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PERFORMANCE ASSESSMENT REPORT OF THE BIENNIAL PROGRAM BUDGET 2002-2003

CONTENTS

I. Introduction

1. The Performance Assessment Report provides a summary review of the performance of the Program Budget for the period 2002-2003, and identifies the key lessons learned that were taken forward in the development of subsequent Program Budgets. This is the second time that the Secretariat is submitting to the Governing Bodies such an assessment of the execution of its program of work. At its 130th Session in June 2002, the Executive Committee received the report of the evaluation of the Biennial Program Budget (BPB) for 2000-2001.

2. The program of work for the 2002-2003 biennium, as reflected in Official Document No. 296, was the last presented within the medium-term planning framework of the strategic and programmatic orientations (SPOs) for the period 1999-2002. The five SPOs which had guided the work of the Secretariat during that period were:

- Health in Human Development
- Health Promotion and Protection
- Environmental Protection and Development
- Health Systems and Services Development
- Disease Prevention and Control

3. The "logical approach" was used in the formulation of the results-based plans for 2002-2003. The biennial proposal offered two levels of objectives: the Purpose objective which described the anticipated outcome or impact of the projects, and the Expected Results with chosen indicators which represented the outputs/deliverables that constitute the manageable interest of the Secretariat.

4. This assessment confronted several challenges as 2002-2003 was a biennium of transition. At the Pan American Sanitary Conference, in September 2002, the Member States approved a Strategic Plan 2003-2007 for the Pan American Sanitary Bureau, and elected a new Director charged with the responsibilities of its implementation. On 1 March 2003, the new administration launched a process of institutional transformation. These changes notwithstanding, the assessment has identified areas which can benefit from a greater concentration of efforts and others that need to be more country-focused.

II. Methodology

5. The program structure was modified during the period 2002-2003 to reflect alignment with the reorganization of the Secretariat undertaken in March 2003. This assessment is based on the cumulative progress reports of the projects as they were structured in *Official Document 296*.

6. The assessment of performance was done by each organizational unit against the measures provided in the indicators defined at the time the proposal was developed. Data and information gaps in the progress reports on execution were completed through interviews with relevant staff from technical units.

7. This assessment is a regionwide analysis of progress attained in each technical area and does not include separate reports on individual organizational units at regional, subregional, or country levels. The impact on countries is highlighted throughout the assessment of the projects contained within the SPOs.

III. Highlights of Achievements

8. The 2002-2003 BPB identified eight flagship projects that maximized the momentum provided by international and regional summits, availability of cost-effective technologies, and the need to call attention to emerging problems. Although not all were fully achieved, significant strides were made; and the following table summarizes the status of achievement of the projects.

Flagship Projects	Status at he end of 2003
1. Saving an additional 100,000 children's lives during the quadrennium	Current estimates indicate that childhood mortality dropped from 34 per 1,000 to 27 per 1,000 live births from 1998 to 2002, a fall of around 20%. Approximately 99,000 deaths were averted. One country, Trinidad and Tobago, did not register a reduction; and estimates for 2002 were higher than those from 1998 in four countries: the Dominican Republic, Haiti, Panama, and Venezuela. Acute respiratory infections and diarrhea, the main diseases targeted by the Integrated Management of Childhood Illnesses (IMCI) Strategy, account for most of the reduction in child mortality rates.
2. Maintaining the Region polio-free	Since 1991, the Region has been without any circulating wild poliovirus. In 2000 a poliovirus-derived vaccine circulated in Hispaniola (21 cases). This was associated with low coverage levels of polio vaccines. No cases have been reported in the last five years.
3. Achieving and maintaining measles elimination throughout the Region	By the end of 2003, the Region was very close to eliminating measles. Only 105 cases were reported in that year, all imported or import-related.
4. Controlling and reducing tobacco use	The most significant achievement in tobacco control was the adoption of the Framework Convention on Tobacco Control (FCTC) by the World Health Assembly in May 2003. Almost all PAHO Member States participated actively in the negotiations and related meetings that began in 1999. The treaty sets out guidelines and specific obligations for ratifying countries and will drive international tobacco control for the next several years. Measures covered by the treaty include fiscal policy, smoke-free environments, health warnings on packages, elimination of tobacco promotion, tobacco control education and programs, surveillance and monitoring, and international cooperation. PAHO continued its Smoke Free Americas initiative, implementing a successful pilot training workshop in Jamaica and other workshops for Honduras, Saint Lucia, Saint Vincent and the Grenadines, and Uruguay. All workshops resulted in action plans for creating smoke-free environments. With PAHO's technical cooperation, Belize, El Salvador, Honduras, Mexico, Paraguay, and Venezuela completed the Global Youth Tobacco Survey (GYTS); and PAHO held a training workshop on GYTS data collection and analysis for 18 countries.

