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**PRELIMINARY REPORT OF THE END-OF-BIENNIUM ASSESSMENT
OF THE PAHO PROGRAM BUDGET 2020-2021 /
FIRST INTERIM REPORT ON THE IMPLEMENTATION
OF THE PAHO STRATEGIC PLAN 2020-2025**

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I. Foreword by the Director

At the midpoint of the Strategic Plan 2020-2025, the Pan American Health Organization (PAHO) finds itself emerging from one of the most challenging periods in its history due to the COVID-19 pandemic and the unprecedented financial crisis of 2020. The situation was very different in 2019, when the Strategic Plan 2020-2025 and the Program Budget 2020-2021 were approved. All of us—in the Pan American Sanitary Bureau (PASB), in Member States, indeed throughout the world—have been impacted in some way by what unfolded. Still, I believe that out of crisis we can always find opportunity, if we take the time to reflect on lessons learned and harness innovations and new ways of working as we chart the way forward with unity and resolve.

Our investments in health over many years and during the past biennium have yielded results. While this assessment is underway, the 120th anniversary of PAHO in 2022 provides an opportunity to draw attention to the Organization's catalytic and pioneering role in health. Though much has changed since its inception, some things remain true today: PAHO remains committed to ensuring the enjoyment of the highest attainable standard of health for all peoples of the Americas. The quest for universal health continues to dominate the overall agenda of the Organization.

I am impressed by what we have achieved together despite the pandemic. We have seen quantum changes in areas that are priorities for Member States, such as information systems for health, telehealth and telemedicine, and progress toward the elimination of communicable diseases, to name just a few. The advances made by countries in improving health outcomes under such circumstances should give us some hope that we could accelerate our efforts for health and well-being. Thus, one of the aims of this report is to identify the most pragmatic strategies to accelerate the Region's recovery, to target interventions more effectively, and to identify the barriers hindering progress. What do we need to do differently? Where do we need to increase our emphasis to meet targets of the Strategic Plan by 2025 and of the Sustainable Development Goals by 2030? And, most importantly, how do we reach those left behind?

Faced with multiple external factors, PASB, Member States, and partners have worked collectively, with many demonstrating extraordinary resilience. PAHO was able to maintain a very high level of performance, with a well-financed Program Budget and overall budget implementation above previous biennia. We accomplished this thanks to the collective commitment and efforts of many, as well as new ways of working and efficiencies that facilitated both the pandemic response and the continuity of technical cooperation. I want to thank all of you for your part in this.

This report will serve as an important reference document for years to come on the work of the Organization during these unprecedented times. As we move forward in 2022-2023 with the vision of *Protect, Recover, and Build Stronger*, lessons learned from 2020-2021 must be documented, with particular attention to preparedness for health emergencies and the impact of emergencies on priority health programs. Even as we

continue to respond to the pandemic, we must increasingly emphasize the recovery and strengthening of health systems. We must start to move the discourse—and shift our own mindset—from crisis and emergency response toward long-term goals in health and development. We must implement bold actions to build resilient health systems, moving beyond “talk” to build health systems and services that are comprehensive, integrated, equitable, fit for purpose, and based on primary health care. We must also continue making the case for robust investment in health as a key building block of sustainable, people-centered development.

We stand on 120 years of achievements of many who have preceded us. Our work today and into the future must guarantee health and well-being for the next generation.

II. Executive Summary

Overview

1. The years 2020 and 2021 will long be remembered as one of the most critical periods during the first 120 years of the Pan American Health Organization (PAHO). The biennium was marked by the unprecedented toll of the COVID-19 pandemic, the financial crisis facing the Organization in 2020-2021, and the evolving socioeconomic and political context in the Region of the Americas. This preliminary end-of-biennium assessment report collects input from across the Organization on these challenging first two years of the PAHO Strategic Plan 2020-2025 (SP20-25). The report also provides an account of the implementation of the PAHO Program Budget 2020-2021 (PB20-21). In this way it serves as a critical instrument of programmatic accountability and transparency for the Organization. The analysis presented in the report is now more relevant than ever as the Organization moves forward, aiming to *protect, recover, and build stronger* as outlined in the PAHO Program Budget 2022-2023. In so doing, it will be working toward the goals in the SP20-25, the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030), and the Sustainable Development Goals (SDGs) for 2030.

Key Findings

2. During 2020-2021, the Region was able to maintain and achieve significant public health gains and to produce transformative action on key priorities for Member States. The COVID-19 pandemic, while causing many adverse impacts and challenges, also served as motivation to reinforce public health functions, particularly those related to the response to public health emergencies. The pandemic also provided a unique opportunity to underscore on the importance of health, ensure the continuity of essential health services, strengthen the stewardship role of the health authorities, improve intersectoral coordination for health and well-being, and to raise awareness of the needs of vulnerable communities. It demonstrated that no one country acting alone can successfully address a health emergency of such magnitude; reaffirming the importance of solidarity and equity. At the same time, the pandemic revealed weaknesses in health systems, the fragility of hard-earned gains, and the inextricable linkages between health, social development, and the economy. Sustainable and equitable economic recovery must therefore have health at the center, with equity as prerequisite of sustainable development.

3. The analysis presented in this report shows that the pandemic has affected performance on the impact indicators in the PAHO SP20-25 at the overall regional level. It is still too early to determine what the trajectory will be for all the indicators, given the rapidly evolving situation and the need for updated data. Nevertheless, it can be observed that setbacks, some from before the pandemic and some that emerged as a result of it, have put at risk progress toward the achievement of the targets in the Strategic Plan, SHAA2030, and the SDGs. The available information also suggests that there has been a greater effect on the most vulnerable populations and that disparities between and within countries have persisted or even widened. Achieving impact requires sustained implementation of proven

interventions and an integrated, Organization-wide approach that looks closely at the determinants of health and the access barriers, as well as at the impact of interventions in health systems and services.

4. The report presents an update on the indicators at impact, outcome, and output levels and on the outcomes of the PAHO SP20-25. Among the key findings:

- a) Six of 35 impact indicator targets are estimated to be on track to be achieved by the end of 2025. The remaining indicators appear to be in trouble or at risk of not being reached by 2025, or the available information did not make it possible to provide a rating.
- b) Seventeen of the 28 outcomes (60%) are assessed as having met expectations for the 2020-2021 biennium. The other 11 outcomes (40%) partially met expectations. Among the outcomes that met expectations, five were rated as high priority by Member States: Outcome 1 (Access to comprehensive and quality health services); Outcome 12 (Risk factors for communicable diseases); Outcome 14 (Malnutrition); Outcome 24 (Epidemic and pandemic prevention and control); and Outcome 25 (Health emergencies detection and response).
- c) At the time of publication of this Executive Summary, Member States were conducting the joint assessment of outcome and output indicators. Therefore, the report to the Executive Committee contains preliminary results of the assessment of these indicators carried out by the Pan American Sanitary Bureau (PASB), which will be updated for the final report to the 30th Pan American Sanitary Conference in September 2022. Initial results show that 54% of outcome indicators and 71% of output indicators were achieved or exceeded or showed significant progress.

5. Significant programmatic achievements were made possible thanks to the tireless efforts of Member States, supported by PASB across all functional levels of the Organization and in collaboration with partners. The Results Report presents preliminary results by clusters of outcomes, along with a preliminary set of country success stories. These results, summarized below, will be complemented with additional information for the 30th Pan American Sanitary Conference.

6. **Health emergencies.** With the support of the entire Organization and the collaboration of Member States and partners, PASB responded to the COVID-19 pandemic and to other emergencies that occurred during the biennium while reinforcing the Region's capacities to face future health crises. Priorities included increasing country preparedness, implementation of the International Health Regulations, and disaster risk reduction; prevention and control of epidemics and pandemics, including surveillance; and early detection, risk assessment, information sharing, and rapid response. PASB supported 23 countries in increasing their medical surge capacities for COVID-19 through the deployment of Emergency Medical Teams (EMT) and the selection and setup of alternative medical care sites (AMCS). In total, 100 national EMTs were deployed and 129 AMCSs became operational, providing a total of 6,899 inpatient beds and 1,078 critical care beds. Despite the pandemic and concurrent disasters that included hurricanes, an earthquake, and

a volcano eruption, all countries and territories were able to continue providing an essential package of life-saving health services during the 2020-2021 biennium. Country success stories are presented from the Bahamas, Costa Rica, and Ecuador on the pandemic response, and from Haiti and Saint Vincent and the Grenadines on the response to natural disasters that took place during the period.

7. **Health systems and services.** PASB supported countries in implementing actions to reorganize and expand health services in response to the COVID-19 pandemic. This included significantly increasing hospital capacities for intensive care, strengthening the first level of care for the management of COVID-19 and the continuity of essential health services, and implementing public health interventions at territorial level. PAHO enabled increased access to essential health supplies for COVID-19 through advocacy, coordination, and negotiation within key global mechanisms such as the COVID-19 global supply consortium and the Access to COVID-19 Tools (ACT) Accelerator, whose three pillars are vaccines, diagnostics, and therapeutics. Bolivia offers a success story on the introduction and extension of oxygen therapy for COVID-19 patients. The PAHO Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund) procured over US\$ 550 million¹ in medicines and public health supplies on behalf of 31 participating entities, benefiting over 70 million people. The PAHO Virtual Campus for Public Health was rapidly adapted for the emergency response and delivery of strategic technical cooperation, with more than 30 COVID-19-related courses provided to 1 million health workers throughout the Americas.

8. **Health throughout the life course, determinants of health, and health promotion.** PASB promoted healthier lives through universal access to comprehensive, quality health services for all women, men, children, adolescents, and older adults in the Americas, focusing on groups in conditions of vulnerability. PASB also supported countries in implementing evidence-based interventions, using the Health in All Policies approach, such as the Familias Fuertes program; promoting the use of COVID-19 vaccines in pregnant women and the professionals who care for them; and developing research, analysis, and data on service coverage, social and environmental determinants of health, and related inequalities. The experience of Dominica in using an evidence-based information system to strengthen maternal and child health services is shared as a success story.

9. **Noncommunicable diseases (NCDs) and their risk factors, malnutrition, mental health, violence, and injuries.** The biennium saw important progress in strengthening the care of people with NCDs, as well as achievements in tobacco control and policies on the elimination of industrially produced trans-fatty acids. Malnutrition continued to decrease. Intersectoral work on violence, including sexual violence, advanced, and there was significant progress on strengthening policies and collaboration to improve the care of people with mental health conditions and implementation of suicide prevention

¹ Unless otherwise indicated, all monetary figures in this report are expressed in United States dollars.

strategies. Intersectoral work on road safety moved forward, and Mexico's achievement in passing a groundbreaking new law on mobility and road safety is a success story.

