding prevalence of raised blood pressure.

| Program Area: Noncommunicable Diseases and Risk Factors | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| | OCM 2.1.7 | Mean population intake of salt (sodium chloride) | 11.5 grams (2010) | 10 grams | 7 grams (to achieve the global target of 30% relative reduction by 2025) |
| | OCM 2.1.8 | Number of countries and territories with cervical cancer screening coverage of 70% by 2019 among women aged 30-49 years, at least once, or more often and for lower and higher age groups according to national policies | 9 BER, BRA, CAN, CHI, COL, CUB, JAM, SAB, USA | 16 ARG, ARU, COR, MEX, STA, TCA, VEN | 28 BAH, BOL, BON, DOM, DOR, ELS GUA, GUY, HON, PAR, SCN, TRT |
| | OCM 2.1.9 | Number of countries and territories with a prevalence rate of treated end-stage renal disease of at least 700 patients per million population | 10 ARG, ARU, BER, CAN, CHI, CUR, PUR, SAB, URU, USA | 16 BRA, COL, MEX, SCN, TCA, VEN | 25 COR, CUB DOR, ELS, GUT, HON, PAN, PER, TRT |

| Program Area: Noncommunicable Diseases and Risk Factors | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.1.1 Countries enabled to develop national multisectoral policies and plans to prevent and control NCDs and risk factors, pursuant to the regional plan of action on NCDs | Number of countries and territories implementing national multisectoral action plans for the prevention and control of noncommunicable diseases and risk factors | 18 ARG, ARU, BAR, BER, BRA, CAN, CHI, COL, CUB, CUR, ELS, GUT, GUY, JAM, MEX, PER, SUR, USA | 33 ANG, BAH, BLZ, BVI, COR, DOM, DSM, ECU, HON, MON, PAR, SAB, SCN, TCA, TRT |
| OPT 2.1.2 Countries enabled to strengthen evidence-based interventions, regulations, and guidelines for the prevention and control of NCDs and risk factors | Number of countries and territories implementing at least one of the most cost-effective interventions (as defined by WHO) to tackle each of the four major NCDs and four risk factors (total of eight interventions) | 16 ARG, ARU, BER, BRA, CAN, CHI, COL, COR, CUB, CUR, MEX, PER, SCN, URU, USA, VEN | 31 ANG, BAH, BAR, BON, BVI, DOM, DSM, DOR, ECU, GUT, GUY, JAM, MON, SAB, TRT |
| OPT 2.1.3 Countries enabled to strengthen their NCD and risk factor surveillance systems | Number of countries and territories reporting regularly on NCDs and risk factors, including chronic kidney disease (CKD) risk markers | 12 ARG, ARU, BRA, CAN, CHI, COL, COR, JAM, MEX, SCN, TRT, USA | 21 BAH, BAR, BER, BON, ELS, PAN, STA, URU, VEN |

| Program Area: Noncommunicable Diseases and Risk Factors | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.1.4<br>Countries enabled to increase the percentage of persons with hypertension taking blood pressure-lowering medication | Number of countries and territories in which at least 50% of persons with hypertension are taking blood pressure-lowering medication | 12<br>ARG, ARU, BRA, CAN, CHI, CUB, CUR, STA, SAB, TRT, USA, VEN | 21<br>ANG, BER, BON, COL, COR, DSM, MEX, MON, URU |
| OPT 2.1.5<br>Countries enabled to increase the percentage of persons with diabetes taking blood glucose-lowering medications | Number of countries and territories in which at least 50% of persons with diabetes are taking blood glucose-lowering medication | 10<br>ARG, BRA, CAN, CHI, CUB, CUR, SAB, STA, USA, VEN | 17<br>BER, BON, COL, COR, DSM, MEX, URU |
| OPT 2.1.6<br>Implementation of the WHO Framework Convention on Tobacco Control (FCTC) | Number of countries implementing policies, strategies, or laws in line with the FCTC | 6<br>CAN, BER, COL, ECU, JAM, VEN | 19<br>ARU, BAH, BAR, BON, CUB, CUR, DSM, ELS, GUY, HON, SAB, STA, SCN |
| OPT 2.1.7<br>Countries enabled to improve their CKD surveillance | Number of countries and territories with high-quality dialysis and a transplantation registry for CKD cases | 18<br>ARG, ARU, BER, BON, BRA, CHI, CAN, COL, CUB, CUR, GUA, JAM, MEX, PUR, SAB, STA, URU, USA | 31<br>BVI, COR, DOR, ECU, GUY, HON, NIC, PAN, PER, SCN, VEN |

## 2.2 Mental Health and Psychoactive Substance Use Disorders

| Program Area: Mental Health and Psychoactive Substance Use Disorders | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 2.2<br>Increased service coverage for mental health and psychoactive substance use disorders | OCM 2.2.1 | Number of countries and territories that have increased the rate of users treated through mental health outpatient and substance abuse treatment facilities above the regional average of 975/100,000 population | 19<br>ARG, BLZ, BOL, BON, BRA, BVI, CHI, COR, CUB, DOM, HAI, JAM, PAN, SAB, SCN, SUR, URU, USA, VEN | 25<br>ARU, BER, CUR, STA, TCA, MEX | 30<br>COL, ELS, HON, PER TRT |

| Program Area: Mental Health and Psychoactive Substance Use Disorders | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.2.1<br>Countries enabled to develop and implement national policies and plans in line with the Regional Strategy on Mental Health and the Global Mental Health Action Plan 2013-2020 | Number of countries and territories that have a national policy or plan for mental health in line with the Regional Strategy on Mental Health and the Global Mental Health Action Plan 2013-2020 | 22<br>ARG, BAR, BOL, BRA, COR, COL, CUB, CUR, DOM, DOR, ECU, ELS, GUT, GUY, MEX, NIC, PER, PAN, SAB, SAL, URU, VEN<br>(policies or plans reviewed after 2002) | 38<br>ANI, ARU, BAH, BER, BON, CHI, DSM, HON, JAM, MON, PAR, SAV, SCN, STA, SUR, TRT |
| OPT 2.2.2<br>Countries enabled to integrate a mental health component into primary health care using the Mental Health Global Action Plan Intervention Guide | Number of countries and territories that have established a program to integrate mental health into primary health care using the Mental Health Global Action Plan Intervention Guide | 10<br>ARG, BLZ, BRA, CHI, CUB, HON, PAN, PER, SAB, VEN | 29<br>ARU, BAH, BAR, BER, BON, BVI, COR, CUR, DSM, DOR, ECU, ELS, GUT, GUY, JAM, PAR, SCN, STA, TRT |
| OPT 2.2.3<br>Countries enabled to expand and strengthen strategies, systems, and interventions for disorders due to alcohol and substance abuse | Number of countries and territories with a national alcohol policy or plan for the prevention and treatment of alcohol use disorders in line with the Regional Plan of Action/Global Strategy to Reduce the Harmful Use of Alcohol | 9<br>ARG, BRA, COL, CUB, CUR, PAR, PER, SAB, VEN | 20<br>ARU, BAH, BER, BON, COL, DOM, DOR, ECU, ELS, MEX, STA |

## 2.3 Violence and Injuries

| Program Area: Violence and Injuries | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 2.3<br>Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth | OCM 2.3.1 | Number of countries and territories with at least 70% use of seat belts by all passengers* | 4<br>CAN, COR, SCN, USA<br>(2013 WHO report) | 6<br>COL, ECU | 7<br>ARG |
| | OCM 2.3.2 | Number of countries and territories that use a public health perspective in an integrated approach to violence prevention | 6<br>ARG, BRA, CAN, JAM, USA, VEN | 10<br>ELS, MEX, SCN, TRT | 17<br>BAH, BER, COL, DOR, HON, NIC, PER |

*Indicator to be reviewed when the global indicator is defined by WHO.

| Program Area: Violence and Injuries | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.3.1<br>Countries enabled to develop and implement multisectoral plans and programs to prevent injuries, with focus on achieving the targets set under the Decade of Action for Road Safety 2011-2020 | Number of countries and territories implementing comprehensive laws on reducing risk factors for road traffic injuries (speed and drunk driving) and increasing protective factors (helmets, seatbelts, and child restraints) | 8<br>ARU, CAN, BER, CUB, ECU, GUY, SCN, VEN | 18<br>ARG, BON, BRA, CHI, COL, ELS, JAM, SAB, STA, URU |
| OPT 2.3.2<br>Countries and partners enabled to assess and improve national policies and programs on integrated violence prevention, including violence against women, children, and youth | Number of countries and territories implementing national policies, plans, or programs on violence prevention that include evidence-based public health interventions | 2<br>ARG, BRA | 12<br>ARU, BER, BON, ELS, JAM, MEX, SAB, STA, TRT, VEN |
| OPT 2.3.3<br>Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines | Number of countries and territories with a national protocol in place for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines | 5<br>ARG, GUY, PER, COL, SCN | 15<br>ARU, BAH, BER, BOL, BON, DSM, ELS, SAB, STA, VEN |

## 2.4 Disabilities and Rehabilitation

| Program Area: Disabilities and Rehabilitation | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 2.4<br>Increased access to social and health services for people with disabilities, including prevention | OCM 2.4.1 | Number of countries and territories reaching 12% access to social and health services for people with disabilities, developed as part of the global plan of action on disability | 3<br>ECU, TRT, SAB | 12<br>ARG, BON, BRA, CHI, CUB, DSM, MEX, STA, VEN | 24<br>BER, BOL, COL, COR, DOR, ELS, HON, GUT, PER, SCN, TCA, URU |
| | OCM 2.4.2 | Number of countries and territories reaching cataract surgical rate of 2,000/million population/year | 19<br>ARG, ARU, BAH, BAR, BRA, CAN, CHI, COR, CUB, CUR, DOM, MEX, SAB, SAL, STA, TRT, URU, USA, VEN | 22<br>BON, ELS, PAN | 27<br>COL, NIC, PER, SCN, TCA |

| Program Area: Disabilities and Rehabilitation | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.4.1<br>Implementation of the recommendations of the World Report on Disability and the United Nations General Assembly High-Level Meeting on Disability and Development | Number of countries and territories implementing comprehensive programs on health and rehabilitation pursuant to the World Report on Disability and the United Nations High-Level Meeting on Disability and Development | 9<br>BRA, CHI, COL, CUB, CUR, ECU, PER, SAB, VEN | 18<br>ARG, ARU, BER, BON, COL, ELS, HON, MEX, STA |
| OPT 2.4.2<br>Countries enabled to implement more effective policies and provide integrated services to reduce disability due to visual impairment and hearing loss | Number of countries and territories implementing eye and ear health policies and services in line with PAHO/WHO recommendations | 26<br>ARG, BAR, BLZ, BRA, COL, COR, CHI, CUB, DOM, ECU, ELS, GRA, GUT, GUY, JAM, MEX, NIC, PAN, PAR, PER, SAB, SAL, SAV, SCN, USA, VEN | 34<br>ARU, BER, BON, DOR, STA, TRT, SUR |

## 2.5 Nutrition

| Program Area: Nutrition | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 2.5<br>Nutritional risk factors reduced | OCM 2.5.1 | Percentage of children less than 5 years of age who are stunted | 13.5% (2010) | 10.5% | 7.5% |
| | OCM 2.5.2 | Percentage of women of reproductive age (15-49 years) with anemia | 22.5% (2010) | 20% | 18% |
| | OCM 2.5.3 | Percentage of children less than 5 years of age who are overweight | 6.9% (2009) | 7% | 7% |

| Program Area: Nutrition | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.5.1<br>Countries enabled to develop, implement, and monitor their action plans based on the global Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition | Number of countries and territories implementing national action plans based on the Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition | 5<br>ARG, COL, CUB, VEN, SCN | 16<br>BER, BOL, BON, DSM, ELS, GUY, JAM, NIC, SAB, STA, TRT |

| Program Area: Nutrition | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 2.5.2<br>Updated norms and standards on maternal, infant, and young child nutrition, population dietary goals, and breastfeeding; policy options provided for effective nutrition actions for stunting, wasting, and anemia | Number of countries and territories implementing effective nutrition actions for stunting, wasting, and anemia, and overweight according to the national context | 8<br>ARG, BRA, CHI, COL, COR, CUR, MEX, PER | 22<br>BER, BON, CUB, ECU, ELS, GUT, GUY, HON, JAM, NIC, SAB, STA, SCN, VEN |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | **Regular Budget** | **Other Sources** | **Total** |
| **2** | **Noncommunicable Diseases** | | | |
| 2.1 | Noncommunicable diseases and risk factors | 12,320,000 | 8,643,000 | 20,963,000 |
| 2.2 | Mental health and psychoactive substance use disorders | 2,344,000 | 915,000 | 3,259,000 |
| 2.3 | Violence and injuries | 1,500,000 | 6,085,000 | 7,585,000 |
| 2.4 | Disabilities and rehabilitation | 1,500,000 | 664,000 | 2,164,000 |
| 2.5 | Nutrition | 6,200,000 | 8,117,000 | 14,317,000 |
| | ***Category 2 Subtotal*** | **23,864,000** | **24,424,000** | **48,288,000** |

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

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

### Scope

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

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

### Priorities for PAHO Technical Cooperation for the Biennium

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

Mandates from the Governing Bodies to fulfill regional plans on maternal, newborn, child, adolescent, and adult health are guiding priorities for the biennium 2014-2015 and beyond. To address these priorities, this program area will target the improvement of strategic information; implement guidelines and standards to

enhance the quality of health services; and conduct capacity building in human resources, with emphasis on primary health care (PHC) and obstetric emergencies. Furthermore, a core priority will be to revise policies and legislation to facilitate universal access in health and build and strengthen strategic alliances.

### 3.2 Aging and Health

This program area will emphasize implementation of the regional Plan of Action on the Health of Older Persons and will focus specifically on the following priorities: promoting integration of the health of older persons into national public policies; adapting health systems to respond to the challenges associated with aging; retraining human resources in primary health care and public health to deal with issues of aging; and building the information capabilities necessary in order to implement and evaluate interventions in the area of aging and health.