Flagship Projects (*cont.*)	**Status at he end of 2003** (*cont.*)
5. Reducing maternal mortality	Countries that have active maternal health programs, and good surveillance systems and annual statistics, generally report official reductions in maternal mortality within at least a five-year period or more (i.e. Chile, Costa Rica, Cuba). However, specific surveys for such Key Countries as Bolivia show reduced maternal mortality by 41% from 1993 to 2003, which, in turn constitutes evidence that the strategy is working. Main policy achievements include the development of the Regional Strategy for the Reduction of Maternal Mortality and Morbidity, a consensus-driven policy endorsed by the Member States at the 26th Pan American Sanitary Conference in 2002. This strategy represents significant efforts by PAHO to incorporate the latest research, best practices, and experience gained in more than a decade of the Safe Motherhood Movement into concrete steps for countries to fulfill national plans and work toward the achievement of the Millennium Development Goals (MDG). ~~Maternal mortality measurement requires at least three series **(of what?)** to establish a trend. Countries that have active maternal health programs, and good surveillance systems and annual statistics, generally report official reductions in maternal mortality within at least a five-year period or more (i.e. Chile, Costa Rica, Cuba). However, specific surveys for such Key Countries as Bolivia show reduced maternal mortality by 41% from 1993 to 2003, which, in turn constitutes evidence that the strategy is working.~~
6. Providing safe blood through regional health services	Despite improvements in the coverage of testing, the goal of universal screening of blood in the Americas was not attained. Between 2000 and 2003, the proportion of units tested for: • HIV went from 99.66% to 99.93%; • Hepatitis B increased from 99.65% to 99.86%; • Hepatitis C from 98.79% to 99.52%; and • Syphilis markers from 99.57% to 99.84%. The lowest coverage was for *T.cruzi* in continental Latin America: 78.98% and 88.09% for the two years, respectively. Nineteen countries and territories screened all units of blood collected for all required markers, up from 16 in 2000. Anguilla, Antigua and Barbuda, Belize, Montserrat, and Saint Kitts and Nevis reported zero screening for hepatitis C in 2003. Seven Latin American countries tested all units for *T. cruzi* in 2003. Voluntary, nonremunerated donors provided only 15% of the

	units of blood collected in Latin America and the Caribbean in 2000. The proportion of units collected from voluntary donors increased to 36% regionwide in 2003; Bolivia, Honduras, Panama, Paraguay, and Peru reported paid donors that accounted for 0.3% of regionwide collected units. In 2003 Aruba, Bermuda, Brazil, Cayman Islands, Cuba, Curaçao, Saint Lucia, and Suriname reported over 50% voluntary blood donors (VBD).

7. Improving mental health through the improvement of mental health services	The main activities included: • creation and training of a group of international consultants on mental health policy and services development; • development of a course on mental health services administration; • dissemination of evidence-based guidelines on mental health policy and service development; collaboration in the development of the WHO policy and services development project; • provision of technical cooperation to 17 LAC countries in the implementation of mental health policy and plans; • training of health professionals in mental health (a project for primary care in collaboration with Dalhousie University); • advocacy for the protection of human rights against stigma and discrimination; • promoting and protecting the rights of people with mental disorders through legislation and other strategies; • preparation of a book on innovative experiences with mental health services in LAC countries.
8. Controlling and reducing the spread of HIV/AIDS	• PAHO provided modular guidelines for comprehensive care—the "building blocks"—and championed equitable access to treatment through the establishment of the Regional Revolving Fund for Strategic Public Health Supplies. • Scaling-up health systems to respond to HIV/AIDS in Latin America and the Caribbean was the subject of a ground-breaking consultation held in Ocho Rios, Jamaica, in February 2002. It promoted the concept of health system strengthening using HIV/AIDS as an entry point. • During 2003, PAHO played a key role in assisting countries to develop successful proposals for the Global Fund against AIDS, Tuberculosis, and Malaria (GFATM). Intercountry technical cooperation in HIV/AIDS between Brazil and Andean countries was implemented with the Department for International Development (DFID), U.K., support. • PAHO supported a series of price negotiations in collaboration with WHO, UNAIDS, and the ministries of health that resulted in significantly reduced costs for antiretroviral therapy (ART). • PAHO hosted the first meeting of the Regional Directors of the UNAIDS cosponsors in June 2003 to define a regional framework for interagency coordination. • On World AIDS Day in 2003, PAHO launched a region-wide media campaign, addressing the issue of stigma and discrimination in the health sector