10. **Prevention, control, and elimination of communicable diseases.** Despite the pandemic, disease elimination efforts advanced on several fronts. Dominica and El Salvador were certified for elimination of mother-to-child transmission of HIV and syphilis and elimination of malaria, respectively. Brazil, Canada, Chile, Guatemala, Suriname, and Trinidad and Tobago achieved 90% HIV suppression among persons receiving antiretroviral therapy. PASB adopted innovative strategies for technical cooperation in the face of emerging threats, such as increased antimicrobial resistance. The Organization also provided technical assistance to countries to prepare them for the introduction of COVID-19 vaccines and to maintain routine immunization services. Brazil offers a country success story in addressing the socioeconomic hardship associated with tuberculosis.

11. **Information systems for health, evidence, and research.** Much progress was made at country and regional levels toward targets on information systems; incorporation of data, information, knowledge, and evidence; and research and innovation. The information systems for health (IS4H) initiative was implemented across the Americas with the support of PASB. Substantive progress was made on the use of platforms, such as Health in the Americas, Core Indicators, and the SDGs monitoring portal, and on the development of evidence and research to respond to the COVID-19 pandemic and address other health system and societal challenges.

12. **Cross-cutting themes: equity, gender, ethnicity, and human rights.** During the 2020-2021 biennium, PAHO ensured that the cross-cutting themes were strategically positioned within the context of the COVID-19 pandemic. This is consistent with the commitment of the 2030 Agenda for Sustainable Development to "leave no one behind," and with efforts to accelerate advances toward universal health. PASB also generated and shared evidence on the COVID-19 situation and trends with respect to gender, ethnicity, and equity, as well as evidence on the health inequalities of Afro-descendant people, among other topics. Efforts to vaccinate indigenous populations in Colombia against COVID-19 are presented as a success story.

13. **Leadership, governance, and enabling functions.** During the biennium, PAHO remained an authoritative voice in the Region of the Americas, calling for a unified Region to address the impact of the COVID-19 pandemic. The Organization gained increased name recognition by providing political, strategic, and technical guidance on the pandemic at the highest levels of national governments and the United Nations and inter-American systems. Its agenda called for ensuring an agile response to Member States while simultaneously advocating for key foundational investments in public health in the Region.

14. Nonetheless, extensive disruptions in health systems and services due to the pandemic posed challenges that hindered the achievement of results. The pandemic highlighted the fragmentation and weaknesses of health systems and the importance of sustained efforts toward resilience and universal health. The focus on pandemic response

required reprioritization of the human, social, structural, and financial resources of PASB and Member States for a significant part of the biennium. As a result, some areas did not receive the necessary attention or resources. The changes in national priorities, the strain on health services, and the limited numbers of national counterparts in relation to the scale of needs all impeded the delivery of products and services directly contributing to the achievement of outcome-level results. Significant political commitment, collaboration, and strategic allocation of resources will be required to strengthen areas that are lagging.

15. PAHO faced an unprecedented threat to its functioning during the biennium due to the delayed payment of assessed contributions from some Member States. This financial crisis, compounded by the effects of the pandemic, forced PASB to establish cost containment measures and reprogram work plans to preserve its core operational capacity. The pandemic tested core functions of the Organization in multiple areas and its capacity to support the emergency response and undertake technical cooperation with Member States. Thanks to prudent and adaptive measures put in place by senior management, the resolve and commitment of staff, collaboration across the three levels of PASB, an increase in resource mobilization, and advocacy with Member States, the Organization was able to navigate through these storms. These efforts allowed PASB to maintain a high level of performance and continue responding to its mandates while building resilience for the future. Furthermore, implementation of the PAHO Program Budget 2020-2021 maintained the highest levels of accountability in an environment with high risk levels due to the unstable social, political, and economic situation in PAHO Member States.²

16. The total approved PB20-21 was \$650 million, comprising \$620 million for base programs and \$30 million for special programs. Funds available to entities for implementation amounted to \$730 million (\$479 million in base programs and \$251 million in special programs). At biennium closure, implementation was \$672 million (\$442 million in base programs and \$230 million in special programs), or 103% of the total approved budget. This level of implementation is historic, representing 23% (\$126 million) more than in 2018-2019, an increase driven by implementation of the special programs segment.

Conclusions and Recommendations

17. Throughout the 2020-2021 biennium, PASB has proven to be of critical value to Member States in its role as catalyst, convener, and trusted broker in times of an unprecedented health emergency. While responding to the COVID-19 pandemic, PASB also acted to protect essential health services in collaboration with Member States and partners and in line with its mission and values. Moving forward, several key actionable recommendations stand out and are highlighted below. Many more recommendations can be found in the detailed Results Report and accompanying outcome cluster reports to be presented to the 30th Pan American Sanitary Conference.

² Pan American Health Organization, Financial Report of the Director and Report of the External Auditor, 1 January-31 December 2020 (*Official Document 362*). Washington, DC: PAHO, 2020.

- a) Intensify advocacy for health at the highest levels of government, ensuring linkages between health, the economy, social protection, and pandemic preparedness and response.
- b) Capitalize on the visibility that PAHO has earned through its response to COVID-19 and extend it to other areas and audiences.
- c) Strengthen the engagement of the Organization, in particular at country level, in high-level dialogue with health and finance ministries, international financial institutions, and donors, to continue advocacy for increased, improved, and sustainable public investment in health.
- d) Strengthen work with other sectors, listening to and involving communities and civil society, to better position health on national agendas and to address topics that involve actors outside the health sector.
- e) Readdress universal health with a view to strengthening and transforming health systems and services as the conduit for delivering essential public health programs and priorities, focusing on the health needs of vulnerable populations and on the determinants of health.
- f) Continue building on existing efficiencies and effectiveness measures of core activities in ways that maximize the use of the Organization's resources.
- g) Implement actions in response to lessons learned and build on the good practices and innovations that were highlighted during 2020-2021.

Action by the Executive Committee

18. The Executive Committee is invited to take note of this report and provide any comments it deems pertinent.

III. Introduction

19. Resolution CD57.R2, adopted by the 57th Directing Council of the Pan American Health Organization (PAHO) in 2019, requests the Director of the Pan American Sanitary Bureau (PASB or the Bureau) to report on the implementation of the Strategic Plan of the Pan American Health Organization 2020-2025 (*Official Document 359*),³ including its Program Budgets, through biennial performance assessment reports. This section presents an overview of the report on the end-of-biennium assessment of the Program Budget of the Pan American Health Organization 2020-2021 (*Official Document 358*),⁴ which also serves as the first interim report on the Strategic Plan 2020-2025 (SP20-25).

20. The end-of-biennium assessment is a critical instrument of programmatic accountability and transparency for the Organization. Given the unprecedented toll of the COVID-19 pandemic, the financial crisis facing the Organization in 2020-2021, and the evolving socioeconomic and political context in the Region of the Americas, this assessment offers an opportunity to collectively take stock of the Region's health gains and remaining gaps and analyze the challenges, lessons learned, and opportunities moving forward. Consistent with the country focus approach adopted by PAHO, success stories are highlighted to showcase the Organization's technical cooperation with countries. The report also presents an analysis of programmatic and budgetary performance by PAHO, particularly budget implementation and risk management. The lessons learned and recommendations from this assessment will be particularly important for guiding interventions during the 2022-2023 biennium. During this period the Organization will continue to respond to the pandemic while implementing its Strategic Plan 2020-2025 and working with Member States and partners toward achievement of the Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030)⁵ and the Sustainable Development Goals (SDGs).

21. A key element of the end-of-biennium assessment is a review of the progress toward achievement of the impact and outcome targets that were defined in the SP20-25 and the output targets defined in the Program Budget 2020-2021 (PB20-21). This draft report to the Executive Committee contains interim results based on an initial stocktaking by PASB. The complete results will be presented to the 30th Pan American Sanitary Conference in September 2022 and will include the results of the joint assessment with

³ Pan American Health Organization. Strategic Plan of the Pan American Health Organization 2020-2025. 57th Directing Council of PAHO, 71st Session of the Regional Committee of WHO for the Americas. Washington, DC: PAHO, 2019 (*Official Document 359*). Available from: <https://iris.paho.org/handle/10665.2/51599>.

⁴ Pan American Health Organization. Program Budget of the Pan American Health Organization 2020-2021. 57th Directing Council, 71st Session of the Regional Committee of WHO for the Americas. Washington, DC: PAHO, 2019 (*Official Document 354*). Available from: https://www3.paho.org/hq/index.php?option=com_docman&view=download&alias=50372-cd57-od358-e-program-budget-paho&category_slug=cd57-en&Itemid=270&lang=en

⁵ Pan American Health Organization. Sustainable Health Agenda for the Americas 2018-2030 (Document CSP29/6, Rev. 3). Washington, DC: PAHO, 2017.

Member States that is currently underway. An update on Member States' progress on the joint assessment will be shared in the presentation to the Executive Committee.

22. Finally, it should be noted that the results of the interim end-of-biennium assessment by PASB served as the main input by the Region of the Americas to the World Health Organization (WHO) Programme budget 2020-2021 assessment, presented to the 75th World Health Assembly in May 2022.

IV. Delivering on Results

Overview

23. The PAHO Strategic Plan 2020-2025 established a set of 28 impact indicators with 35 targets, aimed at measuring sustainable changes in the health of populations, such as improved health and well-being and reduced morbidity, mortality, and equity gaps. The SP20-25 also set out 28 outcomes (OCMs), which are collective or individual changes in factors that affect population health, such as increased service coverage or access to services, increased capacity of health systems, and reduced health-related risks. The outcomes are measured through 105 outcome indicators. The PAHO Program Budget 2020-2021 established 102 outputs that contribute to the achievement of the outcomes. These outline the specific results to be delivered in the biennium, such as policies, strategies, plans, laws, programs, services, norms, standards, and guidelines. The outputs are measured and monitored through 148 output indicators.

24. Impact, outcome, and output results are all defined as requiring the joint intervention of PASB and Member States, together with partners. To contribute to the achievement of these results, the Bureau implements products and services, which are defined in two-year Biennial Work Plans (BWPs) corresponding to the Program Budget period. Through the implementation of BWPs across all entities, PASB contributed during the biennium to the achievement of the higher-level results in the results framework.

25. Section III first presents a preliminary analysis of the public health status of the Region and of progress made toward achievement of the results set out in the SP20-25 and PB20-21. It examines the effects of the COVID-19 pandemic and of the socioeconomic and political situation in the Region on the performance of the indicators. For the 30th Pan American Sanitary Conference, an interim review of progress toward the SHAA2030 and the health-related targets of the SDGs will be presented. The second part of the section outlines the main achievements, challenges, and country success stories from the 2020-2021 biennium, grouped by clusters of outcomes. Finally, there is a brief discussion of the Bureau's efforts to enhance accountability for results and financial resources.