### 3.3 Gender, Equity, Human Rights, and Ethnicity

This program area has the following priorities: developing inter-programmatic plans, policies, and laws on gender, equity, human rights, and ethnicity; maintaining and expanding training modalities on gender, equity, human rights, and ethnicity; generating and publishing technical documents on gender, equity, human rights, and ethnicity; completing the final evaluation of the current Plan of Action for Implementing the Gender Equality Policy; developing a new Plan of Action 2015-2019; and finalizing a regional strategy on ethnicity.

### 3.4 Social Determinants of Health

The priorities for this program area will be to implement the Rio Political Declaration on Social Determinants of Health adopted by the Member States in Rio de Janeiro, Brazil, in October 2011. This effort will entail strengthening governance through partnerships with different sectors of society to address the stark inequities seen in the Region with concrete actions and consensus-based public policies; integrating the social determinants of health within health sector programs; and developing a standard set of indicators to monitor action on the social determinants of health.

### 3.5 Health and the Environment

Guided by the large body of global and regional commitments, agreements, and mandates on issues pertaining to environmental/occupational health, the priorities in this area are *(a)* to increase institutional capacities, including professional competencies in environmental and occupational health risks and health impact assessment, in monitoring health-related inequalities, and *(b)* to generate policies that are informed and evidence-based.

## Program Areas, Outcomes, and Outputs

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

| Program Area: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicators** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| OCM 3.1 Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults | OCM 3.1.1 | Percentage of unmet need for modern family planning methods | 44% | 35% | 25% |
| | OCM 3.1.2 | Percentage of live births attended by skilled health personnel | 95% | 97% | 99% |
| | OCM 3.1.3 | Percentage of mothers and newborns receiving postnatal care within seven days of childbirth | 40% | 55% | 65% |
| | OCM 3.1.4 | Percentage of infants under 6 months of age who are exclusively breastfed | 43.8% | 49% | 54% |
| | OCM 3.1.5 | Percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics | To be determined * | To be determined | To be determined |
| | OCM 3.1.6 | Specific fertility rate in women 15-19 years of age** | 60 | 55 | 52 |
| | OCM 3.1.7 | Number of countries and territories increasing access and coverage of medical occupational evaluations for working adult populations (18-65 years of age) | 3 ARG, CHI, COL | 6 To be confirmed | 10 To be confirmed |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables).

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables).

* Based on WHO 2014 survey.

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

| Program Area: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 3.1.1<br>Implementation of the regional Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity and the Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care | Number of countries and territories implementing an integrated plan for maternal and perinatal mortality in line with regional plans of action on maternal mortality and neonatal health | 7<br>ARG, COL, CUB, ELS, GUY, SAB, VEN | 26<br>ARU, BAH, BOL, BON, BVI, CUR, DOM, DOR, GUT, HAI, HON, JAM, MEX, NIC, PAR, TRT, STA, SCN, SUR |
| OPT 3.1.2<br>Implementation of the regional Strategy and Plan of Action for Integrated Child Health, with emphasis on the most vulnerable | Number of countries and territories implementing a national integrated child health policy/strategy or plan consistent with legal frameworks and regulations | 8<br>ARG, ARU, COL, CUB, CUR, GUY, SAB, VEN | 15<br>BON, ELS, HON, JAM, STA, SCN, TRT |
| OPT 3.1.3<br>Implementation of the global Strategy for Sexual and Reproductive Health, focusing on addressing unmet needs | Number of countries and territories implementing WHO/PAHO guidelines on family planning | 13<br>ARU, BRA, COL, COR, CUB, CUR, DOR, ELS, PAR, PER, SAB, URU, VEN | 25<br>ARG, BLZ, BON, DSM, GUT, JAM, NIC, PAN, STA, SCN, SUR, TRT |
| OPT 3.1.4<br>Research undertaken and evidence generated and synthesized to design key interventions in reproductive, maternal, newborn, child, adolescent, and adult health, and other related conditions and issues | Number of studies conducted to inform the design of new or improved interventions for reproductive, maternal, newborn, child, adolescent, and adult health | 2<br>COL, GUY | 10<br>BON, CUR, DSM, ELS, SAB, STA, SCN, VEN |
| OPT 3.1.5<br>Implementation of the regional Plan of Action on Adolescent and Youth Health | Number of countries and territories implementing national health-related policies or plans on comprehensive adolescent health | 16<br>ARG, ARU, BRA, CHI, COR, CUB, DOR, ECU, ELS, GUY, MEX, NIC, PER, SAB, URU, VEN | 30<br>BAR, BOL, BON, BVI, COL, CUR, DSM, GUT, HAI, HON, STA, SCN, SUR, TRT |

## 3.2 Aging and Health

| Program Area: Aging and Health | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicators** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 3.2<br>Increased access to interventions for older adults to maintain an independent life | OCM 3.2.1 | Number of countries and territories with increased access to integrated community service and self-care programs for older adults | 7<br>CHI, COR, CUB, CUR, MEX, SAB, USA | 12<br>ARG, BON, ELS, COL, SCN | 18<br>DOM, HON, PER, STA, TRT, VEN |

| Program Area: Aging and Health | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 3.2.1<br>Implementation of the regional Plan of Action on the Health of Older Persons, including strategies to promote active and healthy aging | Number of countries and territories that have incorporated strategies to promote active and healthy aging or access to an integrated continuum of care in their national plans | 11<br>ARU, BRA, CAN, CHI, COR, CUB, CUR, DSM, SAB, USA, VEN | 22<br>ARG, BAR, BON, BVI, DOM, ELS, MON, JAM, STA, SCN, TRT |
| OPT 3.2.2<br>Countries enabled to assess and address the health needs of older persons for improved care | Number of countries and territories monitoring and quantifying the diverse health needs of older people, pursuant to WHO-recommended measures and models | 8<br>ARU, CAN, CHI, COL, COR, CUB, CUR, USA | 18<br>ARG, BON, BRA, ELS, JAM, MON, SAB, STA, SCN, VEN |
| OPT 3.2.3<br>Countries enabled to implement policies and plans focusing on the health of women beyond reproductive age | Number of countries and territories implementing national health-related policies, legislation, or plans on the health of women beyond reproductive age | 0<br>To be confirmed | 5<br>To be confirmed |

## 3.3 Gender, Equity, Human Rights, and Ethnicity

| Program Area: Gender, Equity, Human Rights, and Ethnicity | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 3.3<br>Increased country capacity to integrate gender, equity, human rights, and ethnicity in health | OCM 3.3.1 | Number of countries and territories with an institutional response to inequities in health (gender and ethnicity) and human rights | 32<br>ANU, ARG, ARU, BAR, BLZ, BOL, BON, BRA, BVI, CAN, CHI, COL, COR, CUR, DSM, DOR, ECU, ELS, GUT, GUY, HON, MEX, MON, NIC, PAN, PAR, SAB, SUR, STA, TRT, USA, VEN | 36<br>BAH, CUB, PER, HAI | 39<br>SAL, SCN, URU |

| Program Area: Gender, Equity, Human Rights, and Ethnicity | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 3.3.1<br>Gender, equity, human rights, and ethnicity integrated into PAHO programs | Proportion of PASB entities integrating gender, equity, human rights, and ethnicity into operational planning | Data not currently measured | 80% |
| OPT 3.3.2<br>Countries enabled to implement and monitor health policies/plans that address gender equality | Number of countries and territories and territories implementing health policies or plans that address gender equality | 17<br>BAR, BLZ, BOL, COL, COR, CUR, DOR, ELS, GUT, GUY, HON, NIC, PAN, PAR, SAB, SUR, VEN | 26<br>ARG, BON, DSM, ECU, HAI, URU, PER, STA, TRT |
| OPT 3.3.3<br>Countries enabled to implement health policies/plans and/or laws to address human rights | Number of countries and territories using human rights norms and standards to formulate policies, plans, or legislation | 26<br>ANU, ANG, ARG, ARU, BAH, BAR, BLZ, BOL, BON, BVI, COL, CHI, CUR, DOR, DSM, ELS, GUT, GUY, HON, MON, NIC, PAN, PAR, SAB, SCN, VEN | 33<br>ECU, HAI, SAL, JAM, PER, STA, TRT |
| OPT 3.3.4<br>Countries enabled to implement health policies/plans to address equity in health | Number of countries and territories implementing health policies/plans or laws that address health equity | 14<br>ARG, ARU, BRA, BON, CAN, CHI, COL, COR, CUR, ELS, MEX, SAB, STA, VEN | 23<br>BAR, BOL, CUB, DSM, DOR, JAM, PAR, PER, TRT |
| OPT 3.3.5<br>Countries enabled to implement health policies/plans and/or laws to address ethnicity | Number of countries and territories implementing health policies/plans or laws for ethnic/racial populations | 15<br>ARG, ARU, BOL, BRA, BON, CAN, COL, CUR, ECU, GUT, GUY, PAN, PAR, SAB, VEN | 22<br>DSM, ELS, HON, MEX, PER, STA, SUR |

## 3.4 Social Determinants of Health

| Program Area: Social Determinants of Health | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicators** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 3.4 Increased leadership of the health sector in addressing the social determinants of health | OCM 3.4.1 | Number of countries and territories implementing at least two of the five pillars of the Rio Political Declaration on Social Determinants of Health | 6 ARG, BON, BRA, CHI, COR, VEN | 13 BAH, BOL, CUB, ELS, MEX, PAN, TCA | 27 BAR, BLZ, COL, DOM, DOR, ECU, GUY, GUT, NIC, PER, SAB, STA, SUR, TRT |
| | OCM 3.4.2 | Number of countries and territories that have reoriented their health sector to address health inequities | 13 ARG, ARU, BON, BRA, CAN, CHI, COR, COL, DOR, MEX, NIC, SAB, VEN | 18 BAH, BOL, CUB, DSM, TCA | 26 BLZ, ELS, GUY, PAN, PER, SCN, STA, TRT |

| Program Area: Social Determinants of Health | | | |
|---|---|---|---|
| **Output** | **Output Indicators** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 3.4.1 Implementation of the WHO Health in All Policies Framework for Country Action, including intersectoral action and social participation to address the social determinants of health | Number of countries and territories implementing the Health in All Policies Framework for Country Action | 6 ARG, ARU, BRA, CHI, COL, VEN | 18 BON, BVI, COR, CUB, DSM, ECU, ELS, MEX, PAN, SAB, STA, TRT |
| OPT 3.4.2 Countries enabled to generate equity profiles to address the social determinants of health | Number of countries and territories producing equity profiles that address at least two social determinants of health | 1 ARU | 18 ARG, BRA, BON, COL, COR, CUR, ECU, ELS, HON, MEX, NIC, PAN, PER, SAB, STA, TRT, VEN |
| OPT 3.4.3 Countries enabled to scale up local experiences using health promotion strategies to reduce health inequity and enhance community participation and empowerment | Number of countries and territories implementing health promotion strategies to reduce health inequities and increase community participation | 9 ARU, BRA, COL, COR, CUR, ECU, MEX, PAN, VEN | 18 BLZ, CUB, DOR, ELS, PAR, PER, SAB, STA, TRT |
| OPT 3.4.4 Countries enabled to address health in the post-2015 development agenda, responding to the social determinants of health | Number of countries and territories integrating health in the post-2015 development agenda into their national planning processes | 8 ARG, BRA, ECU, ELS, DSM, GUT, PER, SAL | 16 COR, CUR, HON, MEX, PAN, SAB, STA, VEN |

## 3.5 Health and the Environment

| Program Area: Health and the Environment | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicators** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 3.5 Reduced environmental and occupational threats to health | OCM 3.5.1 | Number of countries and territories that have reduced the gap between urban and rural populations' access to quality-controlled water according to WHO guidelines | 14 ARG, ARU, BAR, CAN, COL, CUR, DSM, JAM, SAB, SAV, SCN, TCA, URU, VEN | 18 COR, DOR, STA, TRT | 27 BOL, ELS, GUT, GUY, HAI, HON, MEX, NIC, PER |
| | OCM 3.5.2 | Proportion of the population with access to improved sanitation | 88% | 90% | 92% |
| | OCM 3.5.3 | Number of countries and territories in which the proportion of population relying on solid fuels is reduced | 22 ANI, ARG, ARU, BAH, BAR, BON, CAN, DOR, DOM, DSM, ECU, GRA, JAM, SAB, SAL, SAV, STA, SCN, TRT, URU, USA, VEN | 24 GUT, ECU | 29 COL, ELS, HAI, NIC, PER |
| | OCM 3.5.4 | Number of countries and territories with capacity to address workers' (occupational) health with emphasis on critical economic sectors and occupational diseases | 11 ARG, BON, BRA, CAN, COL, CUR, MEX, PER, SAB, STA, USA | 14 ARU, DOR, VEN | 24 BAH, DOM, DSM, ELS, GUY, HON, JAM, SCN, TCA, TRT |
| | OCM 3.5.5 | Number of countries and territories with capacity to address environmental health | 11 ARG, BON, BRA, CAN, COL, CUR, MEX, PER, SAB, STA, USA | 14 ARU, DOR, VEN | 24 BAH, DOM, DSM, ELS, GUY, HON, JAM, SCN, TCA, TRT |

| Program Area: Health and the Environment | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 3.5.1<br>Countries enabled to strengthen their capacity to assess health risks and develop and implement policies, strategies, and regulations for the prevention, mitigation, and management of the health impact of environmental risks | Number of countries and territories with national monitoring systems to assess health risks and inequities resulting from inadequate water and sanitation | 9<br>ARG, BRA, COL, CUR, DOM, MEX, TRT, USA, VEN | 18<br>ANG, BON, BVI, ELS, MON, JAM, PER, SAB, STA |
| OPT 3.5.2<br>Countries enabled to develop and implement norms, standards, and guidelines for environmental health risks and benefits associated with air quality and chemical safety | Number of countries and territories with national air quality standards based on WHO guidelines and public health services on chemical safety | 17<br>ARG, BRA, CHI, COL, COR, CUR, DOM, JAM, MEX, NIC, PAN, PER, PUR, STA, USA, VEN | 21<br>BON, ECU, SAB, TRT |
| OPT 3.5.3<br>Countries enabled to develop and implement national policies, legislation, plans, and programs on workers' health | Number of countries and territories with an occupational carcinogen exposure (CAREX) matrix and national information systems on occupational injuries and diseases | 8<br>COL, CHI, COR, ELS, MEX, PER, STA, VEN | 11<br>BON, CUR, TRT |
| OPT 3.5.4<br>Implementation of the PAHO/WHO Strategy and Plan of Action on Climate Change | Number of countries and territories implementing the PAHO/WHO Strategy and Plan of Action on Climate Change | 2<br>COL, STA | 8<br>BON, DOM, CUR, ELS, HON, VEN |
| OPT 3.5.5<br>Countries enabled to develop and implement national policies, plans, or programs to reduce the use of solid fuels for cooking | Number of countries implementing large-scale programs to replace inefficient cook stoves with cleaner models that comply with WHO indoor air quality guidelines | 1<br>BRA | 3<br>GUT, COL |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| **3** | **Determinants of health and promoting health throughout the life course** | | | |
| 3.1 | Women, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health | 13,680,000 | 29,059,000 | 42,739,000 |
| 3.2 | Aging and health | 1,500,000 | 181,000 | 1,681,000 |
| 3.3 | Gender, equity, human rights, and ethnicity | 4,759,000 | 3,851,000 | 8,610,000 |
| 3.4 | Social determinants of health | 9,352,000 | 2,203,000 | 11,555,000 |
| 3.5 | Health and the environment | 9,137,000 | 7,061,000 | 16,198,000 |
| | ***Category 3 Subtotal*** | **38,428,000** | **42,355,000** | **80,783,000** |

# Category 4 - Health Systems

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

## Scope

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

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

## Priorities for PAHO Technical Cooperation for the Biennium

40. PASB will work with the Member States on championing UHC and enabling countries to achieve it through the identification of evidence-based policy options, through documentation and dissemination of country best practices using a variety of platforms, and through the development of methodologies and tools for the areas below.