9. During the biennium, an additional flagship initiative, measuring the performance of Essential Public Health Functions (EPHFs), was identified and completed. PAHO/WHO, in close collaboration with the United States Centers for Disease Control and Prevention (CDC) and the Latin American Health Systems Research Center (CLAISS), developed a methodological instrument to assess the performance of 11 essential public health functions. Within the framework of the Public Health in the Americas Initiative,[1] the instrument was applied in 41 countries and territories of the Region of the Americas. The exercise provided each country with baseline measurements on the performance of the public health delivery systems and a national focus for work toward the development of optimal standards for public health practice.

10. Adaptations of the methodology for the subnational level have been completed in Brazil and Colombia. National plans to strengthen the EPHFs are under way in El Salvador, Honduras, and Puerto Rico.

IV. Highlights of Achievements by Strategic and Programmatic Orientation

A. *Health in Human Development*

11. Technical cooperation was structured around the promotion, advocacy, and development of the concept of equity in health.

12. There were important achievements during the biennium with regard to improvements in policies designed to reduce health inequities, including the enactment of pro-poor health policies in the following countries: Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Cuba, the Dominican Republic, Ecuador, El Salvador, Guyana, Honduras, Guatemala, Jamaica, Mexico, Nicaragua, Peru, Trinidad and Tobago, Uruguay, and Venezuela.

13. Gender issues were highlighted. Chile was one of the countries that incorporated gender equity in sectoral reform policies. This entailed, among other things, the design of appropriate intersectoral alliances, the strengthening of advocacy capabilities of civil society groups, and a more sustained presence of gender equity in the media.

14. The capabilities of countries in Latin America and the Caribbean to produce and use scientific knowledge to address priority public health problems in the Region were improved. An important instrument was the continued development of the Virtual Library with the support of science and technology networks, such as the International Network of Sources of Information and Knowledge for the Management of Science, Technology,

[1] PAHO/WHO, Public Health in the Americas, 2002 http://www.campusvirtualsp.org/eng/pub/PublicHealthAmericas/index.html

and Innovation (ScienTI) and a cluster of national science and technology networks. These advances have led to an increase in the accessibility to scientific information in health.

15. With regard to the strengthening of countries' health information systems and networks, emphasis was placed on vital statistics and countries consistently disseminated data on vital and health statistics through their Web pages: Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Jamaica, Mexico, Peru, Puerto Rico, Saint Lucia, and Uruguay. Analyses of the requirements of vital registries systems were prepared for countries with special needs, such as Belize, Bolivia, Guatemala, Guyana, Haiti, Honduras, and Peru.

16. Following the recommendations of PAHO, most countries in the Region started to compile and disseminate basic health data on an annual basis. In addition, at least 23 of the 48 countries and territories were systematically producing basic data and health information at subnational levels. This will lead to improvements in situation analysis and facilitate the identification and monitoring of public health programs.

17. Ethical dilemmas posed by recent technological and scientific developments and their relationships to public health increased the demand for consultancy and advice on bioethics. In partnership with prominent research and academic institutions in Latin America, the Caribbean, and other parts of the world, increased standardization in training and best practices were achieved. Hospital committees and national commissions were organized in several countries.

B. *Health Promotion and Protection*

18. Member States continued to strengthen their capacity to establish or maintain healthy municipalities and communities, including schools and workplaces. Argentina, Brazil, Canada, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Mexico, Peru, and the United States of America started or continued the incorporation of relevant indicators, assessments, and evaluations in their health reporting systems. In addition, there were advances in Member States' national and local capacity to implement and evaluate healthy and supportive environments. The Mayor's Kit was launched during the Health Promotion Forum in Chile. Mayors, health authorities from national and local levels, and technical staff from various sectors of all the countries in the Region participated in workshops and networking sessions, sponsored by PAHO to develop intersectoral plans of action.