Progress toward the Strategic Plan 2020-2025 and Program Budget 2020-2021 Results

26. This section presents an overview of the impact, outcome, and output-level assessment. Prior to the 30th Pan American Sanitary Conference, detailed outcome and output indicator assessments will be made available in outcome cluster reports through the PAHO Program Budget Portal.⁶

⁶ The Program Budget Portal is at <https://open.paho.org/>.

Impact Indicators

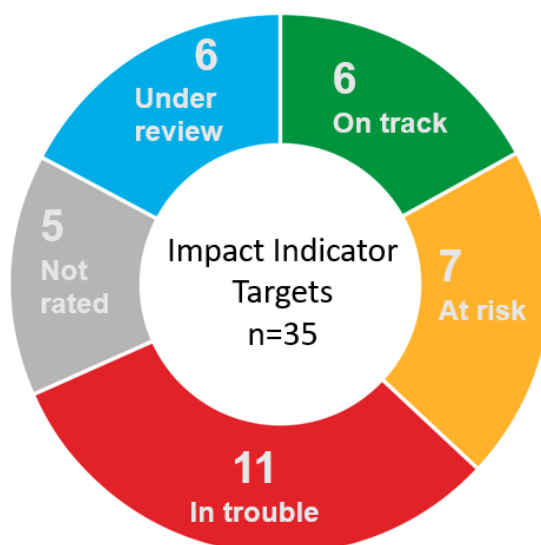
27. The objective of the interim assessment of the PAHO Strategic Plan 2020-2025 impact indicators before the Executive Committee is to take stock of the Region's progress and obtain feedback for the final report to the 30th Pan American Sanitary Conference.

28. As shown in Figure 1 and the table that follows, six of 35 impact indicator targets were estimated to be on track to be achieved by the end of 2025. Seven indicators were rated as at risk, meaning that obstacles are impeding progress at the rate needed to achieve the results, but those obstacles can be overcome through corrective actions. Of concern, 11 indicators were rated as in trouble, meaning that major obstacles exist and the targets are unlikely to be achieved unless significant corrective actions are taken immediately. Five indicators could not be rated at this time due to lack of data or other factors. The status of six indicators is under review, and an update will be prepared for the Pan American Sanitary Conference.

29. Overall, at the regional level, the pandemic has affected the performance of indicators in the short term, but it remains too early to determine what the trajectory will be, given the need for more updated data. At the subregional and country levels, there appears to be a great degree of variation. Several indicators require immediate, accelerated action to address underlying challenges and/or improve the availability of data to better inform evidence-based decision making. Indicators that appear to be on track still require close monitoring and examination of inequities between and within countries.

30. An understanding of the various factors that affect the impact indicators at the programmatic level will reveal opportunities to improve their performance. To contribute to health impacts, PASB works together with countries and partners, principally toward the achievement of outcome- and output-level results. Addressing the determinants of health remains one of the most effective means to achieve higher-level impacts and is a priority for action by PAHO. It is also necessary to examine key health interventions to determine which ones are most cost-effective and have the greatest potential to change the trends in a given country, based on its profile. This report will contain some insights in that regard.

31. In order to accelerate progress toward achieving the impact indicator targets, data and evidence must also drive action at the country, subregional, and regional levels. Crucial measures include expanding information systems for health and strengthening countries' vital and health statistics to improve data quality in terms of completeness, accuracy, consistency, and accessibility. Interim results are based on data that are being updated as they become available. For some indicators the results include available data from 2020 and 2021.

Figure 1. Status of Impact Indicator Targets in 2022

Rating	Indicator	Baseline 2019*	Target 2025	Status 2022*
●	1. Reduction of within-country health inequalities	N/A	17	Under review
●	2. Health-adjusted life expectancy (HALE)	65.76 years (2019)**	66.42 years***	66.10 years
●	3. Neonatal mortality rate	7.9 deaths per 1,000 live births (2017)	6.9 deaths per 1,000 live births ⁷	7.0 deaths per 1,000 live births
●	4. Under-5 mortality rate	14.3 deaths per 1,000 live births (2017)**	11.8 deaths per 1,000 live births***	12.8 deaths per 1,000 live births
●	5. Proportion of children under 5 who are developmentally on track in health, learning, and psychosocial well-being	84.5% (surveys in 15 countries from 2010-2016)	90%	Not rated due to data limitations
●	6. Maternal mortality ratio (MMR) (deaths per 100,000 live births)	59.4 deaths per 100,000 live births (2015)**	35 deaths per 100,000 live births	53.7 deaths per 100,000 live births
●	7. Rate of mortality amenable to health care (MAHR) (deaths per 100,000 population)	137 deaths per 100,000 population (2018)**	117.2 deaths per 100,000 population***	125.8 deaths per 100,000 population
●	8. Proportion of adults 65+ who are care-dependent	~8.0% (2010)	6.5%	Not rated (mapping sources)

⁷ This target was established based on an Average Annual Percent Change of -2.1%, taking as a baseline the 2017 estimates from the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME).

Rating	Indicator	Baseline 2019*	Target 2025	Status 2022*
●	9. Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	14.62% (2017)**	11.70%***	13.73%
●	10. Mortality rate due to cervical cancer	6.79 deaths per 100,000 female population (2018)**	4.60 deaths per 100,000 female population	6.36 deaths per 100,000 female population
●	11. Mortality rate due to homicide among youths 15-24 years of age	33.98 deaths per 100,000 youths 15-24 years of age (2015)**	31.96 deaths per 100,000 youths 15-24 years of age ***	34.07 deaths per 100,000 youths 15-24 years of age
●	12. Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months	7% (2018)**	7% (no increase)	Not rated due to lack of data
●	13. Number of deaths due to road traffic injuries ⁸	154,000 deaths; 15.5 deaths per 100,000 population (2016)	123,000 deaths; 10.85 deaths per 100,000 population***	142,000 deaths; 14.31 deaths per 100,000 population
●	14. Mortality rate due to suicide	8.21 deaths per 100,000 population (2014)	7.38 deaths per 100,000 population ⁹ ***	9.15 deaths per 100,000 population
●	15. Incidence rate of measles	16.69 cases per 1,000,000 population (2018)**	0 cases per 1,000,000 population	2.05 cases per 1,000,000 population
●	16. Incidence rate of HIV infections	0.16 per 1,000 population (2017)**	0.04 per 1,000 population***	0.15 per 1,000 population
●	17. Rate of mother-to-child transmission of HIV	13.6% of births to women living with HIV (2017)**	2.0% of births to women living with HIV	11.1% of births to women living with HIV

⁸ The indicator is expected to be reformulated due to changed methodology; therefore, a new baseline and target are being proposed.

⁹ Target is for a 10% reduction relative to 2014.

Rating	Indicator	Baseline 2019*	Target 2025	Status 2022*
●	18. Incidence rate of congenital syphilis (including stillbirths)	2.1 cases per 1,000 live births (2017)	0.5 cases per 1,000 live births	2.6 cases per 1,000 live births
●	19. Mortality rate due to chronic viral hepatitis	9.73 deaths per 100,000 population (2017)**	5.35 deaths per 100,000 population***	10.32 deaths per 100,000 population
●	20. Incidence rate of tuberculosis	27.49 cases per 100,000 population (2015)**	13.75 cases per 100,000 population ¹⁰ ***	27.86 cases per 100,000 population
●	21. Incidence rate of malaria	0.78 cases per 1,000 population (2015)**	0.19 cases per 1,000 population ¹¹ ***	1.01 cases per 1,000 population
●	22. Number of endemic countries in 2015 that maintain or achieve elimination of malaria	3 of 21 countries and territories that were endemic in 2015 (2018)	6 of 21 countries and territories that were endemic in 2015	Under review
●	23. Case-fatality rate due to dengue	0.056% (2012-2018)	0.050%	0.045%
-	24. Elimination of neglected infectious diseases in countries and territories	-	-	-
●	a. Trachoma	1 of 5 (2019)	3 of 5	1 on track, 1 at risk
●	b. Chagas disease	17 of 21 (2019)	21 of 21	Not rated
●	c. Dog-mediated human rabies	32 of 35 (2019)	35 of 35	Not rated
●	d. Leprosy	17 of 23 (2019)	23 of 23	6 at risk
●	e. Human taeniasis/cysticercosis	0 of 16 (2019)	3 of 16	3 on track
●	f. Lymphatic filariasis	3 of 7 (2019)	5 of 7	2 on track
●	g. Onchocerciasis	4 of 6 (2019)	6 of 6	2 at risk
●	h. Schistosomiasis	3 of 10 (2019)	5 of 10	TBD

¹⁰ Target is consistent with the 2025 global target for a 50% reduction from the 2015 level.

¹¹ Target is for a 75% reduction, consistent with 2025 milestone in the WHO Global Technical Strategy for Malaria 2016-2030.

Rating	Indicator	Baseline 2019*	Target 2025	Status 2022*
●	25. Number of bloodstream infections per 1,000 patients per year caused by carbapenem-resistant organisms	TBD	At least a 10% reduction from the baseline	Under review
●	26. Mortality rate attributed to household and ambient air pollution	13.05 deaths per 100,000 population (2019)	12.40 deaths per 100,000 population ¹²	Under review
●	27. Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene	1.65 deaths per 100,000 population ¹³ (2016)	1.32 deaths per 100,000 population	Under review
●	28. Mortality rate due to disasters per 100,000 population	TBD	At least a 10% reduction from the baseline	Under review

* Or other year as indicated; 2022 status column includes projections.

** Baseline updated with the latest information.

*** Considering the updated baseline information and the nature of the original SP20-25 target, PASB proposes to update the target.

32. It should be noted that since the approval of the Strategic Plan in 2019, updated data and other information has come to light for some indicators. In other cases, new methodologies for calculating the indicators have emerged at the global level. Detailed explanations on proposed changes will be presented in the annex for the 30th Pan American Sanitary Conference. Such changes aim to ensure that the reporting on impact indicators remains consistent with the latest available information and methods, as well as with the ambition of the Strategic Plan to set realistic and measurable impact targets. In this way PAHO and its Member States can make better-informed decisions and put in place interventions to accelerate progress toward the targets, following the good practices of results-based management.

Outcome Ratings

33. This section summarizes the internal assessment of outcomes by PASB. It should be noted that these are interim results, and the assessment will be updated with input from the joint assessment being conducted with Member States.

34. As shown in Figure 2, 17 of the 28 outcomes (60%) were assessed as having met expectations for the 2020-2021 biennium. The other 11 outcomes (40%) partially met expectations. Among the outcomes that met expectations, five were rated as high priority

¹² Target is for a 5% reduction compared to 2019.