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

During 2014-2015, this program area will support countries in the strengthening of health systems with a focus on governance for social protection in health. It will do so through the revision of national health strategies and plans, including the

financing component, in a manner that is consistent with the progressive realization of UHC. PASB will also help strengthen legislative and regulatory frameworks and increase financial protection to guarantee the right to health. Country capacity to institutionalize the tracking of financial resources for health will be improved. Furthermore, PASB will work to support the monitoring and evaluation of health systems and service indicators related to UHC and equity.

### 4.2 People-Centered, Integrated, Quality Health Services

During the 2014-2015 biennium, this program area will focus on increasing access to people-centered, integrated services. This will be done through support for implementation of the Integrated Health Service Delivery Networks (IHSDNs) initiative and the Regional Agenda for Hospitals in IHSDNs, which ultimately will help to strengthen systems based on primary health care. Another key priority will be the implementation of quality care and patient safety plans and programs.

### 4.3 Access to Medical Products and Strengthening of Regulatory Capacity

The priority in this program area will be to promote access to and rational use of safe, effective, and quality medicines, medical products, and health technologies. Support will be provided for the development, implementation, monitoring, and evaluation of national policies on access, quality, and use of medicines and other health technologies. In addition, cooperation for the strengthening of country regulatory capacity will be provided. Another key priority will be implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. Finally, this program area will support the development of processes and mechanisms for assessment, incorporation, management, and rational use of health technologies.

### 4.4 Health Systems Information and Evidence

Health information is a key input, supporting all aspects of health action, such as research, planning, operation, surveillance, monitoring, and evaluation, as well as prioritization and decision making. However, disparities remain between the countries regarding coverage, reliability, timeliness, and quality of the information being provided by health information systems. There are also differences between countries regarding capacities to understand the causes of problems, the best available options for addressing them, and the strategies for implementing interventions that are effective and efficient. Also, analytical skills and standards for the production and use of research for health vary between populations. Improving the living conditions of the population and reducing inequities in health outcomes require strengthening the capacity for health situation analysis, improving evidence generation and sharing, and translation/application of the results in public health practice. Scientific evidence and other forms of knowledge, such as health information, and their integration into decision-making processes

(e.g., evidence-based health care, evidence-informed policy making) at all levels of the health system are key inputs. PASB will maintain its work developing guidelines and tools, producing multilingual and multiformat information products, enabling sustainable access to up-to-date scientific and technical knowledge by PASB staff and national health care professionals, empowering patients through reliable information, managing and supporting knowledge networks, translating evidence into policies and practices, and promoting the appropriate use of information and communication technologies. Health information is considered a basic right of people. A more active role in the generation and dissemination of evidence will better guide the actions aimed at improving health status.

### 4.5 Human Resources for Health

This program area will focus its work on the development and implementation of human resources for health (HRH) policies and plans in order to advance toward UHC and address current and future health needs of the population. Technical guidance will be provided to countries to improve the performance, working conditions, job satisfaction, and stability of their health workforce. Another key priority is to work with academic health institutions to support the reorientation of health science education programs toward PHC. Finally, support will be provided to countries to develop and implement innovative strategies to improve the public health, managerial, and clinical health workforce.

## Program Areas, Outcomes, and Outputs

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

| Program Area: Health Governance and Financing; National Health Policies, Strategies, and Plans | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| OCM 4.1 Increased national capacity for achieving universal health coverage | OCM 4.1.1 | Number of countries and territories that have increased health coverage through social protection mechanisms | 16<br>ARG, ARU, BON, BRA, CHI, COL, COR, CUR, DOR, ELS, MEX, SAB, STA, TRT, URU, VEN | 22<br>BAH, ECU, HAI, GUY, JAM, SCN | 28<br>BOL, DSM, HON, PER, PAR, TCA |
| | OCM 4.1.2 | Number of countries and | 16<br>ANG, ARG, ARU, | 26<br>ANU, BAR, | 34<br>COL, DOM, |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables).

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables).

| Program Area: Health Governance and Financing; National Health Policies, Strategies, and Plans | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| | | territories committing at least 5% of gross domestic product (GDP) to public expenditure for health | BAH, BER, BON, CAN, CHI, CUB, CUR, DSM, MON, SAB, STA, TRT, USA | COR, ECU, ELS, NIC, PAR, SCN, TCA, URU | DOR, GUY HON, PAN, PER, VEN |

| Program Area: Health Governance and Financing; National Health Policies, Strategies, and Plans | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.1.1<br>Countries enabled to develop comprehensive national health policies, strategies, and/or plans, including UHC | Number of countries and territories that have a national health sector plan or strategy with defined goals/targets revised within the last five years | 17<br>BAH, BRA, CAN, COL, CUB, CUR, ECU, ELS, DOM, GUY, JAM, PER, TRT, SAL, SCN, USA, VEN | 29<br>ARG, BON, BVI, CHI, DOR, DSM, MEX, MON, SAB, STA, TCA, URU |
| OPT 4.1.2<br>Countries enabled to develop and implement financial frameworks for health | Number of countries and territories that have financial strategies for UHC | 10<br>BON, BRA, CAN, CHI, COL, CUB, ECU, MEX, SAB, VEN | 23<br>ANG, BAH, BOL, COR, CUR, DOR, ELS, DSM, PAR, PER, STA, SCN, TRT |
| OPT 4.1.3<br>Countries enabled to develop and implement legislative and regulatory frameworks for UHC | Number of countries and territories that have legislative or regulatory frameworks to support UHC | 12<br>BAH, BRA, CAN, COL, CUB, CUR, DOR, PER, SAB, STA, URU, VEN | 19<br>BOL, BON, DSM, ECU, ELS, GUT, PAN |
| OPT 4.1.4<br>Countries enabled to monitor and evaluate health systems and service indicators related to UHC and equity | Number of countries and territories that have conducted studies to monitor and evaluate their health systems and service indicators related to UHC and equity | 8<br>BRA, CAN, CHI, COL, CUR, DOR, JAM, MEX | 17<br>BAH, BON, COR, ELS, GUT, PER, SAB, SCN, VEN |

## 4.2 People-Centered, Integrated, Quality Health Services

| Program Area: People-Centered, Integrated, Quality Health Services | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 4.2<br>Increased access to people-centered, integrated, quality health services | OCM 4.2.1 | Number of countries and territories with increased utilization of first-level care services after implementation of new people-centered model of care | 16<br>ARG, BRA, BOL, CAN, CHI, COR, CUR, ELS, HAI, MEX, NIC, PAN, PER, SAB, STA, VEN | 28<br>ARU, BAH, DSM, ECU, GUT, GUY, HAI, PAR, TCA, TRT, URU, USA | 35<br>BON, DOR, JAM, PER, SAL, SCN, SUR |

| Program Area: People-Centered, Integrated, Quality Health Services | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.2.1<br>Policy options, tools, and technical guidance provided to countries to enhance equitable people-centered, integrated service delivery and strengthening of public health approaches | Number of countries and territories implementing integrated service delivery network strategies | 13<br>ARG, BRA, CAN, CHI, COL, COR, CUB, ELS, PAR, URU, SAB, USA, VEN | 26<br>BAH, BOL, BON, BVI, CUR, DOR, GUY, HON, PAN, SAL, SCN, SUR, TRT |
| OPT 4.2.2<br>Countries enabled to improve quality of care and patient safety in accordance with PAHO/WHO guidelines | Number of countries and territories implementing national strategies and/or plans for quality of care and patient safety | 12<br>ARG, BON, BRA, CHI, COL, COR, CUB, MEX, PER, SAB, STA, TRT | 24<br>BAH, BOL, BVI, CUR, DOR, ELS, GUY, JAM, PAN, PAR, SCN, VEN |

## 4.3 Access to Medical Products and Strengthening of Regulatory Capacity

| Program Area: Access to Medical Products and Strengthening of Regulatory Capacity | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 4.3<br>Improved access to and rational use of safe, effective, and quality medicines, medical products, and health technologies | OCM 4.3.1 | Number of countries and territories that have improved financial protection mechanisms ensuring access to medicines included in the national essential medicines list | 25<br>ANI, ARG, ARU, BAR, BON, BRA, COR, COL, CUB, CUR, DOM, DOR, ECU, ELS, GUY, HON, JAM, MEX, NIC, PAN, PER, SAB, STA, TRT, VEN | 28<br>BOL, SUR, URU | 35<br>BAH, CHI, DSM, GUT, HAI, PAR, TCA |
| | OCM 4.3.2 | Number of countries and territories that have increased their regulatory capacity toward achieving the status of functional regulatory authority of medicines and other health technologies | 11<br>ARG, BON, BRA, COL, CUB, CUR, HAI, MEX, SAB, STA, USA | 24<br>BAH, CHI, COR, DOR, ECU, ELS, GUY, JAM, NIC, PAN, PER, TRT, VEN | 33<br>BOL, DOM, GUT, HON, PAR, SCN, SUR, TCA, URU |

| Program Area: Access to Medical Products and Strengthening of Regulatory Capacity | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.3.1<br>Countries enabled to develop/update, implement, monitor, and evaluate national policies for better access to medicines and other health technologies | Number of countries and territories with national policies on access, quality, and use of medicines and other health technologies updated within the last five years | 17<br>ARG, BAR, BOL, BON, BRA, CHI, COL, CUR, DOR, MEX, NIC, PAN, PAR, SAB, STA, SUR, VEN | 28<br>BAH, BVI, COR, ECU, ELS, DOM, HAI, HON, SCN, TRT, URU |
| OPT 4.3.2<br>Implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property | Number of countries and territories reporting access and innovation indicators through the PAHO Regional Platform on Access and Innovation for Health Technologies (PRAIS) Observatory | 5<br>ARG, BAR, COL, DOR, PAN | 21<br>BOL, BON, BVI, CUR, DOM, ELS, GUT, PER, SAB, SAL, SAV, SCN, STA, SUR, TRT, URU |
| OPT 4.3.3<br>Countries enabled to assess their national regulatory capacity for medicines and other health technologies | Number of countries and territories having conducted an assessment of their regulatory functions for at least two of the following: medicines, medical devices, radiation safety, blood safety, and organ transplantations | 12<br>ARG, BRA, COL, CUB, CUR, ELS, MEX, SAB, SCN, STA, USA, VEN | 26<br>BAH, BON, BVI, CHI, COR, DOR, ECU, GUY, HAI, JAM, NIC, PAN, PER, TRT |
| OPT 4.3.4<br>Countries enabled to implement processes and mechanisms for health technologies assessment, incorporation, and management, and for rational use of medicines and other health technologies | Number of countries and territories with mechanisms for health technologies assessment and evidence-based incorporation, selection, management, and rational use of medicines and other health technologies | 9<br>ARG, BRA, CAN, COL, ECU, MEX, SAB, STA, URU | 27<br>BAH, BAR, BOL, BON, CHI, COR, CUB, CUR, DOR, ECU, ELS, HAI, JAM, NIC, PAN, PAR, PER, VEN |