19. With the involvement of the Caribbean Food and Nutrition Institute (CFNI), Institute of Nutrition of Central America and Panama (INCAP), and Pan American Institute for Food Protection and Zoonoses (INPPAZ), a framework document for the New Agenda for Optimal Nutrition was disseminated throughout the Region. There was

an improvement in regional knowledge and understanding of nutritional problems and the importance of making feeding and nutritional safety a key development issue.

20. To prevent malnutrition, several countries were supported in their efforts to develop, monitor, and evaluate nutrition interventions. ProPAN, a manual containing guidelines of strategies designed to prevent childhood malnutrition, was made available online, in both English and Spanish. The ProPAN strategy was implemented in Bolivia, Brazil, Ecuador, Jamaica, Mexico, and Panama as part of a multicenter study designed to improve understanding of infant-and-young-child feeding practices and access to commercial fortified foods.

21. Improvements in national capabilities to formulate policies, plans, and programs, and in services for adolescents and young adults were noted in the Central American countries where PAHO, in partnership with the Swedish International Development Agency (SIDA), provided support ~~to~~ for the development ~~of relevant policies, plans, and programs~~ of Integrated Management of Adolescent Needs (IMAN). ~~The program~~PAHO also supported activities of violence prevention in partnership with the German Technical Cooperation Agency (GTZ), and of HIV prevention in partnership with the Norwegian Agency for International Development (NORAD)~~, Swedish~~, ~~Agency for International Development Cooperation (SIDA),~~ and Youthnet/United States Agency for International Development (USAID). In addition, support was provided for the mobilization of national resources in Argentina, Ecuador, Guatemala, and Haiti, and for the formulation of intersectoral plans for the youth in almost all Central American countries, Bolivia, Ecuador, and Peru.

22. The Political Framework for the Development of Plans and Programs for Older Adults was made available in English, Spanish, and Portuguese. Argentina, Belize, Bolivia, Chile, Cuba, Dominica, the Dominican Republic, El Salvador, Jamaica, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay were assisted in the implementation of plans and programs in the context of the framework of the International Plan of Action on the Elderly.

23. With regard to tobacco use, several countries have created smoke-free environments in a variety of sectors and jurisdictions and also initiated or developed national plans for extensive and comprehensive smoke-free policies. Argentina, Brazil, Chile, Costa Rica, Jamaica, Honduras, Mexico, Paraguay, Peru, and Uruguay launched the implementation of policies for the creation of smoke-free tobacco environments. Also, there have been several subnational or municipal initiatives in Brazil and in Venezuela that have created similar programs. Some advocacy strategies, such as PAHO's Smoke Free Americas initiative, have had a positive impact as they have contributed to the design of national strategies to protect nonsmokers.

C. *Environmental Protection and Development*

24. The challenges of increasing urbanization and demographic growth continue to pose significant strains on water supply and basic sanitation services, and housing. To address this, PAHO, in partnership with international institutions, including the CDC and the U.S. Environmental Protection Agency (EPA), and in tandem with national and local governments, fostered important advances in the Region to build the relevant capacity to enhance coverage, quality, and efficiency in drinking water supply and sanitation services, to increase awareness of environmental risks, and to improve sanitary surveillance. During the biennium, access and coverage in periurban areas, including those affected by migration from rural areas, were expanded.

25. Technical cooperation focused on the reduction of inequities related to exposure to environmental risks; management of solid waste in municipalities and health facilities; healthy housing and rural environmental sanitation; introduction of quality criteria and standards of environmental surveillance; administration, protection, and preservation of water, air, and soil from a human health perspective; safety of work environments; and increased awareness about health issues in environmental management. The most significant advances are highlighted below.

26. With regard to drinking water and sanitation, there was marked progress in sharing of relevant methodological instruments, i.e. sectoral analysis guidelines, training to improve laboratory analysis of environmental samples, and the dissemination of plans and procedures for regulatory policy alternatives. New methodologies for improved participation of local communities and for health education were available, along with the sharing of analysis and lessons learned on water supply in cases of natural disasters. These actions led to improved coverage of potable water above the baseline of 85% at the regional level. In addition, the vulnerability analysis of water supplies particularly helped such countries as Colombia, Costa Rica, Chile, Ecuador, El Salvador, Mexico, and Peru to make more informed decisions.