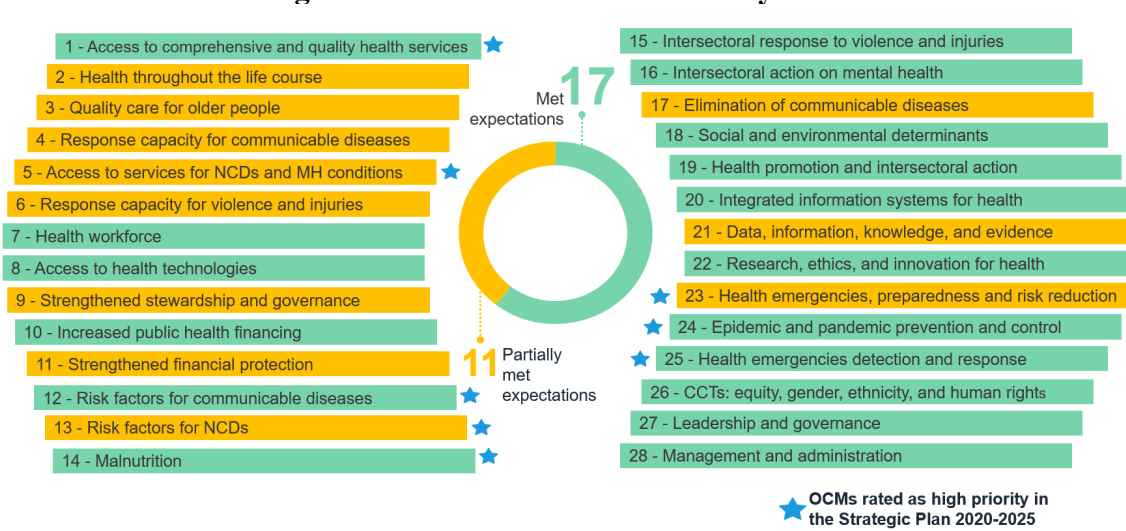
¹³ This rate is calculated using data from 29 countries.

by Member States: Outcome 1 (Access to comprehensive and quality health services); Outcome 12 (Risk factors for communicable diseases); Outcome 14 (Malnutrition); Outcome 24 (Epidemic and pandemic prevention and control); and Outcome 25 (Health emergencies detection and response).

35. Despite the unprecedented challenges during the biennium due to the COVID-19 pandemic and the financial crisis of 2020, the Region was able to maintain and achieve significant public health gains and produced transformative action in key areas, as evidenced in the outcomes that met expectations. The pandemic provided an impetus to improve public health functions, particularly those related to response to public health emergencies. It also provided a unique opportunity to shine a light on the importance of health, strengthen the stewardship role of the health authorities, improve intersectoral coordination to protect and promote health and well-being, and take further actions to address the needs of vulnerable communities that were most affected by the pandemic. Recognizing the linkage between health investment and economic development, countries deployed additional resources to increase and improve public investment in health. At the same time, the pandemic also highlighted the fragmentation and weaknesses of health systems and the importance of sustained efforts toward resilience and universal health.

36. The sudden shift in public health priorities to focus on pandemic response meant that some areas did not receive the necessary attention or resources during the biennium, as reflected by outcomes that partially met expectations. In some countries, response to the emergency took place in a context already marred by fragmented planning and weak or inexistent legal infrastructure for preparedness and implementation of actions. The pandemic then consumed an outsized share of attention and resources, hindering access to health systems and services. Significant political commitment, collaboration, and strategic allocation of resources will be required to strengthen areas that are lagging. Further reasons for less satisfactory outcomes and suggestions as to how PAHO can turn the tide during the next biennium are detailed below.

Figure 2. Assessment of Outcomes by PASB



Assessment of Outcome and Output Indicators

37. Resolution CD57.R2 (2019) requested the PASB Director to “utilize joint monitoring and assessment tools ... to report on the implementation of the Strategic Plan and its program budgets.” The preliminary results presented in this document will be updated for the final report to the 30th Pan American Sanitary Conference, incorporating information from the joint assessment with Member States.

38. By the end of 2021, the Region had made significant collective progress toward the achievement of the outcome and output indicators. As shown in Figure 3, 14 of 105 outcome indicators (13%) were achieved or exceeded, while 43 (41%) were assessed as having shown significant progress, 14 (13%) as limited progress, and 26 (25%) as no progress. Another 8 indicators (8%) could not be assessed due to unavailability of data or because results depend on the joint assessment with Member States. Figure 3 also indicates that 51 of 148 output indicators (34%) were achieved or exceeded, while 54 (37%) were assessed as having shown significant progress, 14 (9%) as limited progress, and 28 (19%) as no progress. One output indicator (1%) was not rated because it depends on the joint assessment with Member States.

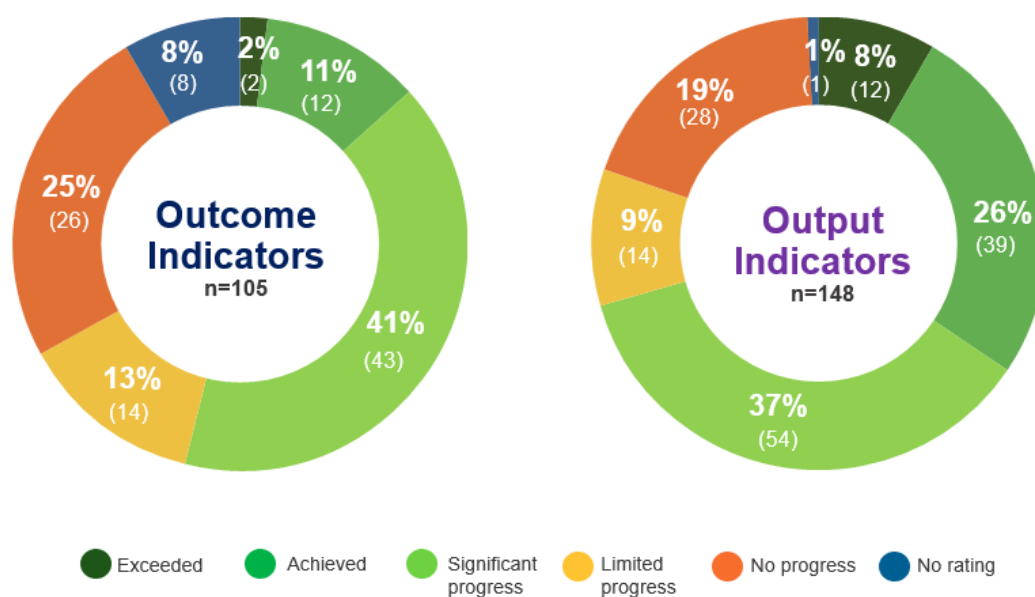
39. Important milestones for the Region were registered among the outcome and output indicators that were preliminarily rated as exceeded by PASB. For example:

- a) The regional average for prevalence of wasting in children under 5 years of age continues to decrease, from 0.8% in 2019 to 0.7% in 2021 (outcome indicator 14.b).
- b) The number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies increased from 42 to 46 (outcome indicator 23.a).
- c) Thirty-one countries and territories reported having an operational surveillance and response system for influenza and other respiratory viruses (output indicator 24.2.a).
- d) Twenty-two countries and territories performed regular monitoring/auditing of infection prevention and control practices in referral care facilities (output indicator 24.3.b).
- e) The regional median number of days between substantiated onset of public health event and date information first received or detected by PAHO was reduced from 47 to 21 days (output indicator 25.1.a).
- f) PASB met its performance standards in all countries with protracted emergencies (output indicator 25.3.a).

40. The main issues that contributed to the underachievement of some outcome and output indicators included the COVID-19 pandemic response; low levels of political commitment to addressing priority areas of public health; absence of, or insufficient, intersectoral action; weaknesses in information systems; insufficient progress on

addressing inequities in health; limited institutional capacity; and shortage of human and financial resources, due in part to competing priorities on regional and national agendas. Many of these issues are explained in further detail in Section VI.

Figure 3. Overview of Outcome and Output Indicators Assessment by PASB



Key Achievements, Challenges, and Country Success Stories

41. This section presents the most notable achievements, challenges, and country success stories during 2020-2021. The section will cover the 28 outcomes of the Strategic Plan 2020-2025, grouped into clusters by thematic area.

Health Emergencies

Outcomes 23-25

Health emergencies
preparedness and risk
reduction

Epidemic and pandemic
prevention and control

Health emergencies detection
and response

Achievements

42. Member States and PAHO/WHO Representative (PWR) Offices have been continuously updated on the Region's epidemiological and operational situation through the 649 situation reports, 481 daily summaries, and 76 epidemiological alerts and updates that were developed and disseminated by PAHO during the biennium (as of 31 December 2021). Weekly reports are published with SARS-CoV-2 surveillance indicators, as well as indicators related to influenza and other respiratory viruses. Daily situation data updates have been shared via the PAHO website since the onset of the pandemic. Information on COVID-19 trends was analyzed and disseminated in the Region on a weekly basis through the collection of COVID-19 line list data and semi-automated daily collection of cases and deaths from official websites. PASB established a database of over 76 million case-report forms for 38 of the 54 countries, territories, and areas in the Americas thanks to support provided to set up and manage nominal COVID-19 surveillance.

43. PAHO developed, updated, and disseminated over 197 technical guidance documents on surveillance, laboratory, health information management, risk assessment, clinical management, and infection prevention and control for COVID-19. These are also relevant for other epidemic-prone diseases and for efforts to strengthen overall health security in the Region and at country level. Many of these documents have been updated periodically to reflect emerging evidence as the global community has learned about the virus and assessed the effectiveness of public health interventions.

44. Molecular diagnosis for COVID-19 strengthened the regional laboratory network and enhanced capacity for timely detection of the SARS-CoV-2 virus and monitoring of the outbreak in 35 countries and territories. One new National Influenza Center, the Central Laboratory of Suriname's Bureau of Public Health, was also designated during the year.

45. The COVID-19 Genomic Surveillance Regional Network involving 15 countries across the Americas was established. It comprises six regional reference labs (in Brazil, Chile, Mexico, Panama, Trinidad and Tobago, and the United States of America) and 14 in-country sequencing labs (two in Brazil and one each in Argentina, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Mexico, Panama, Paraguay, Peru, Uruguay, and Venezuela). In addition to sustaining collaboration to support regular diagnosis and testing of COVID-19, implementation of screening protocols to detect variants of concern early has been particularly useful, and material for screening of the Omicron variant has been delivered to at least 20 countries. To date, over 30 countries and 12 territories have

submitted sequences to GISAID, an initiative that promotes the rapid sharing of data from all influenza viruses and the coronavirus causing COVID-19. Over 261,000 sequences of SARS-CoV-2 have been submitted to the global GISAID platform from PAHO Member States in Latin America and the Caribbean.