## 4.4 Health Systems Information and Evidence

| Program Area: Health Systems Information and Evidence | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 4.4<br>All countries have functioning health information and health research systems | OCM 4.4.1 | Number of countries and territories that have increased coverage and improved quality of their national health information system | 17<br>ARG, BRA, CAN, CHI, COL, DOR, ECU, ELS, GUT, HAI, MEX, NIC, PAN, PAR, PER, SAB, USA | 30<br>ARU, BLZ, BON, COR, CUB, CUR, DSM, ECU, STA, TCA, TRT, URU, VEN | 46<br>ANG,ANI, ANU, BAH, BOL, BVI, DOM, GRA, GUY, HON, JAM, MON, SAL, SAV, SCN, SUR |

| Program Area: Health Systems Information and Evidence | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| | OCM 4.4.2 | Number of countries and territories with functional mechanism for governance of health research | 8<br>ARG, ARU, BAH, BRA, COL, MEX, PER, STA | 17<br>CHI, COR, CUR, ECU, ELS, PAN, SAB, TCA, TRT | 26<br>BOL, DOM, DOR, GUT, GUY, HON, JAM, PAR, VEN |

| Program Area: Health Systems Information and Evidence | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.4.1<br>Countries enabled to comply with comprehensive monitoring of the regional and country health situation, trends, and determinants | Number of countries and territories monitoring the health situation, trends, and determinants biennially | 9<br>ARG, BRA, CAN, COL, CUB, ECU, MEX, USA, VEN | 23<br>BON, COL, CUR, DOM, DSM, ELS, GUT, JAM, NIC, PAR, SAB, STA, TRT, SUR |
| OPT 4.4.2<br>Implementation of the regional Strategy and Plan of Action on eHealth | Number of countries and territories implementing an eHealth strategy | 9<br>BLZ, BRA, CHI, COL, MEX, PAN, PAR, URU, USA | 28<br>ARG, ARU, BAH, BAR, BON, BVI, COR, CUR, DSM, DOR, ELS, GUT, JAM, PER, SAB, SUR, STA, TRT, VEN |
| OPT 4.4.3<br>Implementation of the regional knowledge management strategy | Number of countries and territories implementing the regional knowledge management strategy | 6<br>ARG, COL, COR, ELS, GUY, PAN | 13<br>BLZ, BRA, DOR, JAM, MEX, SAB, STA |
| OPT 4.4.4<br>Implementation of the regional Policy on Research for Health (CD49/10) | Number of countries and territories implementing the regional Policy on Research for Health | 13<br>ARG, BRA, CAN, CHI, COL, DOR, ECU, GUT, GUY, JAM, PAR, SCN, TRT | 41<br>BER, BLZ, BOL, BON, CAY, COR, CUB, CUR, ELS, DSM, DOR, FRG, GRA, GUA, HON, MAR, MEX, NIC, PAN, PER, PUR, SAB, SAL, STA, SUR, URU, USA, VEN |
| OPT 4.4.5<br>Countries enabled to strengthen their capacity to generate and apply scientific evidence | Number of countries and territories integrating scientific evidence into practice, programs, or policies using standardized methodologies | 11<br>ARG, BRA, CHI, COL, COR, ECU, PAR, PER, TRT, MEX, GUT | 16<br>BOL, CUB, ELS, PAN, NIC |
| OPT 4.4.6<br>Countries enabled to address priority ethical issues related to public health and research for health | Number of countries and territories with accountability mechanisms to review research or incorporate ethics into public health | 8<br>BAH, BRA, COL, DOR, MEX, PER, SCN, VEN | 20<br>ARG, BOL, BON, BVI, CHI, CUR, ELS, JAM, PAN, SAB, STA, TRT |

| Program Area: Health Systems Information and Evidence | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.4.7<br>PAHO Core Health Data and Country Profile Initiative expanded to effectively monitor the SP 2014-2019 | Proportion of outcome indicators of the SP 2014-2019 being reported through the Core Health Data and Country Profile Initiative | (10% of indicators in Core Health Data) | To be determined |

## 4.5 Human Resources for Health

| Program Area: Human Resources for Health | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 4.5<br>Adequate availability of a competent, culturally appropriate, well regulated, well distributed, and fairly treated health workforce | OCM 4.5.1 | Number of countries and territories not facing health workforce shortages | 24<br>ANU, ARG, BAH, BAR, BRA, CAN, CAY, CHI, COR, CUB, DSM, FRG, GRA, GUA, MAR, MEX, MON, PAN, SAL, SUR, TRT, USA, URU, VEN | 31<br>BLZ, COL, DOM, ECU, PAR, PER, SCN | 33<br>DOR, ELS |
| | OCM 4.5.2 | Number of countries and territories with 100% of primary health care workers having demonstrable public health and intercultural competencies | 7<br>BON, COR, CUB, GRA, NIC, SAB, SAL | 16<br>BLZ, BRA, GUT, HON, PAN, PER, STA, TCA, TRT | 27<br>ARG, CHI, CUR, COL, DSM, DOR, ECU, ELS, JAM, MEX, VEN |
| | OCM 4.5.3 | Number of countries and territories that have reduced by half the gap in distribution of health personnel between urban and rural | 12<br>ARG, ARU, BAR, CHI, DOM, JAM, MON, NIC, SAB, SAL, SCN, TRT | 16<br>ANI, ELS, PAN, TCA | 24<br>BLZ, BOL, COL, ECU, GRA, PAR, PER, VEN |

| Program Area: Human Resources for Health | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 4.5.1<br>Countries enabled to develop and implement HRH policy and/or plans to achieve UHC and address current and future health needs of their population | Number of countries and territories with an HRH action plan aligned with the policies and needs of their health care delivery system | 11<br>ANG, ARG, BVI, BRA, CAN, CHI, COR, CUB, ELS, MON, URU | 24<br>BAH, BON, COL, CUR, DSM, DOR, ECU, PER, STA, SCN, TRT, USA, VEN |
| OPT 4.5.2<br>Countries enabled to improve the performance, working conditions, job satisfaction, and stability of their health workforce in agreement with the WHO Global Code of Practice on the International Recruitment of Health Personnel | Number of countries and territories with a comprehensive legal framework that ensures appropriate treatment of health workers | 16<br>ARG, ARU, BAH, BON, BRA, CAN, CHI, COL, COR, CUB, CUR, SAB, TRT, URU, USA, VEN | 21<br>ECU, ELS, DOR, PER, STA |
| OPT 4.5.3<br>Technical guidance being provided to academic health institutions and programs for health science education oriented toward primary health care | Number of academic curricula reoriented toward primary health care | 4<br>BON, DOR, SAB, STA | 9<br>BAH, JAM, SCN, TRT, VEN |
| OPT 4.5.4<br>Countries and territories enabled to develop and implement innovative strategies to improve the public health, managerial, and clinical health workforce | Number of countries and territories that have established a node of the Virtual Campus for Public Health or equivalent e-learning network | 13<br>ARG, BRA, CHI, COL, COR, CUB, CUR, ECU, MEX, PAR, PUR, TRT, URU | 39<br>ABM, ANI, ARU, BAH, BAR, BER, BOL, BON, CAY, DSM, DOM, DOR, ELS, GRA, GUY, HON, JAM, MON, PER, SAB, SAL, SAV, SCN, STA, TCA, VEN |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| **4** | **Health systems** | | | |
| 4.1 | Health governance and financing; national health policies, strategies, and plans | 7,700,000 | 4,247,000 | 11,947,000 |
| 4.2 | People-centered, integrated, quality health services | 5,711,000 | 7,869,000 | 13,580,000 |
| 4.3 | Access to medical products and strengthening of regulatory capacity | 8,305,000 | 14,596,000 | 22,901,000 |
| 4.4 | Health systems information and evidence | 17,418,000 | 15,439,000 | 32,857,000 |
| 4.5 | Human resources for health | 9,900,000 | 6,289,000 | 16,189,000 |
| | ***Category 4 Subtotal*** | **49,034,000** | **48,440,000** | **97,474,000** |

## Category 5 - Preparedness, Surveillance, and Response

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

### Scope

41. This category focuses on strengthening countries' 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. Particular attention is given to capacities that come under the requirements of the International Health Regulations (IHR) 2005. Work in this category aims to strengthen hazard-specific capacity building in relation to a range of diseases with the potential to cause outbreaks, epidemics, or pandemics, and also in relation to food safety-related events, zoonoses, antimicrobial resistance, chemical and radiologic emergencies, natural hazards, and conflicts. It considers the human security approach to building coherent intersectoral policies to protect and empower people to increase community resilience against critical and pervasive threats. In addition, this category includes adequate and coordinated international health assistance to help Member States respond to emergencies when required.

### Priorities for PAHO Technical Cooperation for the Biennium

42. During the biennium, emphasis will be placed on the expansion and integration of a comprehensive, efficient, and effective multihazard approach to emergency risk management within the PASB, the Member States, and the international health community.

43. The PASB's technical cooperation for the development of comprehensive national policies and plans for health emergency risk management will integrate the essential elements for building resilience and protecting populations, considering their social gradient vulnerabilities and the principles of the human security approach. Accordingly, a set of criteria and reference standards will be developed to guide countries and the PASB on the actions required in order to meet or exceed minimum capacities to manage public health risks associated with emergencies, with special focus on populations in situation of greatest vulnerability.

44. Emphasis will be placed on the use of existing and new health partnerships and disaster management networks within and external to the health sector, fostering intercountry collaboration and building on country-specific experiences and capacities.

Efforts will also be redoubled to increase political awareness concerning the relevance of infection prevention and control programs within the framework of IHR core capacities, as well as the prevention of exposure to contaminants through the food chain and the safety of new technologies.

45. The PASB will continue to build its internal capacity to efficiently assist countries in the management of acute public health threats. It will further improve its coordinated response mechanisms, when required, including strengthening the event management system and ensuring its operational capacity at all times.

### 5.1 Alert and Response Capacities

(a) Activities will focus on support of country efforts to comply with the commitment and obligation to attain core capacities and establish mechanisms to maintain them, as stipulated in the IHR 2005, and on continued cooperation with those countries that do not attain the core capacities by June 2014.

(b) PAHO, as the regional contact point for the IHR, will continue to develop its regional ability to provide evidence-based and timely policy guidance, risk assessment, information management, and communication for all acute public health events and coordinate the regional response to outbreaks.

### 5.2 Epidemic- and Pandemic-Prone Diseases

(a) The focus of this program area during the biennium will be on improving the sharing of knowledge and information available on emerging and reemerging infectious diseases, enhancing surveillance and response to epidemic diseases, and networking to contribute to global mechanisms and processes, in accordance with IHR provisions.

(b) PAHO will support countries in developing and maintaining the relevant components of their multihazard national preparedness plans for responding to major epidemics, including epidemiological surveillance, laboratory strengthening and networking, guidance for case management and infection control, and intersectoral coordination to address the needs of marginalized populations and those in situations of vulnerability.

### 5.3 Emergency Risk and Crisis Management

(a) Emphasis will be placed on strengthening the national leadership roles of preparedness, monitoring, and response within the ministries of health; promoting the adoption of benchmarks for disaster preparedness; and strengthening PAHO response capacity.

(b) PAHO will promote coordination, monitoring, and implementation of the Plan of Action on Safe Hospitals through the integration of actions by the PAHO program areas in order to reduce the health consequences of emergencies, disasters, and crises and ease their social and economic impact, especially on populations in situations of greatest vulnerability.

### 5.4 Food Safety

(a) PAHO will enable countries to establish efficient food safety systems to prevent and reduce foodborne diseases and promote consumer safety. PAHO will work toward the strengthening of risk-based integrated national food safety systems, increase the scientific advice and implementation of food safety standards and guidelines, and promote cross-sectoral collaboration for reducing foodborne risks, including those arising from the human-animal interface.

### 5.5 Outbreak and Crisis Response

(a) During the biennium, the PASB will support countries in establishing efficient and effective response teams and adapted tools for coordination of international humanitarian assistance in the health sector. Additionally, the Organization will enhance its own capacity to respond based on the Institutional Response to Emergencies and Disasters policy and fully perform all its functions as a health cluster lead agency.

## Program Areas, Outcomes, and Outputs

### 5.1 Alert and Response Capacities (for IHR)

| Program Area: Alert and Response Capacities | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| OCM 5.1<br>All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response | OCM 5.1.1 | Number of countries and territories meeting and sustaining IHR 2005 requirements for core capacities* | 6<br>BRA, CAN, CHI, COL, COR, USA | 16<br>ARG, BAH, CUB, DOM, ELS, GUY, MEX, SAV, SCN, URU | 35<br>ANI, BAR, BLZ, BOL, DOR, ECU, GRA, GUT, HAI, HON, JAM, NIC, PAN, PAR, PER, SAL, SUR, TRT, VEN |

| Program Area: Alert and Response Capacities (for IHR) | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.1.1<br>Countries enabled to develop the core capacities required under the International Health Regulations (2005) | Number of countries provided with direct technical cooperation that enabled them to meet and sustain IHR core capacities within the biennium* | 3<br>BRA, COL, COR | 12<br>ARG, BRA, CHI, CUB, DOM, ELS, MEX, SAV, URU |
| OPT 5.1.2<br>PAHO has the capacity to provide evidence-based and timely policy guidance, risk assessment, information management, and communications for all acute public health emergencies | Proportion of public health emergencies of international concern for which information is made available to IHR National Focal Points in the Region within the first 48 hours of completing the risk assessment | 40% | 80% |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables).

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables)

* The denominator for this indicator is 35 States Parties to the IHR.