27. Although water contamination continues to be a serious regional challenge strongly linked to disposal of liquid and solid residues in rivers, lakes, and oceans, and insufficient facilities for the treatment of sewage, progress is reported as a result of awareness campaigns, such as the “children out of garbage initiative.” Information on prevention of contamination of water resources from hospital and industrial sewage, and/or from the use of pesticides and fertilizers has been disseminated. PAHO assisted in the formulation of plans, policies, and procedures in matters pertaining to the orderly disposal of solid waste. However, there remained a lot to do as coverage of solid waste collection services was below 65% for the Region.

28. Lessons learned were shared through the increasing use of electronic media and the Web. Investments in this area also facilitated the sharing of training programs.

Argentina, Brazil, Chile, Colombia, the Dominican Republic, Ecuador, Peru, and Uruguay benefited from training in risk assessment, including environmental epidemiology, toxicology, and risk communication. The design and implementation of the Regional Information System (SISAM) was an important vehicle for the dissemination of relevant data and information on lessons learned and best practices through electronic media and the Internet.

29. With regard to healthy housing, achievements include the organization of the Inter-American Healthy Housing Network that helped to expand multisectoral and multidisciplinary action, and contributed to the dissemination of policy, programmatic- and project-related knowledge, and the exchange of relevant data and information throughout the Region. The network benefited Argentina, Brazil, Costa Rica, Guatemala, Guyana, and Paraguay, in particular. It also led to the development of technical country cooperation between Cuba and Haiti, Cuba and El Salvador, and Brazil and Peru.

30. The challenging social conditions surrounding employment tend to make the working population more susceptible to disease, more vulnerable to injuries, and more subject to burnout and physical exhaustion. Prevention programs and surveillance were strengthened at both regional and subregional levels, benefiting large numbers of working men and women in the factories of Mexico and Central America, as well as in urban and rural enterprises in the Andean region and the Southern Cone. The model developed contributed to reduce the costs of occupational injuries and diseases.

D. *Health Systems and Services Development*

31. Work in this area emphasized the development of tools to strengthen national capabilities of Member States to analyze the health sector, identify needs for change, and design required transformation in the development of health systems. The Secretariat concentrated on the areas of health sector analysis; health financing; essential public health functions; social protection in health and improvement of social security schemes; human resources development; reorienting content of health care delivery models; models to improve performance of health services networks; and essential drugs and health technology.

32. In the area of health systems development, measurement of public health functions continued in 40 countries and territories. Instruments for the development of the institutional capacity of the health authority to perform the steering role function were prepared and disseminated regionwide. Also, technical support was provided to Bolivia, Brazil, Costa Rica, Ecuador, and Nicaragua at the national and subnational levels; and tools and methodologies were developed to support national efforts to improve the financing schemes, resource allocation practices, expenditure patterns, and provider payment mechanisms. In addition, 36 regional countries conducted studies to monitor and evaluate sectoral reforms on the basis of methods, models, and technologies developed

for the strengthening of national capabilities for performance assessment and improvements in health systems profiles.

33. The health sector reform processes implemented in all countries of the Region of the Americas had considerable repercussions on the management of human resources. In response, the Organization launched the observatories of human resources in health, as a cooperation strategy to generate national sets of core data, to characterize emerging issues and problems related to the reform agenda, and to promote the creation of interinstitutional mechanisms for the development of human resources policies. By the end of the biennium, 20 countries were actively involved in the initiative. A distance education course was produced and implemented to strengthen the managerial and leadership capacities of ministries of health in human resources. Special importance was given to the development of the public health work force within the framework of the essential public health functions, through the improvement of the quality of education of the postgraduate programs in public health, the development of the Virtual Campus in Public Health, the incorporation of public health in nursing schools, and the training of leaders in international health.

34. In the context of health services organization, the Medium-Term Plan for Nursery and Midwife Services was updated along the lines of the WHO strategic directions, with the contribution of 28 national and international partners and the participation of the 15 WHO/PAHO collaboration centers. In addition, training was provided to dentists on the innovative Atraumatic Restorative Treatment technology (PRAT) in Bolivia, Brazil, Costa Rica, El Salvador, Guatemala, Paraguay, Puerto Rico, Peru, Panama, and Venezuela, for the improvement and prevention of oral services.

35. In the field of essential drugs and health technology, Level I of the Pharmaceutical Assessment by WHO was successfully implemented in the Region with participation of 70% of the countries. Training for Level II implementation was completed in Barbados, Bolivia, Brazil, the Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Nicaragua, Saint Lucia, Trinidad and Tobago, and Venezuela. In addition, technical cooperation in the field of drug policy was provided to Argentina, Bahamas, Ecuador, El Salvador, Guyana, Paraguay, the Central American region, and the CARICOM and MERCOSUR countries.