46. Thirty-eight laboratories reported 100% concordance in the SARS-CoV-2 External Quality Assessment, with the other two achieving between 90% and 95% concordance, thanks to PASB's ongoing support for implementation of molecular diagnosis in the Region. Four countries (Argentina, Ecuador, Mexico and Peru), using a tool designed to assess all-cause excess mortality, established capacities to determine possible additional impacts of COVID-19 on mortality that were not being reported through the normal surveillance systems.

47. To ensure continuity in diagnostic and laboratory surveillance processes, critical reagents and supplies for molecular detection of arboviruses were distributed to 11 countries (Antigua and Barbuda, Barbados, Chile, Colombia, Costa Rica, Ecuador, Grenada, Peru, Saint Lucia, Saint Vincent and the Grenadines, Venezuela). Member States were given support in the laboratory surveillance of arboviruses and improvement of algorithms to include emerging viruses (including Mayaro, Oropouche, and equine encephalitis). Both molecular and serological diagnosis for arenaviruses and hantaviruses were successfully implemented in Bolivia.

48. Member States improved their capacities for case management, investigation of transmission chains, and contact tracing surveillance for COVID-19 and other potential emerging diseases. This was achieved through the use of, most notably, Epidemic Intelligence from Open Sources (EIOS), which has been expanded throughout the Region to support Member States in Event-Based Surveillance. Counterparts in six countries were trained in the use of this tool (Argentina, Brazil, Dominica, Guatemala, Haiti, Saint Lucia). In Brazil, use of EIOS was expanded to all jurisdictions of the country. In addition, the Early Warning, Alert and Response System (EWARS) was implemented in Dominica, Haiti (following the earthquake on 14 August 2021), and Saint Vincent and the Grenadines (following the eruption of La Soufrière volcano). PASB trained 35 countries in the use of Go.Data, an outbreak investigation tool developed by WHO, which is now used by 17 countries and territories to facilitate field data collection, contact tracing, and transmission chain visualization. These initiatives have expanded countries' capacities to operationalize and tailor contact tracing operations.

49. During the biennium, 348 international shipments totaling 747 tons of strategic stock maintained in PAHO's logistics hub in Panama were delivered to 36 countries. The criticality of this mechanism has been reaffirmed during the COVID-19 pandemic and response to concurrent emergencies, where rapid delivery of high-demand, low-availability medicines and health supplies has been made possible by the efficiency of PAHO's prepositioned strategic stock. The stock is maintained by PASB with support from voluntary contributions and partner donations. Additionally, reserve centers for the strategic prepositioning of emergency stock were established in the Dominican Republic

and Ecuador, and agreements on logistics were established or continued with strategic partners such as Direct Relief and DHL.

50. The Inter-American Health Humanitarian Assistance Network expanded with the newly established reserve centers in the Dominican Republic and Ecuador. The reserve center in the Dominican Republic has been supplied with strategic prepositioned stock donated by PAHO's standby partner Direct Relief, while goods in the temporary reserve center in Ecuador (since fully distributed) were drawn from PAHO's own resources. The existence of a reserve in the Dominican Republic was a critical instrument for the rapid procurement and mobilization of life-saving health commodities in response to the Haiti earthquake in August 2021.

51. Forty-seven safer and greener ("smart") health facilities are now providing health care across seven countries in the Caribbean (Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, Saint Vincent and the Grenadines). Another six health facilities are currently being retrofitted, and the designs have been completed for an additional five facilities. Several retrofitted Smart Health facilities were used as respiratory clinics or sites for COVID-19 vaccination campaigns because of their strategic location, improved functionality, and ability to guarantee the cold chain to safely store vaccines (Grand Bay in Dominica, , Princess Royal Hospital and Hillsborough Health Centre in Grenada, Diamond in Guyana, Vieux Fort in Saint Lucia, Port Elizabeth and Chateaubelair in Saint Vincent and the Grenadines). Many other project facilities were used to triage, isolate, and care for individuals with signs and symptoms of COVID-19, followed by referral to another health center or hospital for a higher level of care if necessary.

52. Increased medical surge capacities in 23 countries were achieved through the deployment of emergency medical teams (EMT) and the selection and setup of alternative medical care sites (AMCS) for COVID-19 cases. In total, 100 national EMTs were deployed and 129 AMCSs became operational, providing a total of 6,899 inpatient beds and 1,078 critical care beds. Many of these EMTs facilitated the setup of temporary COVID-19 vaccination sites using the existing structures.

53. Given the global scope of the COVID-19 pandemic, all countries and territories in the Americas were impacted, yet all were able to provide an essential package of life-saving health services during the 2020-2021 biennium. Simultaneously, at least 15 countries and territories managed to deliver life-saving operations in response to concurrent health emergencies that either began during this biennium or had been ongoing. These included emergencies arising from hurricanes, flooding, the Haiti earthquake, the Saint Vincent volcano, and the Venezuela crisis, among others. Nine countries actively monitored migratory movements at entry points and ensured readiness for potential health emergencies caused by sudden mass migrations (Brazil, Chile, Colombia, El Salvador, Guatemala, Honduras, Mexico, Panama, Peru). As part of these efforts, the countries expanded their COVID-19 epidemiological surveillance, emergency mental health care, and psychosocial support capacities, as well as available surge health services.

54. PASB supported 19 countries and territories to conduct simulations to identify gaps in national capacities and systems needed for emergency preparedness and response. In addition, two simulation exercises focused specifically on epidemiological aspects were conducted in Brazil. Six after-action reviews (AAR) were supported in the Region: a multi-partner AAR of Hurricane Dorian in January 2020, an AAR of Hurricanes Eta and Iota in 2021, an AAR in Costa Rica for COVID-19 response in 2021, and three AARs in Brazil (arenavirus, arboviruses, and flooding).

55. PASB developed new emergency preparedness tools to strengthen the capacity of countries to respond to emergencies. This technical cooperation included the development and/or updating of Emergency Response Plans and implementation of the Preparedness Index for Health Emergencies and Disasters (IPED) and the Strategic Tool for Assessing Risks (STAR), all with the objective of determining and prioritizing risks and guiding emergency response planning in health. Bolivia, Chile, Ecuador, Nicaragua, Paraguay, and Peru adopted these tools during the 2020-2021 biennium.

56. No cholera case was confirmed in Hispaniola during the biennium, thus continuing the absence of transmission since February 2019. This has been the result of concerted efforts by Haiti and sustained technical cooperation from PASB and other partner agencies to address the root causes of cholera through increased surveillance to detect and respond to possible flare-ups, implementation of rapid diagnosis initiatives, and treatment of cases with adequate rehydration and care. For Haiti to end cholera and receive validation from WHO for eliminating the disease, the country must maintain effective surveillance systems and remain cholera-free for three consecutive years.

Challenges

57. The response to the COVID-19 pandemic posed the greatest challenge to program implementation during the 2020-2021 biennium. It required the near-complete reprioritization of human, social, structural, and financial resources, on the part of both PASB and Member States, for a significant part of the biennium. The overwhelming focus on the COVID-19 response in the countries and territories curtailed their capacity to absorb technical cooperation directed at other high-impact pathogens, including other respiratory and emerging pathogens such as influenza, yellow fever, arboviruses, and viral hemorrhagic fevers. The changes in national priorities, the strain on health services, and the limited numbers of national counterparts in relation to the scale of needs all hindered the delivery of essential products and services. Despite this, PASB has been successful in identifying and designing alternative strategies and methodologies to support Member States in achieving outcome-level results.

58. Some countries set up parallel COVID-19 response and management structures outside the established health emergency and disaster management mechanisms. By creating two channels for managing health emergencies, this resulted in overlap and inefficiencies within ministries of health, as preexisting disaster management units within ministries of health were not included in COVID-19 planning and response.

59. During the pandemic, it became evident that Member States need to increase investments in more robust surveillance systems that are capable of rapidly detecting health events down to the subnational level in order to produce timely information for action. Despite efforts, registration of data on the COVID-19 national platforms continues to face challenges, including, among others, capacity at the first level of care for case detection, availability of registration tools and a document adapted to each country to capture the information, and knowledge of the surveillance strategy for COVID-19. Nevertheless, there is ongoing data management of COVID-19 line list data for this Region, with nominal data submitted by 38 of 54 countries, territories, and areas.

60. The extraordinary nature of the pandemic required PASB to rapidly scale up its information technology capacities to develop and implement new tools to support technical cooperation. The Bureau will continue to reinforce these areas of knowledge to better respond to existing and future health emergencies, recognizing the need for greater investments in in-house storage capacity and specialized and collaborative software for data management and analytics.

Building a health care system better prepared for health emergencies in the Bahamas



COVID-19 vaccines received through the COVAX facility.

Photo credit: The Bahamas Ministry of Health and Wellness.

The Bahamas has a health system that aims to provide equitable access to quality health care for approximately 389,000 people; however, fragmentation of service delivery presents a challenge. Recent natural disasters and the COVID-19 pandemic have stretched the health system to capacity, exposing longstanding structural and systemic deficiencies. PAHO provided technical cooperation for capacity building to the Bahamas to build resilience and rapidly detect and respond to future health emergencies. There are five main areas of focus:

- Strengthen policy and technical norms and guidelines in areas including clinical management; infection prevention and control; disease surveillance; case and contact management; mental health and psychosocial support; implementation of public health measures for travel, workplaces, and schools; and social support for vulnerable groups.
- Strengthen surveillance and data management for COVID-19, including epidemiological surveillance, contact tracing, case isolation, quarantine of contacts, and classification of deaths due to COVID-19. Strengthen the Ministry of Health and Wellness (MHW) Emergency Operating Centre and vaccine distribution.
- Increase clinical and hospital surge capacities and expand acute care services.
- Support the MHW in mobilizing funds for the COVID-19 response from other United Nations (UN) agencies, foreign missions, the public sector, and civil society.
- Enable risk communication and education on mental health, cyber safety for children, prevention of gender-based violence and substance abuse, parenting during COVID-19, and tips for isolation. This includes the preparation of communication products in Haitian Creole for use with the Haitian migrant community through collaboration with other UN agencies.

By overcoming multiple challenges, including human resources shortages, scarce financial resources, and the need for multitasking, the Bahamas significantly improved its capacities in key aspects of the health system to rapidly detect and respond to future health emergencies sustainably. The government's enhanced ability to respond is likely to have already prevented thousands of COVID-19 infections and deaths. Strengthening is still required in some key areas, including reinforcing the MHW surveillance unit with additional trained human resources and further support for data management and analysis to sustain the progress made over the past two years. By building a more resilient health care system, the Bahamas is now much better equipped to detect and respond to natural disasters and disease outbreaks in the future, which is expected to save thousands of lives.

Debunking myths about COVID-19 vaccines in Costa Rica



Leader of an indigenous community where one of the workshops took place.

Photo credit: PAHO/WHO Representative Office for Costa Rica.