## 5.2 Epidemic- and Pandemic-Prone Diseases

| Program Area: Epidemic- and Pandemic-Prone Diseases | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 5.2<br>All countries are able to build resilience and adequate preparedness to mount a rapid, predictable, and effective response to major epidemics and pandemics | OCM 5.2.1 | Number of countries and territories with installed capacity to effectively respond to major epidemics and pandemics | 9<br>ARG, BRA, CAN, CHI, COL, COR, CUR, SCN, USA | 21<br>ARU, BAH, CUB, DOM, ELS, JAM, MEX, SAB, SAV, STA, TCA, URU | 43<br>ANI, BAR, BON, BLZ, BOL, CHI, DSM, DOR, ECU, GRA, GUT, GUY, HAI, HON, NIC, PAN, PAR, PER, SAL, SUR, TRT, VEN |

| Program Area: Epidemic- and Pandemic-Prone Diseases | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.2.1<br>Countries enabled to develop and implement operational plans in line with WHO recommendations on strengthening national resilience and preparedness to cover pandemic influenza and epidemic and emerging diseases | Number of countries and territories implementing a national preparedness plan for major epidemics and pandemics | 15<br>ARG, ARU, BAH, BAR, BRA, CAN, CHI, COL, COR, CUR, DOR, SCN, TRT, USA, VEN | 28<br>BON, BVI, CUB, DSM, DOM, ELS, HON, JAM, MEX, SAB, SAV, STA, URU |
| OPT 5.2.2<br>Countries with improved disease control, prevention, treatment, surveillance, risk assessment, and risk communications | Number of countries and territories with a surveillance system for influenza based on international standards | 24<br>ARG, ARU, BAR, BOL, BON, BRA, CAN, CHI, COL, COR, CUR, DSM, DOM, DOR, HON, JAM, MEX, PAR, SAL, SAV, SCN, SUR, TRT, USA | 36<br>ANG, BAH, BLZ, CUB, ECU, ELS, GUY, PAN, SAB, STA, URU, VEN |
| OPT 5.2.3<br>Mechanisms in place to strengthen country capacity for risk management of emerging zoonotic diseases | Number of countries and territories with risk management mechanisms for emerging zoonotic diseases | 10<br>ARG, BRA, CAN, CHI, COL, COR, CUB, DOM, URU, USA | 28<br>DOM, BON, CUB, CUR, DOR, ECU, ELS, GUY, JAM, MEX, PAN, PAR, SAB, SAV, STA, SCN, TRT, VEN |

## 5.3 Emergency Risk and Crisis Management

| Program Area: Emergency Risk and Crisis Management | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 5.3 Countries have an all-hazards health emergency risk management program for a disaster-resilient health sector, with emphasis on vulnerable populations | OCM 5.3.1 | Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies addressing vulnerable communities | 16 ARG, ARU, BON, BRA, CAN, CHI, CUR, ECU, FRG, GUA, GUT, MAR, MEX, NIC, PER, USA | 31 BAR, BOL, COR, COL, DOR, DSM, ELS, GUY, JAM, PAN, SAB, TCA, TRT, URU, VEN | 43 ANI, BAH, BLZ, CUR, DOM, GRA, HON, SAL, SAV, SCN, STA, SUR |
| | OCM 5.3.2 | Number of countries and territories implementing disaster risk reduction interventions in the health sector that increase community resilience | 14 ARG, BAR, BON, CAN, CHI, COL, DOR, ECU, ELS, GUT, MEX, NIC, PER, USA | 26 ARU, BOL, COR, CUB, DSM, HAI, JAM, PAN, SCN, STA, TCA, TRT | 41 ANI, BLZ, BRA, CUR, DOM, GRA, GUY, HON, PAR, SAB, SAL, SAV, SUR, URU, VEN |

| Program Area: Emergency Risk and Crisis Management | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.3.1 Country health clusters reformed in line with the Transformative Agenda of the Inter-Agency Standing Committee | Number of countries and territories with a health emergency coordination mechanism that meets minimum requirements for satisfactory performance | 3 BAR, COL, TRT | 17 ARG, CHI, CUR, DOR, ELS, GUY, HAI, JAM, MEX, MON, PER, SAB, SCN, STA |
| OPT 5.3.2 Health established as a central component of global multisectoral frameworks for emergency and disaster risk management; national capacities strengthened for all-hazard Emergency and Disaster Risk Management for Health (ERMH) | Number of countries and territories conducting an ERMH capacity assessment | 1 COL | 23 BAH, BAR, BER, BVI, CHI, DOM, DOR, ELS, FRG, GUA, GUY, HAI, JAM, MAR, MEX, PER, SAB, SAL, STA, SCN, TRT, VEN |
| OPT 5.3.3 Mechanisms in place to ensure organizational readiness to fully implement the WHO Emergency Response Framework (ERF) and PAHO Institutional Response to Emergencies and Disasters | Number of PAHO/WHO offices fully complying with WHO readiness checklist | Data not currently measured | 15 ARG, BAH, BRA, CHI, COL, ECC, ECU, ELS, HAI, JAM, PAN, PER, MEX, SAB, VEN |

| Program Area: Emergency Risk and Crisis Management | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.3.4<br>Development, implementation, and reporting on health sector strategy and planning in all targeted protracted-emergency countries by an in-country network of qualified and trained PAHO emergency staff | Percentage of protracted-emergency countries meeting PAHO performance standards | Data not currently measured | 70% |
| OPT 5.3.5<br>Implementation of the Plan of Action on Safe Hospitals, in accordance with specific national priorities and needs | Number of countries and territories with a safe hospitals program to ensure continuity of health services for the population in need | 17<br>BOL, CHI, COL, COR, CUB, DOR, ECU, ELS, GUT, MEX, PAN, PAR, PER, SAB, TRT, USA, VEN | 36<br>ANG, ARG, ARU, BAH, BAR, BLZ, BON, BRA, BVI, CUR, CAY, DSM, DOM, FRG, GRA, GUA, HON, MAR, SCN |

## 5.4 Food Safety

| Program Area: Food Safety | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 5.4<br>All countries have the capacity to mitigate risks to food safety and respond to outbreaks | OCM 5.4.1 | Number of countries and territories that have adequate mechanisms in place for preventing or mitigating risks to food safety and for responding to outbreaks, including among marginalized populations | 7<br>BON, CAN, CHI, COL, CUR, USA, VEN | 16<br>ARG, ARU, ELS, GUY, PAN, PAR, PER, STA, TRT | 20<br>COR, DOR, HON, SAB |

| Program Area: Food Safety | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.4.1<br>Countries enabled to implement the Codex Alimentarius Commission guidelines and recommendations | Number of countries and territories having adopted the international standards and recommendations to promote their implementation | 8<br>ARG, BRA, CAN, CHI, COL, DOR, MEX, USA | 23<br>ARU, BON, COR, CUR, DSM, ELS, GUT, GUY, PAN, PAR, PER, STA, SCN, TRT, VEN |
| OPT 5.4.2<br>Multisectoral collaboration mechanisms in place to reduce foodborne public health risks, including those arising at the animal-human interface | Number of countries and territories with a mechanism for multisectoral collaboration on reducing foodborne public health risks, including among marginalized populations | 10<br>ARG, CAN, CHI, COL, DOR, JAM, MEX, SCN, USA, VEN | 23<br>ARU, BAH, BON, COR, CUR, DSM, ELS, GUY, PAN, PAR, PER, STA, TRT |

| Program Area: Food Safety | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.4.3<br>Countries enabled to establish risk-based regulatory frameworks to prevent, monitor, assess, and manage foodborne and zoonotic diseases and hazards along the entire food chain | Number of countries and territories with risk-based policies and regulatory and institutional frameworks for their food safety systems | 9<br>BRA, CAN, CHI, COL, JAM, PER, SCN, USA, VEN | 22<br>ARG, ARU, BON, COR, CUR, ELS, DSM, DOR, GUY, MON, PAN, PAR, TRT |
| OPT 5.4.4<br>Implementation of the Hemispheric Program for the Eradication of Foot-and-Mouth Disease (PHEFA) | Number of countries and territories implementing prevention, control, and elimination programs for foot-and-mouth disease (FMD) in accordance with the timeline and expected results established in the PHEFA Plan of Action 2011-2020 | 1<br>PER | 9<br>ARG, BOL, BRA, COL, ECU, PAR, URU, VEN |

## 5.5 Outbreak and Crisis Response

| Program Area: Outbreak and Crisis Response | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 5.5<br>All countries adequately respond to threats and emergencies with public health consequences | OCM 5.5.1 | Percentage of countries that demonstrated adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset | Not applicable | 100% | 100% |

| Program Area: Outbreak and Crisis Response | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 5.5.1<br>Implementation of the WHO Emergency Response Framework (ERF) in acute emergencies with public health consequences | Percentage of Grade 2 and Grade 3 emergencies from any hazard with public health consequences, including any emerging epidemic threats, in which the ERF has been fully implemented | Not applicable | 100% |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| **5** | **Preparedness, surveillance, and response** | | | |
| 5.1 | Alert and response capacities (for IHR) | 5,520,000 | 4,334,000 | 9,854,000 |
| 5.2 | Epidemic- and pandemic-prone diseases | 3,720,000 | 4,296,000 | 8,016,000 |
| 5.3 | Emergency risk and crisis management | 6,050,000 | 12,930,000 | 18,980,000 |
| 5.4 | Food safety | 2,680,000 | 6,855,000 | 9,535,000 |
| 5.5 | Outbreak and crisis response | — | — | — |
| | ***Category 5 Subtotal*** | **17,970,000** | **28,415,000** | **46,385,000** |

## Category 6 - Corporate Services/Enabling Functions

*Fostering and implementing the organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of the Organization, enabling it to deliver effectively on its mandates.*

### Scope

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

### Priorities for PAHO Technical Cooperation for the Biennium

47. For the biennium 2014-2015, the focus will be on organizational effectiveness to meet the changing health needs and realities of Member States and the demands of the international community. The Organization's governance will be strengthened to develop capacity at all its levels to act as leaders and conveners for health; to make its work more efficient and effective in delivering technical cooperation; and to implement a system of control and accountability, including risk management. Major focus will be on strengthening the Organization's position by enhancing its presence and the capacity of its leaders as health diplomats and conveners and by updating and modernizing the Organization's financial systems, including program planning, budget, procurement, and human resources management. This will include revising profiles and training for its personnel and changing current business processes so they more efficiently support the work of PAHO at all levels, resulting in a more agile and effective Organization.

### 6.1 Leadership and Governance

(a) Support Member States in their governance role with respect to PAHO, as well as in their involvement in the WHO reform process.

(b) Establish strategic partnerships with relevant stakeholders to ensure that health figures prominently in the political and development agendas at the regional and country levels.

(c) Strengthen country presence in order to efficiently address country health needs.

(d) Develop and enhance the concept of global health diplomacy. This will call for an enhanced role at the regional level, as well as for PAHO/WHO Representative Offices, to reach beyond the health sector with greater focus on the human rights dialogue within a solid framework for understanding and negotiating global health issues. It will also be necessary to identify instruments and mechanisms for engaging with other stakeholders and promoting an intersectoral approach to addressing health inequalities and the social determinants of health.

(e) Strengthen the role of PAHO in convening and advocating, building partnerships, mobilizing resources, sharing and brokering knowledge, and analyzing and monitoring progress.

48. Performance of these functions will be informed by the nine PAHO overarching leadership priorities:

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

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

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

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

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

(f) Conclude work on the health-related MDGs and influence the integration of health in the post-2015 agenda for sustainable development.

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

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

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

### 6.2 Transparency, Accountability, and Risk Management

49. PAHO will strengthen existing mechanisms and introduce new measures designed to ensure that it continues to be accountable, transparent, and adept at effectively managing risks.

(a) A coordinated approach and ownership of the evaluation function will be promoted at all levels of the Organization. Objective evaluation will be facilitated, in line with the proposed PAHO evaluation policy, and will be supported by tools, such as clear guidelines.

(b) The internal audit function in PAHO has been significantly strengthened in the past few years. The Organization will continue to perform audits of Headquarters and PWR operations, taking into account specific risk factors.

(c) The Ethics Office will continue to focus on strengthening standards of ethical behavior by staff and will perform risk assessments to identify any vulnerabilities that may affect the image and reputation of the Organization.

(d) PAHO will continue to develop its risk management processes and monitoring systems to ensure that all risks are properly identified, managed, and reported regularly to PAHO senior management to enable informed decisions and actions to be taken on a timely basis. To ensure the effective working of the risk management system, as well as compliance and control activities, PAHO will continue to operationalize an Enterprise Risk Management (ERM) system at all levels of the Organization.

### 6.3 Strategic Planning, Resource Coordination, and Reporting

(a) PASB will continue to advance and consolidate Results-based Management (RBM) as the central operating framework for the improvement of organizational effectiveness, efficiency, alignment with results, and accountability. During the biennium, efforts will focus on optimizing and simplifying the operational planning and program management processes based on lessons learned. This will include the implementation of a refined performance, monitoring, and assessment process.

(b) In line with the programmatic approach and the prioritization framework of the SP 2014-2019, approved by the Member States, the Organization will refine its mechanisms for resource management. This should result in increased effectiveness of the resources available to PASB.

(c) Based on lessons learned and recommendations, PASB will develop and implement a comprehensive framework for project management using the appropriate guidelines and tools.

(d) The development, negotiation, and implementation of new approaches to external relations, resource mobilization, and partnerships will be designed to increase the visibility of health in the development agenda and health outcomes. During the period 2014-2015, PAHO will implement a corporate resource mobilization strategy in coordination with WHO that will focus on diversifying PAHO sources of Voluntary Contributions while developing a more coordinated and strategic approach to resource mobilization. PAHO will draw on its lessons learned in multi-stakeholder partnerships and develop and enhance the capacity of PAHO staff to collaborate with partners within and outside the health sector in addressing the social determinants of health.

### 6.4 Management and Administration

(a) The Bureau will seek to implement the PASB Management Information System (PMIS), a modern system that will simplify administrative processes and improve performance controls and indicators. In the area of financial resources management, financial processes will be reviewed and updated along with efficiencies and personnel skills as they relate to integration of the new system. In addition, this function will include oversight of financial transactions and financial assets, investment of financial resources, and general management and financial administration activities across all levels of the Organization.

(b) Human resource management equally involves all executives, managers, supervisors, and staff. Under this function, the Organization will strive to be a steward of good human resource practices; further the awareness and accountability of managers, supervisors, and staff; and ensure consistent and fair application of PAHO human resource policies, regulations, and rules in order to promote a productive work environment. Key focus in the biennium will be placed on maintaining strategic performance goals with corresponding objectives and performance targets to attract top talent; reducing the time spent in recruitment processes (including selection integrity and efficiencies); and promoting motivation and retention strategies that encourage increased job satisfaction, improve staff performance management, encourage continuous learning and knowledge sharing, promote work-life balance and staff well-being, foster accountability and innovation, and enhance organizational flexibility and staff mobility.

(c) Procurement is a key component of the Organization’s mission, supporting technical cooperation through the procurement of goods and services on behalf of Member States to ensure access to affordable drugs, vaccines, and other public health supplies. Focus during the 2014-2015 biennium will be on strengthening knowledge and awareness at all levels (internal and external) to ensure optimal use

of tools, efficiency, and effectiveness of actions and processes, as measured by the implementation of a business intelligence model. In an effort to continuously improve procurement capabilities within the Organization, there will be increased focus on the use of partnerships and strategic alliances with agencies in the UN system and other critical stakeholders at every level of the procurement supply chain, as well as on policy and process compliance to sustain integrity of the procurement processes. In addition, there will be emphasis on development of a market intelligence approach in order to better understand market dynamics and anticipate challenges and opportunities.