36. Evaluations of the quality and safety of Radiology Services in Turks and Caicos Islands, Belize and Dominica, and of Radiation Therapy Services in Costa Rica, Colombia, Nicaragua, and Panama were conducted.

37. The image quality and radiation doses in mammography services were evaluated in 11 countries as part of the regional project “Evaluation of the Mammography Services in LAC” in collaboration with the Inter-American College of Radiology. The

International Action Plan for the Radiological Protection of Patients was jointly prepared with the International Atomic Energy Agency (IAEA),~~.~~ ~~—~~WHO and other relevant international organizations. More than 100 radiation therapy units in the Region were verified through the IAEA/PAHO joint program of dose verification by postal dosimetry.

38. The publication of the Manual *Sistema de Garantía de la Calidad, Conceptos Generales para Laboratorios de Salud Pública* in 2002, which is based on the ISO 9001 standard, triggered the implementation of a quality assurance system in several referral institutions in the Region and facilitated technical support to laboratory networks restructuring in such countries as Bolivia, Colombia Dominican Republic, Ecuador, Honduras, Panama, Paraguay, and Uruguay. The publication of the *Guía ~~de~~ para la Elaboración de Manuales de* Acreditación *de Laboratorios Clínicos para América Latina,* prepared jointly with the Latin American Confederation of Clinical Biochemistry (COLABIOCLI), will pave the way to the gradual implementation of an accreditation system for sustained improvements in clinical laboratories.

39. With regard to natural and man-made disasters, with PAHO support, Chile, Colombia, Costa Rica, Mexico, and Peru continued their national hospital disaster reduction programs. Vulnerability studies of health facilities were promoted in several countries, and regional and subregional multisectoral networks were fostered to increase awareness about disasters, to design and carry out relevant training programs, and to prepare and disseminate guidelines through the Internet and other media. In addition, PAHO's technical areas, units, and country offices continued to incorporate disaster management into their work plans.

E. *Disease Prevention and Control*

40. Communicable diseases continue to be a major focus of work as new threats emerged while countries continued their efforts against already established infectious diseases.

41. With PAHO support, countries continued to develop a response to antimicrobial resistance. Bolivia, Ecuador, the Dominican Republic, El Salvador, Guatemala, Paraguay, and Peru all adapted clinical treatment guides for infectious diseases. The eight countries of the Amazon Basin began conducting drug resistance studies for malaria and sharing results with financial support from USAID. In addition, each of the four subregions (the Southern Cone, Andean, Central American, and Caribbean) developed action plans for priority syndromes agreed upon for surveillance and laboratory diagnosis.

42. In the area of disease elimination:

- Mexico interrupted transmission of *onchocercosis* in two important foci (North Chiapas and Oaxaca), and Colombia verified interruption of transmission.
- Three countries—Costa Rica, Suriname, and Trinidad and Tobago—verified elimination of *lymphatic filariasis,* and four other endemic countries have taken steps to address this disease.
- Elimination of *leprosy* as a public health problem seems possible in the near future as multidrug treatment coverage was greater than 90% in the countries of the Region.
- With regard to *Chagas' disease* elimination, all six countries ~~of the Southern Cone Initiative to Control/Eliminate Chagas Disease (INCO Sur/Chagas)~~ completed an international evaluation of their programs. With the increase of screening coverage, transmission by blood transfusion was reduced in all countries, except Bolivia. In addition, the Central American countries of Guatemala, El Salvador, Honduras, and Nicaragua evaluated their national programs for Chagas' disease control and began implementation of programs with the support of the Japan International Cooperation Agency (JICA).

43. Similarly there were significant achievements in the area of disease control in which PAHO cooperated.

- Malaria - (a) All 21 endemic countries for malaria adopted the Roll Back Malaria Initiative and began redefining indicators, utilizing epidemiologic stratification to identify priority areas for activity. Honduras and Nicaragua made successful proposals to the Global Fund. (b) The expansion of the Directly Observed Therapy Strategy (DOTS) to prevent and control tuberculosis continued. Fifteen countries achieved 100% DOTS coverage.
- Dengue - The new integrated strategy to prevent and control dengue was endorsed by all countries at the PAHO Directing Council. Costa Rica, the Dominican Republic, Guatemala, and Nicaragua developed plans and began implementation of this strategy, while Belize, El Salvador, Honduras, and Panama had plans developed.
- Food safety - Export possibilities have helped in motivating countries to address food safety issues. All countries have created mechanisms for intersectoral collaboration with regard to food safety. There has been widespread commitment to the hazard analysis critical control point (HACCP) method of food safety inspection, and 55 laboratories from 22 countries are participating in a laboratory network to improve quality and transparency.
- Dog-transmitted rabies - The elimination of dog-transmitted rabies has been a commitment of the countries of the Region since the early 1980s. In this

biennium, only 5 of the 21 countries of Latin America reported cases of dog-transmitted rabies.