As Costa Rica began to acquire COVID-19 vaccines through the COVAX Facility and bilateral agreements, an abundance of information, including some misinformation, fueled uncertainty, skepticism, and distrust, causing some Costa Ricans to reject safe and efficacious COVID-19 vaccines. To empower people to make evidence-informed choices, PAHO launched the Debunking Myths about COVID-19 Vaccines communication initiative in Costa Rica. Messages were transmitted through radio, television, in-person events, and virtual platforms, resulting in 29 virtual workshops in 2021, with 673 attendees and 7,794 views of Facebook Live videos.

The initiative was well received by community members, and PAHO received many requests from local, regional, and national stakeholders to replicate the workshops. This led to an increase in vaccine coverage, particularly in the segments of the population targeted by the initiative. The following approaches were implemented:

- **Involving diverse stakeholders.** New alliances were established at national and subnational levels to expand the campaign's reach. In addition to traditional partners such as the Ministry of Health and the Costa Rican Social Security Fund, new partnerships were forged with entities such as the Ministry of Justice, Ministry of Communications, National Emergency Committee, and National Patriotic Alliance for COVID-19 Vaccination, led by the Catholic Church.
- **Reaching indigenous communities.** PAHO collaborated with indigenous associations to adapt messages in ways that would resonate. Two radio programs and 37 in-person workshops were delivered in 11 indigenous communities.
- **Overcoming access barriers for people with disabilities.** Together with the National Council for People with Disabilities, multimedia materials were developed in sign language, and workshops were held with 31 people living with intellectual disabilities and caregivers.
- **Training health workers.** To address low vaccination rates in pregnant women, PAHO developed training focused on pregnancy and lactation and integrated it into an online continuing education course at Hospital México. Promoted nationwide, the course reached 150 obstetric nurses.

PAHO's approach was successful because it recognized that COVID-19 myths and misinformation cut across all segments of the population. A collaborative, participatory approach was taken to address them and reach more people with vital information.

Engaging community stakeholders to respond to public health threats in Ecuador



Children in a Shuar indigenous community receiving the storybook “My Hero is You,” adapted and translated in the Shuar language as “Naatka Muruitme.” The book, developed by an Inter-Agency Standing Committee, aims to support children in coping with the effects of COVID-19.

Photo credit: PAHO/WHO Representative Office for Ecuador.

Ecuador is a multiethnic country with wide cultural diversity and indigenous villages distributed across different geographic areas. In many cases, indigenous communities are in remote locations and access to health care services is limited, leaving the population at high risk from COVID-19 and other public health threats.

To mitigate the impact of the pandemic on these communities, PAHO engaged with two local civil society organizations, Pachamama Foundation and the Confederation of Indigenous Nationalities in the Ecuadorian Amazon. These organizations received support to scale up their community assistance programs through jointly planned interventions. PAHO provided technical cooperation as part of a global initiative, financially supported by the COVID-19 Solidarity Response Fund, that aimed to train and equip communities and health workers to

prevent, detect, and treat COVID-19 and strengthen the resilience and readiness of communities to face future public health emergencies.

PAHO and the civil society organizations implemented the following actions:

- Strengthened capacities of indigenous Amazonian women to become agents of change who could engage their communities against COVID-19 and future emergencies. It was important to incorporate their knowledge because of their role as guardians of cultural and ancestral values in their communities.
- Supported workshops, with the presence of indigenous leaders, to promote risk management in communities and the use of PAHO guidelines. Inclusion of the indigenous leaders ensured integration of their ancestral knowledge and their participation and effective inclusion in the response and recovery plans.
- Worked with organizations that had an existing presence in the communities as well as a good relationship with PAHO. This encouraged the communities to accept the implementation of actions.
- Supported the elaboration and wide dissemination of information to address vaccine misinformation and hesitancy. The messages were adapted to be culturally appropriate to more than 200 indigenous communities.
- Supported better hygiene and the continuum of essential health services. A series of workshops was organized to build capacity in local communities, training 223 indigenous community health workers in the Amazon region. Trainings on safe deliveries to prevent maternal and neonatal deaths were supported through the distribution of 400 childbirth kits. COVID-19 awareness and health promotion were supported through training in artisanal soap production, enabling 20 local women to become agents of hygiene change while generating a source of sustainable income.
- Provided gender-inclusive workshops. These included, for the first time, a training for indigenous men (only) on ways to end the cycle of violence and better address gender-based violence.

Taken together, these actions focus on improving access to information, providing continued support for essential health services, and promoting inclusive community participation. They are expected to encourage Amazon’s indigenous communities to improve vaccine uptake, including for COVID-19, and support other public health interventions. In the longer term the interventions are expected to help build more resilient communities and strengthen health systems for better preparation and response to future public health emergencies. Overall, the Ecuador initiative showcased the need for systematic engagement at the community level, working with trusted civil society organizations and local leaders, to facilitate quality service delivery to communities within the global commitment to the SDGs and universal health coverage.

Launching a rapid, comprehensive post-earthquake response to support health recovery in Haiti



An assembly point for people displaced by the earthquake in the Corail commune, Grand'Anse Department.

Photo credit: PAHO/WHO Representative Office for Haiti.

On 14 August 2021, a 7.2 magnitude earthquake struck the southern peninsula of Haiti, killing over 2,000 people and injuring more than 12,000. In all, 600,000 people required immediate humanitarian assistance, 150,000 homes were destroyed, and more than 80 hospitals and health centers were damaged.

PAHO provided effective support to Haiti in the emergency and immediate recovery phases of the response. Multidisciplinary field response teams continued their work to maintain and reestablish essential health services three months after the earthquake to facilitate the transition from immediate response to recovery efforts. The following were areas of focus:

- **Delivery of emergency supplies.** During the emergency phase of the response, more than 80 tons of medical products and equipment worth US\$ 1.2 million were received and dispatched to the affected areas, benefiting over 70 health facilities.
- **Damage assessment.** PAHO assisted the Ministry of Public Health and Population (MSPP) in rapidly **assessing** structural, water, and sanitation damage to health infrastructure in the three earthquake-affected departments. This information was key for the post-disaster needs assessment and national recovery plan. PAHO directly supported the rehabilitation of seven health facilities to facilitate continuity of essential services.
- **Coordination.** PAHO supported the MSPP and the General Directorate for Civil Protection by organizing and facilitating weekly health response coordination meetings. PAHO also coordinated the **deployment** of 18 emergency medical teams from other countries, the care of over 30,000 people in the three departments, and the establishment of multidisciplinary field response teams in health directorates in each of the three departments. These teams were key in reestablishing essential health services, including maternal and child health, mental health, and vaccination.
- **An early warning system for outbreak detection.** PAHO supported the MSPP in establishing the first Early Warning, Alert and Response System in Haiti. Support included training; delivery of mobile data collection devices and internet access at 37 assembly points; and deployment of nurses to help screen, collect specimens, and test for selected infectious diseases, including COVID-19. Over 2,800 people were sampled for COVID-19 and diarrheal diseases, and over 100 alerts were investigated.
- **Developing capacity to deliver mental health support and priority health services at the first level of care.** PAHO provided technical support to establish mental health coordination units that organized integrated mobile clinics offering immediate psychological support. Psychological first aid training of trainers was organized; 41 trainers in four departments of the Great South of Haiti trained and refreshed 610 community health workers in psychological first aid and the other priority programs of the MSPP.

PAHO supported a rapid needs assessment, coordination of health sector partners, and rapid mobilization of human, financial, and material resources, improving mental and physical health outcomes for thousands of Haitians affected. The longer-term impact is yet to be realized, but the many lessons already learned from the earthquake response are expected to strengthen multi-hazard preparedness and response capacity in Haiti.

Rapid response to a volcano eruption amid a pandemic in Saint Vincent and the Grenadines

On 8 April 2021, volcanic activity from the La Soufrière volcano on the main island of Saint Vincent and the Grenadines rapidly increased. A same-day evacuation order was issued by the prime minister, and the volcano erupted the following day. Ash and gas impacted basic services (water, transport, and communications), and many health facilities were evacuated. There was a surge in demand for health services in the remaining operational facilities, which were already struggling due to a high caseload from the COVID-19 pandemic. One-fifth of the island population was affected and displaced by the event.



View of Kingstown, Saint Vincent, one day after La Soufrière volcano erupted on 9 April 2021.

Photo credit: Alex Williams/PAHO Consultant

PAHO provided comprehensive, rapid, and effective support to the government to increase access and continuity of health services in the emergency and recovery phases of the response. The support helped to improve mental and physical outcomes for thousands of people affected by the natural disaster. The cooperation focused on improving access to integrated health services and on long-term efforts to strengthen the health system through the following actions:

- **Mobilizing public health professionals.** PAHO mobilized specialists in water, sanitation, and hygiene (WASH), health emergency coordination and logistics, and damage and needs assessment.
- **Delivering emergency supplies and strengthening the supply chain.** PAHO provided administrative support to access an initial 24,000 doses of COVID-19 vaccines through the COVAX Facility, with the delivery of additional doses arranged for later in the year, under the COVAX Humanitarian Buffer assistance mechanism. The PAHO Strategic Fund also purchased and delivered essential medical supplies and equipment.
- **Ensuring the safety of vital health infrastructure.** PAHO provided WASH experts and financial support for the assessment and improvement of 20 health facilities. Technical support for syndromic surveillance of COVID-19 and other diseases was provided through training of 35 health surveillance teams in EWARS. PAHO also procured insecticides, insecticide application equipment, and rodenticides for controlling and preventing outbreaks of vector-borne diseases.
- **Providing care for noncommunicable diseases (NCDs) and mental health.** PAHO transported nutritionists to serve people with NCDs in shelters and provided NCD kits (medicines and diagnostic supplies) and training for over 40 health professionals to assist with the management of diabetes, hypertension, and cardiovascular disease in a population of 10,000 for three months. PAHO evaluated mental health and psychosocial support (MHPSS) capacity, forming a MHPSS Technical Working Group to address identified gaps, and trained three senior clinical health managers in MHPSS coordination in humanitarian emergencies, enabling the delivery of MHPSS in 86 shelters. PAHO also conducted an MHPSS and Psychological First Aid online course for frontline workers, which attracted 568 participants from 22 countries.
- **Communicating with the public.** PAHO designed messages, developed communication materials, commissioned a videographer, and printed and distributed materials to communicate to the public through social media (with UNICEF) and through public service announcements (with the Ministry of Health). The aim was to increase vaccine uptake as well as knowledge about hygiene and sanitation, volcanic ash exposure, mental health, and healthy eating.

Strong coordination was vital to the success of the response. PAHO worked in close cooperation with national and local authorities and with emergency response entities such as the Ministry of Health and the National Emergency Management Office, UN entities, and other health partners and international organizations.¹⁴

¹⁴ More information about the PAHO/WHO response to the La Soufrière volcano eruption is available at <https://youtu.be/HH-8EIpqhU8>.