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

(e) During the biennium, PAHO will continue to work on the PAHO information technology (IT) governance structure to ensure an IT decision-making process that promotes optimal IT investments throughout PAHO. Emphasis will be placed on advancing the consolidation of infrastructure support services, improving customer service, ensuring business continuity for corporate applications, and creating a data management strategy to improve stewardship of the Organization's corporate information. All these activities will be carried out in concert with the Organization's new management information system, PMIS.

### 6.5 Strategic Communications

Health is an issue of public and political concern in the Americas. The increasingly complex institutional landscape, the emergence of new players influencing health decision making, the changes in the news media and social media, the Region's marked inequality in access to health, and a growing demand from donors, governments, and the public for information on the impact of PAHO's work will require appropriate positioning of the Organization in the external environment. Rapid, effective, well-coordinated, and segmented communications efforts to reach the various audiences are essential. Key elements of the communications strategy for 2014-2015 include a more proactive approach to working with the news media and social media in order to explain PAHO's role and impact; developing and sharing evidence-based information and knowledge produced by the Member States and PASB; and promoting the individual, social, and political changes necessary for the achievement and maintenance of health.

# Program Areas, Outcomes, and Outputs

## 6.1 Leadership and Governance

| Program Area: Leadership and Governance | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012[+]** | **Target 2015 (baseline +)** | **Target 2019[++]** |
| OCM 6.1<br>Greater coherence in regional health, with PAHO/WHO playing a leading role in enabling the many different actors to contribute effectively to the health of all people in the Americas | OCM 6.1.1 | Level of satisfaction of stakeholders with PAHO/WHO's leading role on global and regional health issues | High (based on composite rating from stakeholders' survey, November 2012) | At least high (based on stakeholders' survey, 2015) | At least high (based on stakeholders' survey, 2019) |
| | OCM 6.1.2 | Number of national health plans or strategies that incorporate the Areas of Action of the Health Agenda for the Americas (HAA) 2008-2017 | 20 (from HAA Mid-Term Evaluation) | 22 | 26 (To be confirmed) |
| | OCM 6.1.3 | Percentage of Summit of the Americas declarations reflecting priorities of the PAHO Strategic Plan 2014-1019 | 12% (Based on percentage of health topics included in the Sixth Summit of the Americas, 2012) | At least 12% | At least 12% |

[+] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data. (This note applies to all tables).

[++] The 2019 Target includes, in addition, the 2012 Baseline and the 2015 Target. (This note applies to all tables).

| Program Area: Leadership and Governance | | | |
|---|---|---|---|
| **Output** | **Output** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.1.1<br>Effective PAHO/WHO leadership and management in place | Number of countries and territories with country cooperation strategies in which at least 50 percent of the implications of the CCS have been addressed | 14<br>ARG, BAH, BAR, BOL, BLZ, COL, COR, CUB, ECU, ELS, GUY, JAM, NIC, URU. | 35<br>ANU, ARU, BER, BON, BRA, BVI, CAY, CUR, DOR, DSM. GUT, HAI, HON, MEX, MON, PAR, PER, SAB, SUR, STA, TCA, |
| OPT 6.1.2<br>Effective engagement with other stakeholders in building a common health agenda that responds to the priorities of the Member States | Number of countries and territories having an active multi-partner country coordinating mechanism for implementation of the principles of the Busan Partnership for Effective Development Cooperation that affect health | 26<br>ARG, BAR, BLZ, BOL, BRA, CHI, COL, COR, CUB, DOR, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SUR, SAV, TRT, URU, VEN | 35<br>ANI, BAH, CUR, DOM, ECU, GRA, SAB, SAL, SCN |
| OPT 6.1.3<br>Strengthened PAHO governance with effective oversight of the meetings of the Governing Bodies | Proportion of agenda items of PAHO Governing Bodies aligned with the PAHO Strategic Plan | Not applicable | 90% |
| OPT 6.1.4<br>WHO reform integrated into the work of the Organization | Proportion of items relevant to PAHO from the WHO reform completed or on track | Not applicable | 100% |
| OPT 6.1.5<br>Implementation of the Health Agenda for the Americas (HAA) 2008-2017 | Number of countries and territories monitoring implementation of the HAA | To be determined | To be determined |

## 6.2 Transparency, Accountability, and Risk Management

| Program Area: Transparency, Accountability, and Risk Management | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 6.2<br>PAHO operates in an accountable and transparent manner and has well-functioning risk management and evaluation frameworks | OCM 6.2.1 | Proportion of corporate risks with approved response plans implemented | Not applicable | 66% | 100% |

| Program Area: Transparency, Accountability, and Risk Management | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.2.1<br>Increased accountability though strengthened corporate risk management and evaluation at all levels of the Organization | Proportion of entities in the Organization with completed risk assessment and approved mitigation response plans implemented | 12% | 75% |
| OPT 6.2.2<br>PAHO/WHO evaluation policy implemented across the Organization | Percentage of Director-approved evaluations' lessons learned implemented during the biennium | Data not currently measured | To be determined |
| OPT 6.2.3<br>Improved ethical behavior, respect within the workplace, and due process across the Organization | Level of staff satisfaction with the ethical climate and internal recourse procedures of the Organization | To be determined (2013 survey) | High (2015 survey) |
| OPT 6.2.4<br>Strengthened audit function | Proportion of internal audit recommendations accepted by the Director closed within the biennium | 80 (cumulative) | 85% (cumulative) |

## 6.3 Strategic Planning, Resource Coordination, and Reporting

| Program Area: Strategic Planning, Resource Coordination, and Reporting | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 6.3<br>Financing and resource allocation aligned with priorities and health needs of the Member States in a Results-based Management framework | OCM 6.3.1 | Percentage of approved PAHO budget funded | 80%<br>To be updated based on 2012-2013 end-of-biennium (EOB) assessment | 95%<br>To be updated based on 2012-2013 EOB assessment | 100% |
| | OCM 6.3.2 | Percentage of outcome indicator targets achieved | 89%<br>To be updated based on 2012-2013 EOB assessment | 90% | 90% |

| Program Area: Strategic Planning, Resource Coordination, and Reporting | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.3.1.<br>Consolidation of the PAHO Results-based Management framework, with emphasis on the accountability system for corporate performance assessment | Percentage of outputs achieved | 75% | 90% |
| OPT 6.3.2<br>Alignment of PAHO allocation of resources and financing with agreed priorities facilitated through strengthened resource mobilization, coordination, and management | Percentage of program areas with funded budgets of 75% or greater | 75%<br>(based on 2012-2013 Strategic Objective funding level)<br>To be updated based on 2012-2013 EOB assessment | 75%<br>To be updated based on 2012-2013 EOB assessment |
| OPT 6.3.3<br>PAHO resource mobilization strategy implemented | Number of partners contributing at least 10% of the PAHO Voluntary Contributions budget | 2<br>To be updated based on 2012-2013 EOB assessment | 4 |

## 6.4 Management and Administration

| Program Area: Management and Administration | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 6.4.1<br>Effective management and administration across the three levels of the Organization | 6.4.1 | Proportion of management and administration metrics (as developed in Service Level Agreements) achieved | Data not currently measured | 80% | 95% |

| Program Area: Management and Administration | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.4.1<br>Sound financial practices in place through an adequate control framework, accurate accounting, expenditure tracking, and timely recording of income | Unqualified audit opinion | Yes | Yes |

| Program Area: Management and Administration | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.4.2<br>Effective and efficient human resources management in place to recruit and support a motivated, experienced, and competent workforce in an environment conducive to learning and excellence | Proportion of HR-agreed Service Level Agreements achieved | Data not currently measured | 95% |
| OPT 6.4.3<br>Efficient and effective computing infrastructure, network and communications services, corporate and health-related systems and applications, and end-user support and training services | Proportion of end-user support provided according to Service Level Agreements | 80% | 95% |
| OPT 6.4.4<br>Effective and efficient operational and logistic support, procurement, infrastructure maintenance, asset management, and secure environment for PAHO/WHO staff and property | Proportion of agreed Service Level Agreements reached | Data not currently being measured | 95% |

## 6.5 Strategic Communications

| Program Area: Strategic Communications | | | | | |
|---|---|---|---|---|---|
| **Outcome** | **Ind. #** | **Outcome Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** | **Target 2019** |
| OCM 6.5<br>Improved public and stakeholders' understanding of the work of PAHO/WHO | OCM 6.5.1 | Percentage of Member States and other stakeholder representatives evaluating WHO/PAHO performance as excellent or good | 77% | 90% | 100% (WHO Stakeholder Perception Survey, November 2019) |

| Program Area: Strategic Communications | | | |
|---|---|---|---|
| **Output** | **Output Indicator** | **Baseline 2012** | **Target 2015 (baseline +)** |
| OPT 6.5.1<br>Improved communication by PAHO/WHO staff, leading to a better understanding of the Organization's action and impact | Number of PAHO/WHO offices having completed the training component of the Organization's knowledge management and communication strategy | 4<br>ARG, COL, MEX, PER | 12<br>COR, CUB, CUR, DOR, ECU, GUT, GUY, HAI |
| OPT 6.5.2<br>Effective and innovative communication platforms, policies, and networks | Number of PAHO/WHO offices having completed the platform, policy, and network component of the Organization's knowledge management and communication strategy | 3<br>ARG, ELS, NIC | 25<br>BOL, BRA, CHI, COL, CUB, CUR, DOR, ECU, FEP, GUT, GUY, HAI, HON, JAM, MEX, PAN, PAR, PER, SUR, TRT, URU, VEN |

## Budget by Program Area (US$)

| Category and Program Area | | Base Programs | | |
|---|---|---|---|---|
| | | Regular Budget | Other Sources | Total |
| **6** | **Corporate services/enabling functions** | | | |
| 6.1 | Leadership and governance | 54,235,000 | 4,232,000 | 58,467,000 |
| 6.2 | Transparency, accountability, and risk management | 2,790,000 | 2,052,000 | 4,842,000 |
| 6.3 | Strategic planning, resource coordination, and reporting | 21,960,000 | 27,584,000 | 49,544,000 |
| 6.4 | Management and administration | 39,602,000 | 27,830,000 | 67,432,000 |
| | 6.4.1 Special project - PMIS | — | 10,000,000 | 10,000,000 |
| 6.5 | Strategic communications | 10,073,000 | 3,000,000 | 13,073,000 |
| | ***Category 6 Subtotal*** | **128,660,000** | **74,698,000** | **203,358,000** |

## Monitoring and Reporting, Assessment, Accountability, and Transparency

50. Performance monitoring and assessment are essential for proper management of the Program and Budget and to inform the revision of policies and strategies and interventions. As a result, assessment of the Program and Budget 2014-2015 is the means by which the PAHO Strategic Plan 2014-2019 itself will be monitored and assessed. Monitoring of implementation of the Program and Budget 2014-2015 will be conducted in two stages: *(a)* a midterm review at the end of the first 12-month period; and, *(b)* a full assessment upon completion of the biennium (Program and Budget Performance Assessment), which is reported to the Member States.

51. The midterm review provides a means of tracking and appraising progress made toward the achievement of results—in particular, progress made in delivering outputs. It facilitates corrective action and the reprogramming and reallocation of resources during implementation. This process allows PASB to identify and analyze the impediments and risks encountered, together with the actions required to ensure achievement of results. The end-of-biennium Program and Budget Performance Assessment is a comprehensive appraisal of the performance of the Organization at the end of the two-year period. It will include an assessment of the achievement of the outputs along with an assessment of progress made toward attainment of the stated outcomes.

52. The improved results chain is expected to lead to greater clarity and coherence in the division of labor and the reporting of achievements. Demonstrating how PASB's work contributes to, or influences, health outcomes and impacts is important for the Member States and has been emphasized in the WHO reform. This not only allows for assessment of the effectiveness of the work of the Bureau but also enables the Member States to better communicate the Organization's contribution toward achieving better health for the peoples of the Americas.

## Acronyms and Abbreviations

| ACRONYM | DESCRIPTION |
|---|---|
| **AIDS** | acquired immunodeficiency syndrome |
| **ART** | antiretroviral therapies |
| **CCG** | Countries Consultative Group |
| **CKD** | chronic kidney disease |
| **cVDPV** | circulating vaccine-derived poliovirus |
| **DTSC** | direct technical support to countries |
| **EOB** | end-of-biennium |
| **ERF** | WHO Emergency Response Framework |
| **ERM** | Enterprise Risk Management |
| **ERMH** | Emergency and Disaster Risk Management for Health |
| **FCTC** | WHO Framework Convention on Tobacco Control |
| **GPW** | WHO General Programme of Work |
| **HAA** | Health Agenda for the Americas |
| **HIV** | human immunodeficiency virus |
| **HRH** | human resources for health |
| **IHR** | International Health Regulations |
| **IHSDN** | Integrated Health Services Delivery Network |
| **IMS-Dengue** | Integrated Management Strategy for Dengue Prevention and Control |
| **IT** | information technology |
| **MDG** | Millennium Development Goal |
| **MDR-TB** | multidrug-resistant tuberculosis |
| **MORSS** | Minimum Operating Residential Security Standards |
| **MOSS** | Minimum Operating Security Standards |
| **NCD** | noncommunicable disease |
| **NID** | neglected infections disease |
| **NVC** | National Voluntary Contributions |
| **OCR** | Outbreak and Crisis Response |
| **PAHO** | Pan American Health Organization |
| **PASB** | Pan American Sanitary Bureau |
| **PB 2014-2015** | PAHO Program and Budget 2014-2015 |
| **PHC** | primary health care |
| **PHEFA** | Hemispheric Program for the Eradication of Foot-and-Mouth Disease |

| ACRONYM | DESCRIPTION |
|---|---|
| **PMIS** | PASB Management Information System |
| **PRAIS** | PAHO Regional Platform on Access and Innovation for Health Technologies |
| **PWR** | PAHO/WHO Representative |
| **RBM** | Results-based Management |
| **SP 2014-2019** | PAHO Strategic Plan 2014-2019 |
| **STI** | sexually transmitted infection |
| **TB** | tuberculosis |
| **TB-HIV** | HIV-associated tuberculosis |
| **UHC** | universal health coverage |
| **UN** | United Nations |
| **WHA66** | 66th World Health Assembly |
| **WHO** | World Health Organization |

# Annex I. Programmatic Priority Stratification Framework

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

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

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

4. The criteria and method will be applied across the program areas (approved by Executive Management and the Countries Consultative Group) to identify priority levels (e.g., priority levels 1, 2, and 3).