- Foot-and-mouth disease - Following the outbreaks of foot-and-mouth disease in Argentina, Brazil, and Uruguay in 2000, a renewed commitment to its elimination was undertaken at the Inter-American Meeting, at the Ministerial Level, on Health and Agriculture (RIMSA), in 2001, in São Paulo. The Pan American Foot-and-Mouth Disease Center (PANAFTOSA) was given additional authority to conduct audit missions to countries, and 9 of the 10 South American countries (excluding Chile) received such audit visits in this biennium.

44. With regard to noncommunicable diseases (NCD), the following achievements could be attributed to PAHO's cooperation:

- The number of countries with a budget allocation for NCD prevention and control increased from 9 to 21.
- Thirteen countries now belong to the CARMEN Network (from five in December 2001), which is devoted to developing integrated programs to address chronic noncommunicable diseases in countries and to sharing information. All these countries conducted some level of assessment of the situation of NCDs.
- Several countries began conducting behavioral risk factor surveys and testing the adaptation of North American models to their particular conditions.
- The burden of diabetes in Latin America and the Caribbean was evaluated and a publication was produced allowing countries to begin to address this important health problem.
- Extrabudgetary funds from the Bill and Melinda Gates Foundation allowed El Salvador and Peru to test screening and treatment techniques and quality control measures for cervical cancer in low resource settings.

Regular Budget Summary by Appropriation Section for the Financial Period 2002-2003
US$ Thousands

Section	Appropriation Title	Approved Budget	Disbursed
P1	Health in Human Development	41,357	42,597
P2	Health Promotion and Protection	24,400	23,109
P3	Environmental Protection and Development	21,270	19,222
P4	Health Systems and Services Development	42,313	37,549
P5	Disease Prevention and Control	41,730	36,078
P6	Governing Bodies and Coordination	48,761	47,153
P7	General Direction	13,002	12,343
P8	Administrative Services	28,648	26,306
Total		**261,482**	**244,356**

Note:

The difference between the level of the Approved Budget and that of the Disbursed or Effective Working Budget is due to the difference between budgeted income (the total level of assessed contributions from Member States and estimated miscellaneous income) approved for the biennium versus the actual level of assessed contributions and miscellaneous income collected during the biennium and available for expenditure.

It should also be noted that the total Approved Budget of $261,482,000 includes the WHO share approved for the Region of the Americas by the World Health Assembly (WHA). In 2001, WHA54 approved $74,682,000 for the Region of the Americas for the period 2002-2003.

Extrabudgetary Resources Summary by Appropriation Section for the Financial Period 2002-2003: Estimated versus Actually Mobilized and Disbursed US$ Thousands

Section	Appropriation Title	OD 296 Estimates	Disbursed
P1	Health in Human Development	5,949	5,701
P2	Health Promotion and Protection	3,357	8,461
P3	Environmental Protection and Development	2,740	6,439
P4	Health Systems and Services Development	19,487	48,305
P5	Disease Prevention and Control	14,475	56,505
P6	Governing Bodies and Coordination	1,217	1,365
P7	General Direction	1,285	30
P8	Administrative Services	7,082	0
Total		**55,592**	**126,805**

Note:

The level of extrabudgetary resources included as an estimate in Official Document OD296 was based only on known and firm commitments from partners at the time of the preparation of the program budget document and does not take into consideration resource mobilization efforts which were to be carried out prior to and during the biennium. Therefore, the ~~actual~~ **~~(OK?)~~** level of extrabudgetary resources actually mobilized and disbursed, in comparison, is significantly higher.

The practice for estimating extrabudgetary resources in the budget formulation process has evolved and is now being done differently starting with the 2006-2007 biennium. In response to the emphasis on results-based management, and consequently on results-based budgeting, the focus is now on the overall expected results to be attained and the totality of estimated resources required to achieve them.