Health Systems and Services

Outcomes 1 and 7-11

**Access to
comprehensive and
quality health services**

Health workforce

**Access to health
technologies**

**Strengthened
stewardship and
governance**

**Increased public
financing for health**

**Strengthened financial
protection**

Achievements

61. Countries accelerated efforts to reorganize and expand service delivery to respond to the needs of COVID-19 cases, including critical care, while at the same time maintaining essential services. These included the diagnosis and treatment of cancer, mental health disorders, and noncommunicable diseases, as well as immunizations and sexual and reproductive health services, among others. The substantial increase in hospital and critical care capacity in a short period of time was a significant achievement in most countries of the Region. A study in four countries reported a sustained increase ranging from 117% to 318% for intensive care units (ICUs) between March 2020 and January 2022. Even though many countries reached a breaking point in their hospital occupancy rate, many more deaths would have occurred without these sustained efforts.

62. Most countries introduced strategic changes in service delivery platforms and public health services to forestall the collapse of health systems. Nineteen countries have plans in place for continuity of essential health services during the COVID-19 pandemic, and five have plans for building health service resilience and preparedness over the long term. Another 10 countries are planning to develop a recovery plan, and 10 countries have allocated additional funding for longer-term health system recovery and health service resilience and preparedness. Nine countries reported having made investments to improve access to medicines, supplies, and other health products and to strengthen the capacities of health workers; eight reported having made investments in digital health technology, infodemic management, and new health facilities. Although they have done so unevenly, all countries have made significant efforts to strengthen the capacities of the first level of care with respect to COVID-19 inpatient management, diagnosis, provision of personal protective equipment, and vaccination. Investments included telemedicine and home care, hiring more staff and other measures to increase capacity to purchase essential products, implementing public communication strategies, and incorporating private sector health services to provide essential services with public funding.

63. Some countries, such as Guatemala, Mexico, and Paraguay, advanced in reforming their models of care. Other countries reactivated national initiatives to improve the quality of care in delivering health services, such as Argentina, Costa Rica, Ecuador, and Peru.

Still others, including Paraguay and Peru, implemented interventions to improve access to essential health services, such as maternity care, for populations in conditions of vulnerability.

64. Advance Market Commitment (AMC) countries, including Bolivia, Dominica, El Salvador, Grenada, Guyana, Haiti, Honduras, Nicaragua, Saint Lucia, and Saint Vincent and the Grenadines, have been supported in the development of COVID-19 Delivery Support (CDS) grants with Gavi, the Vaccine Alliance, and UNICEF. The objective of this new envelope is to ensure successful rapid roll-out and scale-up of COVID-19 vaccines, technical assistance, and strengthening health systems in countries.

65. The PAHO Virtual Campus for Public Health was rapidly adapted for the virtualization of PAHO's emergency work and delivery of strategic technical cooperation. More than 30 COVID-19-related courses were delivered to 1 million health workers throughout the Americas, and the Virtual Campus has incorporated on average 40,000 new health workers every month over the last two years. This effort was critical in the rapid deployment of vaccines as part of the COVID-19 response.

66. Two important global reports were published with the prominent participation of PAHO Member States. The State of the World's Nursing 2020 and The State of the World's Midwifery 2021 provide the latest evidence on policy options for the global nursing and midwifery workforce and present a compelling case for substantial, yet feasible, investment in nursing education, jobs, and leadership.

67. A subregional study investigated concerns, attitudes, and intended practices on COVID-19 vaccines among 1,200 physicians, nurses, and other health care workers from 14 countries in the Caribbean. The study was published by PAHO and its results shared in different forums, including with heads of state, ministers of health, chief medical officers, and the Regional Nursing Body. The findings supported communication strategies and policy development, including a policy brief that addressed COVID-19 vaccine hesitancy among health care workers in the Caribbean. That brief was approved by ministries of health and CARICOM, along with another policy brief on strengthening human resources for health to respond to COVID-19 and other emerging pandemics in the Caribbean. The Human Resources for Health Action Task Force for the Caribbean launched in April 2021 was expanded to 15 countries and two territories.

68. In Central America, human resources information systems were essential during the pandemic, with the Dominican Republic, Guatemala, Honduras, and Panama having made progress in developing and improving their systems.

69. PAHO enabled increased access to essential health supplies for COVID-19 through advocacy, coordination, and negotiation within global mechanisms such as the COVID-19 global supply consortium and the Access to COVID-19 Tools (ACT) Accelerator, whose three pillars are vaccines, diagnostics, and therapeutics. PAHO was the only regional office

of WHO with formal representation in the supply consortium and in each pillar of the ACT Accelerator.

70. In collaboration and coordination with WHO, PAHO selected manufacturers Bio-Manguinhos/Fiocruz (Brazil) and Sinergium Biotech (Argentina) for the development of COVID-19 mRNA vaccines. They are working with Afrigen Biologics and Vaccines in South Africa to receive training on mRNA vaccine technology, supported by WHO, the Medicines Patent Pool (MPP), and PAHO. Manufacturers from seven countries in the Region submitted expressions of interest in producing reagents and supplies for mRNA vaccines, and these proposals are currently being evaluated by PAHO, WHO, and the MPP.

71. The PAHO Regional Revolving Fund for Strategic Public Health Supplies (the Strategic Fund) procured over \$550 million in medicines and public health supplies on behalf of 31 participating entities, benefiting over 70 million people. This represented an approximately fourfold increase in the utilization of the Fund compared to the 2018-2019 biennium. The Strategic Fund helped mitigate major disruptions to health care supply chains by successfully procuring over \$290 million worth of COVID-19 diagnostic tests, personal protective equipment, laboratory and medical equipment, and ICU-critical medicines for 20 countries with over 38 million people in the Region. Additionally, the 2020-2021 biennium saw critical progress in advancing other strategic priorities, such as establishing long-term agreements for 15 antihypertension medicines and incorporating the first similar biotherapeutic for breast cancer.

72. The Caribbean Regulatory System (CRS) issued 145 product recommendations to its Member States, including nine COVID-19 vaccines and its first orphan drug for a rare disease. The review of COVID-19 vaccines by the CRS was instrumental in supporting regulatory decisions and enabled national authorities to make decisions about procurement, including receipt of donations brokered through the Caribbean Public Health Agency (CARPHA) and CARICOM. A Central American regulatory mechanism was established to review dossiers for new medicines with the participation of Costa Rica, Guatemala, Honduras, and Panama. This mechanism is being used to share regulatory information during the COVID-19 pandemic, especially about vaccines.

73. Ten institutions in eight countries improved capacities for accurate antiretroviral (ARV) demand estimation based on morbidity and using the new PAHO platform QUANTMET (Bolivia, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay). This led to important savings on procurement. In addition, seven countries used QUANTMET to strengthen their ARV national supply chains and promote sustainability (Bolivia, Ecuador, Honduras, Nicaragua, Panama, Paraguay, Venezuela).

74. Thirty-two out of 35 countries had COVID-19 national preparedness and response plans in place, while many enhanced their research and epidemiological surveillance. The pandemic sparked awareness of the importance of research and of having comprehensive reports on access and coverage conditions. Countries also enhanced capacities for epidemiological surveillance of COVID-19, with positive spillovers on national capacities.

Many countries also implemented innovations in the delivery of individual and population-based health services, using technologies and improvements in planning and distribution of human resources through better contractual policies and definition of professional profiles. Of the 17 countries in the Region that responded to WHO's national pulse survey on continuity of essential health services during the pandemic, carried out in the fourth quarter of 2021, 57% reported allocating additional government funding for the purpose of ensuring essential health services.

75. PASB supported countries in implementing interventions and actions to promote and protect the health and well-being of the migrant population within national health policies, plans, and programs. In 2021, Panama approved a technical norm on mental health care for migrants and refugees. Peru established mechanisms for the care of migrants through its Comprehensive Health Insurance scheme in the context of the pandemic. Guatemala developed guidelines for the care and protection of unaccompanied children and adolescents returning to Guatemala in the context of the pandemic, and the Guatemalan Migration Institute started developing a policy with the support of the health sector. Honduras developed a guide for migrant health care, and Brazil launched a plan for mental health and psychosocial support for migrants, refugees, asylum seekers, and stateless persons in the context of the pandemic.

76. Direct support was provided to several countries for the implementation of ethics guidance, including target countries Panama and Peru along with five baseline countries. They further strengthened their public health ethics capacities on key topics, such as assessing the ethics of mandatory COVID-19 vaccination (Panama) and of COVID-19 vaccine surveillance (Peru). Member States are also strengthening their ethics capacities with guidance and tools that are embedded in other areas of PAHO technical cooperation (e.g. immunization, vector-borne disease, emergency response). Efforts are underway to address ethics with a more systematic public health approach.

77. Countries continued efforts to strengthen health systems resilience, increasing health investment in sustained improvements toward universal health with equity and efficiency. In 2019 Suriname surpassed the recommended threshold of 6% gross domestic product (GDP) in public spending on health, while Panama and four other countries came close to it.

78. In 2021, significant additional resources were pooled from different sources. These were primarily external sources—loans and bonds through international financial institutions (IFIs) and domestic debt—as well as contingency funds and reallocations, when still possible. Support was provided to countries in the development of COVID-19-specific grant requests, as well as in the reprogramming of existing loans and grants to redirect resources required to tackle COVID-19. The IFIs—the World Bank, Development Bank of Latin America (CAF), and Inter-American Development Bank (IDB)—along with donors continued supporting efforts to address COVID-19-related impacts through new operations and by redirecting funds from existing projects. The amount of additional preapproved loans and grants (including through COVAX Facility and the Global Fund to

Fight AIDS, Tuberculosis and Malaria) exceeded \$3.3 billion. Almost 50% of these resources were used to reinforce COVID-19 vaccination programs and work with partners and the private sector to address supply chain issues and delivery. The remainder was directed to strengthen health systems and disease surveillance, provide services related to COVID-19, and support continuity of essential health services. The expansion of domestic and external funding has played a paramount role in securing an improved provision of essential health services, expansion of testing, and swift vaccination coverage. At the end of 2021, 32 countries received external funding from IFIs for a commitment estimated at nearly \$4 billion.

79. Panama started a process of institutionalization of health accounts, and Costa Rica continued improving and expanding this process in terms of its breadth and depth. Costa Rica produced the first report in the Region on COVID-19-related spending in a standardized way, using the PAHO System of Health Accounts 2011 (SHA 2011). This has triggered stronger collaboration between the Costa Rican Social Security Institution and the Ministry of Health, as well as South-South cooperation interventions with Panama.