5. Given that Category 6 (Corporate Services/Enabling Functions) supports the delivery of technical cooperation in Categories 1 through 5, including country presence, and that it is dependent on the Regular Budget (RB), it is important to ensure that the necessary funds are available to cover such functions. The level of funding for this category will be determined based on analyses of essential costs, efficiencies, and cost-effective measures, among others (PASB to undertake such analyses). Because the cross-cutting themes in program area 3.3 (gender, equity, human rights, and ethnicity) apply to all categories, the same criteria used for funding the program areas in Category 6 apply to this program area.

6. Taking into consideration that the Organization has already established the program areas, representing the priorities of the SP 2014-2019, a Regular Budget floor should be set for each program area. This will ensure a minimum coverage of the Organization to maintain the gains and institutional response capacity. The historic RB expenditure over the last two biennia will be a key input for determining the budget floor by program area (average to be determined by PASB).

7. After the items in paragraphs 5 and 6 have been covered, the allocation of remaining funds will be guided by the priority stratification method and the criteria defined in this framework. This will be complemented by the criteria established in the resource coordination mechanism, including the outcome indicator gap (the distance between the baseline and the expected target to be achieved by the end of a biennium), based on the costing of the Program and Budgets. Allocation of flexible resources mobilized will be done according to the priority level and programmatic gap. This methodology provides a means to compare different health issues in a relative, not absolute, framework, as equally as possible, and in a somewhat objective manner.

8. The methodology is qualitative in nature, and in this sense it involves individual value judgments used to generate consensus. The results reflect the collective perception of topics, issues, or problems assessed. Therefore, its application benefits from a multidisciplinary approach.

**Methodology**

9. The methodology is based on the well-known and widely accepted Hanlon Method for health priority setting.

10. The method is based on the following components: *(a)* magnitude, *(b)* seriousness, *(c)* effectiveness, and *(d)* feasibility (see definition below of each component). Weighting is done according to the Hanlon-modified Priority Rating System (PRS) method (APEXPH/NACHO 1991). These four components take into consideration the public sector, particularly the health sector. In addition, the institutional strategic positioning of the Organization is considered as a fifth component, including criteria proposed by Musgrove (1999).

**Magnitude of the issue (size of the issue/problem)**

(a) Relative contribution to the regional burden of disease or relative importance to the regional health agenda (based on the PAHO Regional Core Health Data and Country Profile Initiative, Health in the Americas 2012, and the Global Burden of Disease Study 2010 main results)

(b) Relative contribution to the global burden of disease or relative importance to the global health agenda (based on the PAHO Regional Core Health Data and Country Profile Initiative, Health in the Americas 2012, and the Global Burden of Disease Study 2010 main results)

(c) Public goods (critical for improving public health and not necessarily attractive to markets)

**Seriousness of the issue (severity and urgency of the issue/problem)**

(a) Emergent nature of the problem

(b) Burden to the health services

(c) Potential to cause premature mortality and disability

(d) Contribution to global and regional health security

(e) Threat to sustainable human development

(f) Disproportional impact on population groups living in conditions of vulnerability

(g) Threat to universal access to health

(h) Potential economic losses at the individual and community levels

**Effectiveness of the interventions for addressing the issue (how well the issue can be solved, if at all)**

(a) Availability of cost-effective interventions (includes best practices and best buys)

(b) Potential to work with other sectors, organizations, and stakeholders to have a significant impact on health

(c) Public demands (includes political aspects, public opinion, pressures for public expenditure, among others)

**Feasibility of addressing the issue (the PEARL criteria)**

(a) Propriety: Does the issue fall within the health sector mandate/responsibility?

(b) Economic feasibility: Does it make economic sense to address the issue; are there economic consequences if the issue is not addressed? (includes proximity to elimination or eradication of a disease or infection)

(c) Acceptability: Will the Member States and/or target population accept the issue being addressed? (includes existence of evidence-based knowledge, science, and technology for improving health, and the capacity to apply it)

(d) Resources: Are resources available to address the issue? (includes national institutional capacity, involvement of other agencies/partners addressing the issue, and availability of financial resources from national or external sources)

(e) Legality: Do current laws, regulations, and mandates (at global, regional, and/or national levels) allow the issue to be addressed?

**Institutional strategic positioning**

(a) PAHO's value-added (includes PAHO's technical cooperation cost-effectiveness to attain the health outcomes defined in PAHO Strategic Plan 2014-2019).

(b) Key for PAHO's governance and leadership.

(c) PAHO's ability to contribute to capacity building in Member States.

(d) Issue explicitly designated as a priority in PAHO Country Cooperation Strategies (CCS) or national health strategies or plans (or state or provincial strategies or plans in the case of federated countries).

**Application**

11. A Hanlon-PRS PAHO-adapted Priority Stratification Matrix Tool is being used to assign scores by evaluators in initially independent scoring iterations. Next, an overall score for each programmatic area will be determined by computing the trimmed mean of the individual scores distribution (i.e., excluding minimum and maximum values). The CCG validated the methodology in a pilot exercise conducted jointly with PASB. The methodology will be applied by Member States as part of the national consultations for the SP 2014-2019. A Priority Stratification Matrix Tool will be used to capture the scores of each Member State. All scores will be integrated to obtain the regional average scores by program areas (trimming extreme values), which will result in the three priority strata or tiers, as outlined in the methodology above.

12. PAHO/WHO Representative Offices will facilitate the national consultations in joint collaboration with the health authority.

13. The results will be included in the SP 2014-2019, and its application in the Program and Budget will be submitted for approval by Member States.

# Annex II. List of Countries and Territories with their Acronyms

| | Country | Acronym |
|---|---|---|
| | **Member States** | **35** |
| 1 | Antigua and Barbuda | ANI |
| 2 | Argentina | ARG |
| 3 | Bahamas | BAH |
| 4 | Barbados | BAR |
| 5 | Belize | BLZ |
| 6 | Bolivia (Plurinational State of) | BOL |
| 7 | Brazil | BRA |
| 8 | Canada | CAN |
| 9 | Chile | CHI |
| 10 | Colombia | COL |
| 11 | Costa Rica | COR |
| 12 | Cuba | CUB |
| 13 | Dominica | DOM |
| 14 | Dominican Republic | DOR |
| 15 | Ecuador | ECU |
| 16 | El Salvador | ELS |
| 17 | Grenada | GRA |
| 18 | Guatemala | GUT |
| 19 | Guyana | GUY |
| 20 | Haiti | HAI |
| 21 | Honduras | HON |
| 22 | Jamaica | JAM |
| 23 | Mexico | MEX |
| 24 | Nicaragua | NIC |
| 25 | Panama | PAN |
| 26 | Paraguay | PAR |
| 27 | Peru | PER |
| 28 | Saint Kitts and Nevis | SCN |
| 29 | Saint Lucia | SAL |
| 30 | Saint Vincent and the Grenadines | SAV |
| 31 | Suriname | SUR |
| 32 | Trinidad and Tobago | TRT |
| 33 | United States of America | USA |
| 34 | Uruguay | URU |
| 35 | Venezuela (Bolivarian Republic of) | VEN |

| | Country | Acronym |
|---|---|---|
| | **Associate Members** | **4** |
| 36 | Aruba | ARU |
| 37 | Curaçao | CUR |
| 38 | Puerto Rico | PUR |
| 39 | Sint Maarten | DSM |
| | **Participating States** | **3** |
| | France | **3** |
| 40 | French Guiana | FRG |
| 41 | Guadeloupe | GUA |
| 42 | Martinique | MAR |
| | Kingdom of the Netherlands | **3** |
| 43 | Bonaire | BON |
| 44 | Saba | SAB |
| 45 | Sint Eustatius | STA |
| | United Kingdom of Great Britain and Northern Ireland | **6** |
| 46 | Anguilla | ANU |
| 47 | Bermuda | BER |
| 48 | British Virgin Islands | BVI |
| 49 | Cayman Islands | CAY |
| 50 | Montserrat | MON |
| 51 | Turks and Caicos | TCA |

# Annex III. PAHO Mandates, Resolutions, Strategies, and Plans of Action

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| **1** | **Communicable Diseases** | |
| 1.1 | HIV/AIDS and STIs | - Regional Strategic Plan for HIV/AIDS/ STIs for the Health Sector [2006-2015] (Resolution CD46.R15 [2005])<br>- Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis [2010-2015] (Resolution CD50.R12 [2010])<br>- Viral Hepatitis (Resolution WHA63.18 [2010])<br>- Prevention and Control of Viral Hepatitis Infection: Framework for Global Action (WHO, 2012) |
| 1.2 | Tuberculosis | - Regional Strategy for Tuberculosis Control for 2005-2015 (Resolution CD46.R12 [2005])<br>- Plan for Expansion of the Programmatic Management of Drug Resistant Tuberculosis: Toward Universal Access to TB-D/M/XDR in the Americas 2010-2015 (OPS, 2011) |
| 1.3 | Malaria and other vector-borne diseases (including dengue and Chagas) | - Strategy and Plan of Action for Malaria [2012-2015] (Resolution CD51.R9 [2011])<br>- Dengue Prevention and Control in the Americas (Resolution CSP27.R15 [2007])<br>- Strategy and Plan of Action for Chagas Disease Prevention, Control, and Care [2010-2013] (Resolution CD50.R17 [2010])<br>- Integrated Vector Management: A Comprehensive Response to Vector-borne Diseases (Document CD48/13 [2008]). |
| 1.4 | Neglected, tropical, and zoonotic diseases | - Toward the Elimination of Onchocerciasis (River Blindness) in the Americas (Resolution CD48.R10 [2008])<br>- Elimination of Neglected Diseases and other Poverty-Related Infections (Resolution CD49.R9 [2009])<br>- Control and Elimination of Five Neglected Diseases in Latin America and the Caribbean [2010–2015] (PAHO, 2010)<br>- Neglected Tropical Diseases (Resolution WHA66.R12 [2013]) |
| 1.5 | Vaccine-preventable diseases (including maintenance of polio eradication) | - Global Vaccine Action Plan (Resolution WHA65.17 [2012])<br>- Vaccines and Immunization (Resolution CSP26.R8 [2002])<br>- Strengthening Immunization Programs in the Americas (Resolution CD50.R5 [2010])<br>- Plan of Action for Maintaining Measles, Rubella, and Congenital Rubella Syndrome (CRS) Elimination in the Region of the Americas, 2012-2014 (Resolution CSP28.R16 [2012]) |

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| | | - Poliomyelitis: Intensification of the Global Eradication Initiative (Resolution WHA65.5 [2012]) |
| **2** | **Noncommunicable Diseases and Risk Factors** | |
| 2.1 | Noncommunicable diseases and risk factors | - Strategy for the Prevention and Control of Noncommunicable Diseases (Resolution CSP28.R13 [2012])<br>- Plan of Action to Reduce the Harmful Use of Alcohol [2012-2021] (Document CD51/8 [2011])<br>- Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control [2008-2015] (Document CD48/6 [2008])<br>- Regional Strategy and Plan of Action on Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet, Physical Activity, and Health [2006-2015] (Document CD47/17 [2006])<br>- Population-based and individual approaches to the prevention and management of diabetes and obesity (Resolution CD48.R9 [2008])<br>- WHO Framework Convention on Tobacco Control (FCTC) (WHO, 2003)<br>- Strengthening the Capacity of Member States to Implement the Provisions and Guidelines of the WHO Framework Convention on Tobacco Control (Resolution CD50.R6 [2010])<br>- WHO Framework Convention on Tobacco Control: Opportunities and Challenges for its Implementation in the Region of the Americas (Resolution CD48.R2 [2008]) |
| 2.2 | Mental health and psychoactive substance use disorders | - Strategy and Plan of Action on Epilepsy [2012-2021] (Document CD51/10 [2011])<br>- Strategy and Plan of Action on Mental Health [2009-2019] (Resolution CD49.R17 [2009])<br>- Plan of Action on Psychoactive Substance Use and Public Health [2012-2021] (Resolution CD51.R7 [2011])<br>- Comprehensive mental health action plan 2013–2020 (Resolution WHA66.R8) |
| 2.3 | Violence and injuries | - Plan of Action on Road Safety [2012-2017] (Resolution CD51.R6 [2011])<br>- Preventing Violence and Injuries and Promoting Safety: a Call for Action in the Region (Resolution CD48.R11 [2008]) |
| 2.4 | Disabilities and rehabilitation | - Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment [2009-2013] (Resolution CD49.R11 [2009])<br>- Disability (Resolution WHA66.9 [2013])<br>- Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Health and Other Related Rights (Resolution CD47.R1 [2006]) |

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| 2.5 | Nutrition | - Regional Strategy and Plan of Action on Nutrition in Health and Development [2006-2015] (Resolution CD47.R8 [2006])<br>- Strategy and Plan of Action for the Reduction of Chronic Malnutrition, [2010-2015] (Resolution CD50.R11 [2010]) |
| **3** | **Determinants of Health and Promoting Health throughout the Life Course** | |
| 3.1 | Women's, maternal, newborn, child, and adolescent, and adult health, and sexual and reproductive health | - Plan of Action on Adolescent and Youth Health [2010-2018] (Resolution CD49.R14 [2009])<br>- Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity [2012-2017] (Resolution CD51.R12 [2011])<br>- Regional Strategy for Improving Adolescent and Youth Health [2008-2018] (Resolution CD48.R5 [2008])<br>- Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care [2008-2015] (Resolution CD48.R4, Rev1 [2008])<br>- Strategy and Plan of Action for Integrated Child Health [2012-2017] (Resolution CSP28.R20 [2012]) |
| 3.2 | Aging and health | - Plan of Action on the Health of Older Persons, Including Active and Healthy Aging [2009-2018] (Resolution D49.R15 [2009]) |
| 3.3 | Gender, equity, human rights, and ethnicity | - Plan of Action for Implementing the Gender Equality Policy [2009-2013] (Resolution CD49.R12 [2009]) |
| 3.4 | Social determinants of health | - Strategy and Plan of Action on Urban Health [2013-2021] (Resolution CD51.R4 [2011]) |
| 3.5 | Health and the environment | - Strategy and Plan of Action on Climate Change [2012-2017] (Resolution CD51.R15 [2011]) |
| **4** | **Health Systems** | |
| 4.1 | Health governance and financing, national health policies, strategies, and plans | - Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges (Resolution CD44.R6 [2003])<br>- Extension of Social Protection in Health: Joint Initiatives of the Pan American Health Organization and the International Labour Organization (Resolution CSP26.R19 [2002])<br>- Essential Public Health Functions (CD42.R14 [2000])<br>- Health and International Relations: Linkages with National Health Development (CD48.R16 [2008]) |
| 4.2 | People-centered integrated, quality health services | - Regional Policy and Strategy for Ensuring Quality of Health Care, Including Patient Safety [2007-2013] (Resolution CSP27.R10 [2007])<br>Integrated Health Services Delivery Networks Framework, Concepts, Policy Options and a Road Map for Implementation in the Americas (PAHO, 2010)<br>- Integrated Health Services Delivery Networks based on Primary Health Care (Resolution CD49.R22 [2009]) |