VI. Lessons Learned

45. The need to be country focused was evident overall in this biennium. This was further addressed in the preparation of the 2006-2007 BPB by the phasing of the reviews of the BPB to allow the regional units to gain a better perspective of the issues that were being addressed in the countries.

46. The AMRO Planning and Evaluation instruments have the structural components for good programming, planning, and monitoring at different levels of the hierarchy within a log frame, but its value for facilitating good program management will depend on the degree to which there is widespread institutional commitment to its use. Further, there is a need for more consistency in the application of planning principles to allow better comparability. In particular, the definition of the manageable level of interest requires further harmonization, especially in light of WHO requirements to report at the outcome level in the future (i.e. beyond manageable components), which poses a challenge in the forecasting of the level of proposed indicators as well as of assumptions external to the management of programs.

47. Choice of appropriate indicators continues to be a challenge. At times, chosen indicators are under the control of program managers, but there are still a good number of cases where the indicator selected for an expected result is more within the responsibility of Member States (such as the implementation of a policy). There are some cases where stated expected results seemed hard to achieve in a short time period.

48. Some lessons were learned in relation to the challenges of the specific technical programs. For example, programs and activities in the area of health promotion show that appropriate practices are those entailing processes and activities that are consistent with the values and beliefs of the countries' population and reflect an adequate understanding of the environment of public health. As such, promotion will add value to public health when it is intersectoral and interagency, and when country authorities and population are deeply engaged in the processes of positively changing attitudes and behaviors. Progress regarding tobacco control and protection of nonsmokers demonstrates the influence of public health advocacy on key issues. The success has been based on clear public health evidence, effective interorganizational collaboration, consistent and persistent focus on the achievable tasks, and effective building of momentum toward tangible results.

49. Success of interventions pertaining to the environment regarding health continues to require integrated work at the policy (macro), institutional (meso), and project (micro) levels, with each level reinforcing and optimizing the impact of other levels—thus, the importance of integrated approaches. In addition, sustainability of programs designed to improve potable water, sanitation, and other human services demands significant support by local consumers and governance structures.

50. Environmental challenges cannot be met through social development alone. Economic development interventions must be implemented in parallel with social interventions. In addition, and for enhanced results, international partners and national authorities should link and coordinate environment-related interventions with interventions in good governance and democratic development. Not less important, new and improved roles need to be found for the private sector in providing and sustaining environmental needs, which will require improvements in regulatory policies.

51. The prevention and control of diseases and the protection and promotion of the health of people are primary mandates of public health. The fulfillment of these goals does not solely rely on the government, PAHO, or international partners but requires overarching alliances by all these actors working in tandem with national and local governments, the private sector, communities, families, and individuals.

VII. The Way Forward

52. Reporting on the progress and achievements of institution-wide expected results during the 2002-2003 biennium has been a challenge as the indicators selected were at times either inappropriate or insufficient, or insufficient information was provided in the routine AMPES progress report on achievements and lessons learned. There were also expected results whose achievement was unfeasible in the short term, such as behavioral or policy changes that by nature require longer time periods to effectively materialize.

53. Addressing these challenges will require a systematic capacity-building effort to improve choices of appropriate measurable targets, purposes, expected results, and indicators in future planning exercises. It will also require moving the institution from results-based planning to results-based management, and steps are being taken towards the preparation of the Proposed Program Budget for 2006-2007. This is consistent with the WHO results-based management framework with its integrated "one" program budget, which entails increasing coordination among WHO, regional, and country offices. This will lead to the development of a strong system of performance monitoring, quality assurance, evaluation, and reporting. The new approach will further facilitate the design of log frame components with monitoring and evaluation for results and impact in mind.

54. Another challenge to overcome in the future is the fact that the assessment is currently based on a self assessment only, with indicators which often present a great diversity in terms of specificity. This, in turn, makes it extremely difficult to compare levels of achievement across different organizational units. The addition of program evaluations or even random audits of the achievements of the outcomes will help to keep the Organization on track to ensure that it does the right thing to address the health problems of the Region.

55. Effective quality management and performance-oriented planning are key to building institutional excellence. The encompassing lesson of the 2002-2003 BPB assessment is that the success of PAHO will increasingly be a function of improved coordination at all institutional levels. This is consistent with the main tenet of the institutional restructuring process initiated in 2003 that aims at transforming PAHO into a well-synchronized institution: one that operates as a single team in the delivery of programmatic objectives, tasks, and activities.

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