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| | | - Ensuring the Quality of Health Care Including Patient Safety (Resolution CE140.R18) |
| 4.3 | Access to medical products and strengthening of regulatory capacity | - Access to Medicines (Resolution CD45.R7 [2004])<br>- Strengthening National Regulatory Authorities for Medicines and Biologicals (Resolution CD50/R.9 [2010])<br>- Medical Devices (Resolution CD42.R10 [2000])<br>- Drug Regulatory Harmonization (Resolution CD42.R11 [2000])<br>- Public Health, Health Research, Production and Access to Essential Medicines (Resolution CD47.R7 [2006])<br>- Improving Blood Availability and Transfusion Safety in the Americas (Resolution CD48.R7 [2008])<br>- Public Health, Innovation and Intellectual Property-A regional perspective (Resolution CD48.R15 [2008])<br>- Policy Framework for Human Organ Donation and Transplantation (Resolution CD49.R18 [2009])<br>- Health Technology Assessment and Incorporation into Health Systems (Resolution CSP28.R9 [2012])<br>- Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards (Resolution CSP28.R15 [2012]) |
| 4.4 | Health systems information and evidence | - Regional Plan of Action for strengthening Vital and Health Statistics, 2008-2013 (Resolution CD48.R6 [2008])<br>- Strategy for Strengthening Vital and Health Statistics in Countries of the Americas, 2008-2013 (Resolution CSP27.R12 [2007])<br>- Strategy and Plan of Action on eHealth (2012-2017) (Resolution CD51.R5 [2011])<br>- Strategy and Plan of Action on Knowledge Management and Communications, 2013-2018 (Resolution CSP28.R2 [2012])<br>- Public Health, Health Research, Production and Access to Essential Medicines (Resolution CD47.R7 [2006])<br>- Policy on Research for Health (Resolution CD49.R10 [2009]) |
| 4.5 | Human resources for health | - Toronto Call to Action for a Decade of Human Resources in Health in the Americas (2006-2015)<br>- Development and Strengthening of Human Resources Management in the Health Sector (Resolution CD43.R6 [2001])<br>- Observatory of Human Resources in Health (Resolution CD45.R9 [2004])<br>- Strategy for Health Personnel Competency Development in Primary Health Care based Health Systems (Resolution CD50.R7 [2010]) |

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| | | - Regional Goals for Human Resources for Health (Resolution CSP27.R7 [2007])<br>- Expanded Textbook and Instructional Materials Program (PALTEX) (Resolution CSP28.R3 [2012]) |
| **5** | **Preparedness, Surveillance, and Response** | |
| 5.1 | Alert and response capacities | - Implementation of the International Health Regulations (2005) (Resolution WHA64.1 [2011])<br>- Revision of the International Health Regulations (Resolution WHA58.3 [2005])<br>- Application of the International Health Regulations (2005) (Resolution WHA59.2)<br>- Implementation of the International Health Regulations (2005) (Resolution WHA61.2 [2008])<br>- Implementation of the International Health Regulations (2005) (Resolution WHA65.23 [2012])<br>- International Health Security, Implementing the International Health Regulations (2005) (Resolution CSP27.R13 [2007]) |
| 5.2 | Epidemic-and Pandemic-prone Diseases | - International Health Regulations (2005), Second Edition (WHO, 2008) |
| 5.3 | Emergency risk and crisis management | - Plan of Action on Safe Hospitals (2010-2015) (Resolution CD50.R15 [2010])<br>- Safe Hospitals: A Regional Initiative on Disaster-resilient Health Facilities (2008-2015) (Resolution CPS27.R14 [2007])<br>- Coordination of International Humanitarian Assistance in Health in case of Disasters (Resolution CSP28.R19 [2012])<br>- Hurricanes Katrina and Rita and Disaster Preparedness in the Region of the Americas (Resolution CD46.R14 [2005])<br>- Disaster Preparedness and Response (Resolution CD45. R8 [2004])<br>- Hurricanes Georges, Mitch and Floyd (Resolution CD41:R6 [1999])<br>- Health emergency preparedness for disasters caused by El Niño (Resolution CD40 R13 [1997])<br>- Emergency Preparedness and Disaster Relief Coordination (CD31.R23 [1985])<br>- Emergency Preparedness Program (Resolution CD27.R40 [1980])<br>- Emergency Preparedness and Disaster Relief Coordination Program in the Americas (Resolution CD26.R36 [1979]) |
| 5.4 | Food safety | - Advancing Food Safety Initiatives (Resolution WHA63.3 [2010]) |
| 5.5 | Outbreak and Crisis Response | - Coordination of International Humanitarian Assistance in Health in case of Disasters (Resolution CSP28.R19 [2012]) |

| Category and Program Area | | Mandates, Resolutions, Strategies and Plan of Actions |
|---|---|---|
| | | - Disaster Preparedness and Response (Resolution CD45.R8 [2004])<br>- Emergency Preparedness and Disaster Relief Coordination (Resolution CD32.R10 [1987]) |
| **6** | **Corporate Services/Enabling Functions** | |
| 6.1 | Leadership and governance | - United Nations Reform Process and WHO's Role in Harmonization of Operational Development Activities at Country Level (Resolution WHA58.25 [2005])<br>- The Busan Partnership for Effective Development Cooperation (2011)<br>- WHO Reform (Document WHA66/4 [2013])<br>- United Nations Millennium Declaration (Document A/55/L.2 [2000])<br>- Triennial Comprehensive Preview of Operational activities for development of the United Nations system (Document A/62/208 [2008])<br>- Cooperation among countries for health development in the Americas (Document CE152/15 [2013]) |
| 6.2 | Transparency, accountability, and risk management | - PAHO Results-Based Management Framework (Document SPB4/5, Rev. 2 [2010]) |
| 6.3 | Strategic planning, resource coordination, and reporting | - Health Agenda for the Americas 2008-2017<br>- PAHO Budget Policy (Resolution CSP28.R10 [2012])<br>- WHO 12th General Programme of Work 2014-2019 (Document A66/6 [2013])<br>- WHO Programme Budget 2014-2015 (Document A66/7 [2013]) |
| 6.4 | Management and administration | |
| 6.5 | Strategic communications | - Strategy and Plan of Action on Knowledge Management and Communication (CSP28/12 [2012]) |

# Annex IV. Budget Policy at Country Level: First Biennium Phased-in Application

| Member State | Approved 2012-2013 Program Budget | 2012-2013 percentage distribution | Adjustment to 90% allocation for comparison | Change due to budget reduction and application of new budget policy | Proposed 2014-2015 Program Budget | 2014-2015 percentage distribution |
|---|---|---|---|---|---|---|
| | A | | B | | E=C+D | |
| Antigua and Barbuda | 515,400 | 0.46% | 488,300 | (82,600) | 405,700 | **0.37%** |
| Argentina | 3,618,900 | 3.23% | 3,428,400 | 409,000 | 3,837,400 | **3.50%** |
| Aruba (*) | | | | | 79,500 | **0.07%** |
| Bahamas | 929,900 | 0.83% | 881,000 | 730,700 | 1,611,700 | **1.47%** |
| Barbados | 627,400 | 0.56% | 594,400 | (122,900) | 471,500 | **0.43%** |
| Belize | 784,300 | 0.70% | 743,000 | 660,400 | 1,403,400 | **1.28%** |
| Bolivia | 5,490,000 | 4.90% | 5,201,100 | (815,500) | 4,385,600 | **4.00%** |
| Brazil | 11,316,000 | 10.10% | 10,720,400 | (633,500) | 10,086,900 | **9.20%** |
| Canada | 549,000 | 0.49% | 520,100 | (114,400) | 405,700 | **0.37%** |
| Chile | 2,453,700 | 2.19% | 2,324,600 | 679,500 | 3,004,100 | **2.74%** |
| Colombia | 4,560,000 | 4.07% | 4,320,000 | 263,000 | 4,583,000 | **4.18%** |
| Costa Rica | 2,050,300 | 1.83% | 1,942,400 | 425,800 | 2,368,200 | **2.16%** |
| Cuba | 4,201,500 | 3.75% | 3,980,400 | (702,200) | 3,278,200 | **2.99%** |
| Curacao (*) | | | | | 79,500 | **0.07%** |
| Dominica | 571,400 | 0.51% | 541,300 | (102,700) | 438,600 | **0.40%** |
| Dominican Republic | 3,753,300 | 3.35% | 3,555,800 | (157,000) | 3,398,800 | **3.10%** |
| Ecuador | 6,576,700 | 5.87% | 6,230,600 | (1,461,300) | 4,769,300 | **4.35%** |
| El Salvador | 3,294,000 | 2.94% | 3,120,600 | (94,500) | 3,026,100 | **2.76%** |
| France (French Department in the Americas) | 358,500 | 0.32% | 339,600 | (32,600) | 307,000 | **0.28%** |
| Grenada | 694,600 | 0.62% | 658,000 | (153,700) | 504,300 | **0.46%** |
| Guatemala | 6,453,500 | 5.76% | 6,113,800 | (1,191,000) | 4,922,800 | **4.49%** |
| Guyana | 2,140,000 | 1.91% | 2,027,400 | 143,500 | 2,170,900 | **1.98%** |
| Haiti | 5,579,600 | 4.98% | 5,285,900 | (757,800) | 4,528,100 | **4.13%** |
| Honduras | 4,918,600 | 4.39% | 4,659,700 | (614,000) | 4,045,700 | **3.69%** |
| Jamaica | 2,083,900 | 1.86% | 1,974,200 | 284,400 | 2,258,600 | **2.06%** |
| Mexico | 6,778,400 | 6.05% | 6,421,600 | (40,600) | 6,381,000 | **5.82%** |
| Netherlands (Bonaire, St. Eustatious and Saba) (*) | 358,500 | 0.32% | 339,600 | (21,600) | 79,500 | **0.07%** |
| Nicaragua | 4,403,200 | 3.93% | 4,171,500 | (553,400) | 3,618,100 | **3.30%** |
| Panama | 1,591,000 | 1.42% | 1,507,300 | 586,800 | 2,094,100 | **1.91%** |
| Paraguay | 3,159,600 | 2.82% | 2,993,300 | 208,300 | 3,201,600 | **2.92%** |
| Peru | 6,352,700 | 5.67% | 6,018,300 | (920,000) | 5,098,300 | **4.65%** |
| Puerto Rico | 179,300 | 0.16% | 169,900 | 60,300 | 230,200 | **0.21%** |
| St Kitts and Nevis | 459,400 | 0.41% | 435,200 | (73,400) | 361,800 | **0.33%** |
| St Lucia | 672,200 | 0.60% | 636,800 | (121,500) | 515,300 | **0.47%** |
| St Vincent & the Grenadines | 638,600 | 0.57% | 605,000 | (89,700) | 515,300 | **0.47%** |
| Sint Maarten (*) | | | | | 79,500 | **0.07%** |
| Suriname | 1,109,200 | 0.99% | 1,050,800 | 593,800 | 1,644,600 | **1.50%** |
| Trinidad and Tobago | 1,602,200 | 1.43% | 1,517,900 | 521,400 | 2,039,300 | **1.86%** |
| United Kingdom (United Kingdom Overseas Territories) | | | | | | |
| *Anguilla, the British Virgin Islands, and Montserr* | 246,500 | 0.22% | 233,500 | 7,700 | 241,200 | **0.22%** |
| *Bermuda and the Cayman Islands* | 67,200 | 0.06% | 63,700 | 13,000 | 76,700 | **0.07%** |
| *Turks and Caicos Islands* | 56,000 | 0.05% | 53,100 | 12,700 | 65,800 | **0.06%** |
| United States | 358,500 | 0.32% | 339,600 | (21,600) | 318,000 | **0.29%** |
| Uruguay | 1,322,100 | 1.18% | 1,252,500 | 775,800 | 2,028,300 | **1.85%** |
| Venezuela | 3,562,900 | 3.18% | 3,375,400 | 341,400 | 3,716,800 | **3.39%** |
| | | | | | | |
| Core allocations | 106,438,000 | 95% | 100,836,000 | (2,160,000) | 98,676,000 | 90% |
| | | | | | | |
| Variable - 5% | 5,602,000 | | | | 5,482,000 | 5% |
| | | | | | | |
| Results Based Component 5% | - | | | | 5,482,000 | 5% |
| | | | | | | |
| Total country allocations | 112,040,000 | | | (2,160,000) | 109,640,000 | 100% |
| | | | | | | |
| Total budget | 285,100,000 | | | | 279,100,000 | |
| Less: Retirees' Health Insurance | (5,000,000) | | | | (5,000,000) | |
| Total net budget | 280,100,000 | | | | 274,100,000 | |
| Country share | 40% | | | | 40% | |
| | | | | | | |
| (*) New Associate Members included after the Budget Policy approval. Inclusion in the Budget Policy under this new condition is pending discussion. | | | | | | |
| | | | | | | |
| Note: this allocation assumes Assessed Contribution from WHO of $80.7 million. | | | | | | |

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