Challenges

80. The overarching need is to sustain and adapt the health services' capacity to respond to the local epidemiological situation while at the same time ensuring access to high-quality essential health services. This implies moving from a reactive reorganization of health services to a more planned and sustainable model. A continuing challenge is the coordination and integration of different stakeholders—first level of care and hospitals, emergency medical teams, and alternative medical care sites, including public and private providers—to maintain access to quality health services. The difficulties reflect a lack of robust stewardship and governance of the health authority and weak intersectoral coordination.

81. The emphasis on increasing clinical capacity without proactively addressing quality and safety of care negatively affected patients and health workers in most countries. Similarly, concrete interventions in prevention and health promotion were subordinated to efforts to increase capacity to care for the growing numbers of patients.

82. Despite the demands, sound decisions were made to safely maintain essential health services and avoid cascading impacts of health service outages. This required adaptations to policies and regulations as well as to service delivery: using telemedicine, adopting safety protocols, tightening scheduling, and modifying clinical approaches. In addition, the composition of COVID-19 response teams was enhanced by mobilizing community-based workers, optimizing roles, and engaging retirees and students. All of these adaptations posed a significant challenge.

83. The pandemic triggered setbacks in the improvement of regulatory capacities in the Americas. Due to political and social pressures, many countries disregarded formal regulatory pathways and oversight for the authorization and use of medicines and other

health technologies. There were many situations in which lack of regulatory enforcement allowed products to be used with no scientific evidence to recommend their use. Despite production, dissemination, and availability of evidence-based information about the lack of specific therapeutic options for COVID-19, most countries allowed, officially or unofficially, the use of products and interventions that were not proven efficacious in treating COVID-19 or were even harmful.

84. The pandemic limited the availability of national counterparts, and political priorities were reoriented to the immediate pandemic response. This situation interrupted the implementation of programmed activities, including the launch of the essential public health functions assessment tool and national assessments of access barriers to health services. There are concerns about the stability of the personnel of national regulatory authorities and/or the timely appointment of managerial staff.

85. Countries are facing challenges in the capacity of information systems to provide accurate and timely data on access barriers and on the capacities of frontline health services and facilities to deliver essential health services. Routine data systems are falling short in their ability to detect and track the extent of disruptions across essential health services during the COVID-19 pandemic—information that is needed to inform mitigation strategies, respond to evolving community needs, and reduce barriers to accessing care.

86. The pandemic generated complex circumstances that require a broad and deep understanding of existing bottlenecks in resource allocation. In addition, the rigidity and multiplicity of reporting systems hampers the health expenditure tracking needed to enhance transparency and makes the systems less responsive to accountability requirements. The incipient level of institutionalization of health accounts as the tool for resource tracking and allocation becomes a barrier to measuring countries' progress toward meeting regional commitments for health financing. These include increasing public spending on health to at least 6% of GDP, with 30% of these resources invested in the first level of care, as the most efficient and equitable way to spend resources and pursue health outcomes.

87. Countries' capacity to monitor indicators related to financial protection was significantly impacted by the pandemic. These indicators rely on in-person household expenditure surveys that were mostly put on hold during 2020 and 2021.

88. Another difficulty affecting many countries with segmented health systems was the reduction in employment that left many people out of contributory schemes. This moved them back under the umbrella of public tax-based schemes or, in the worst scenario, left them uncovered.

Introduction and extension of oxygen therapy for COVID-19 patients in Bolivia



A COVID-19 patient receiving high-flow oxygen therapy in El Alto Sur Hospital.

Photo credit: WHO.

The first case of COVID-19 in Bolivia was officially reported on 11 March 2020. By December 2021, after four waves of COVID-19 hit the country, the total number of cases reached nearly 600,000. The situation strained the national health care system. Efforts were focused on providing oxygen therapy to COVID-19 patients at the first level of care with a view to reducing number of patient referrals to secondary- and tertiary-level hospitals and intensive care units and increasing the availability of oxygen therapy. In addition to the need to avoid overburdening capacity, there are also social and psychological benefits in keeping patients close to their family and communities.

By mid-May 2021, within the framework of the Bolivian Sistema Único de Salud or Unified Health System, the Ministry of Health of Bolivia (MoH), with technical assistance from PAHO, announced the implementation of a comprehensive plan aimed at providing oxygen therapy for all levels of care in the public health system. In support of this plan, and focusing on the first level of care, PAHO donated 260 oxygen concentrators, 360 hand oximeters, 592 finger oximeters, and other health supplies worth approximately \$365,000. By the end of November 2021, the MoH strategy for coping with moderate COVID-19 cases was reinforced with the support provided to hospitals

with high-flow oxygen therapy. PAHO donated 20 high-flow oxygen therapy devices (\$103,000 approximately) that were distributed by the MoH to four large urban hospitals: El Alto Sur, Hospital del Norte in Cochabamba, San Juan de Dios in Oruro, and Santa Bárbara in Sucre. PAHO also provided technical support, including hands-on training to 120 health care professionals (specialists, general doctors, and nurses) on the correct use of these devices.

With the continuous support of PAHO, Bolivia has strengthened its capacity to provide oxygen in a sustainable way in primary-level health care facilities as well as in key secondary- and tertiary-level hospitals. The benefits of this strategy are expected to extend beyond the COVID-19 pandemic, as Bolivians now have better access to oxygen for a wide array of needs. This integrated health network approach makes it likely that fewer patients will need to undergo intubation and visit intensive care units in the future.

Health throughout the Life Course, Determinants of Health, and Health Promotion

Outcomes 2, 3, 18, and 19

**Health throughout the
life course**

**Quality care for older
people**

**Social and
environmental
determinants**

**Health promotion and
intersectoral action**

Achievements

89. PASB provided technical support for the implementation of the Familias Fuertes program, resulting in adoption of the intervention as a national strategy in Mexico and Uruguay. The program was also adapted for virtual implementation in the context of the pandemic, reaching more than 60,000 families during the biennium.

90. Updated analysis of mother-to-child transmission of syphilis was completed in Argentina, Bolivia, Honduras, Paraguay, and Peru, measuring the impact of the pandemic using the Perinatal Information System Plus. It includes new records to monitor sexual, reproductive, maternal, and neonatal health programs such as those addressing contraception, gender-based violence, and neonatal and maternal COVID-19.

91. Bolivia and Brazil participated in a WHO global project funded by the Bill and Melinda Gates Foundation and made progress in ensuring the continuity of maternal, child, and adolescent health services as a component of their response to the pandemic. The project has managed to raise the level of priority assigned to the maintenance of services as part of pandemic response at the national level. Both countries are using administrative data to monitor the effects of the pandemic on health services and inform decisions to maintain the continuity of maternal, reproductive, childhood, adolescent, and elderly health services.

92. Training in prenatal care was provided to traditional midwives and community workers in Colombia, Ecuador, and Peru. The training emphasized early identification and timely treatment of obstetric emergencies, in line with guidance provided by the regulatory entities of each country, with the aim of strengthening the networks that connect the community to first-level care centers and referral centers.

93. Equity profiles were developed for social inequalities in maternal, child, and adolescent health indicators for 21 countries of Latin America and the Caribbean.

94. A mechanism was established for monitoring outcomes in women and newborns through a collaborative database on maternal health and COVID-19. An analysis of the direct and indirect effects of COVID-19 was carried out in eight countries (Bolivia, Colombia, Costa Rica, Dominican Republic, Ecuador, Honduras, Paraguay, Peru). This

database is the largest published to date on maternal mortality and the virus and allows for evidence-based decision making.

95. A research protocol was implemented to assess the impact on maternal and perinatal outcomes of COVID-19 vaccines administered to pregnant women. The study was carried out through Latin American Center of Perinatology, Women and Reproductive Health (CLAP/WR) network of sentinel centers for the surveillance of maternal health in 15 countries.

96. PASB has promoted the use of vaccines of proven effectiveness to immunize professionals who care for pregnant women and has provided technical support for countries to administer vaccines against COVID-19 in pregnant women. Webinars have been held with professional associations of gynecologists and obstetricians, midwives, and obstetric nurses, as well as with the maternal health programs of ministries of health in countries such as Colombia, Panama, Paraguay, Peru, and Uruguay. In addition, the dissemination of a field guide on maternal and neonatal immunization for Latin America and the Caribbean was encouraged. Similar activities were developed within the framework of the interagency Regional Task Force for the Reduction of Maternal Mortality (GTR).

97. The UN Decade of Healthy Aging (2021-2030) was launched regionally with strong support from Member States and integration with different agencies of the UN and the inter-American systems. PASB hosted the regional kickoff as an interagency event, with participation from the United Nations Population Fund (UNFPA), Economic Commission for Latin America and the Caribbean (ECLAC), International Labour Organization (ILO), and Organization of American States (OAS). Along with ECLAC and the Government of Chile, PASB held a regional forum with the participation of Argentina, Barbados, Chile, Costa Rica, Mexico, Paraguay, Suriname, and Uruguay. Participants shared their perceptions and commitments around the development of the Decade of Healthy Aging in their countries and the importance of this global movement for the Region in the context of the demographic transition. Many Member States are working on developing plans of action to establish priorities at country level, which has led to an increase in technical cooperation on healthy aging.

98. PASB supported the ratification by Peru of the Inter-American Convention on Protecting the Human Rights of Older Persons and provided technical-legal cooperation to enable the Colombian Congress to pass a law ratifying the Convention.

99. The virtual course ACAPEM-B (International Accreditation of Competences in Health Care for Older Persons - Basic Level) was launched in Portuguese. The course is now available in three languages (English, Spanish, and Portuguese) and has reached health professionals around the world. From January 2020 to December 2021 the course reached over 41,000 participants in 80 countries, a significant increase from the 11,000 participants in 55 countries registered during the previous biennium.

100. The implementation of nonpharmacological public health measures in vulnerable populations in the context of COVID-19 improved through a regional call for proposals to implement guidance developed by PAHO. More than 146 proposals were received, of which 43 were selected from 23 countries and have been implemented in the areas of communication, adaptation, and evaluation. This highlighted the wealth of experience in the Region with respect to innovation, solutions, and adaptation of products developed by the Organization to benefit populations in local communities and nationwide.

101. As part of the COVID-19 response and recovery, an initiative promoting policies and practices to address social determinants of health for advancing health equity was implemented in Chile, Colombia, Costa Rica, El Salvador, and Peru. In each of these countries, case studies were developed to map policies and programs in relation to social protection, unemployment, labor, gender, housing, and migration. In addition, systematic reviews were conducted on unemployment, migration status, and informal workers and the impact of health and policy interventions.

102. Two environmental strategies were included in the PAHO Elimination Initiative: the elimination of polluting fuels for cooking, and the elimination of open defecation. Road maps to phase out use of polluting fuels for cooking were launched in Honduras, Panama, Paraguay, and Peru.

103. Twenty countries analyzed the governance of the WASH sector (water, sanitation, and hygiene) as part of the Global Analysis and Assessment of Sanitation and Drinking-Water. In addition, a guidance document, *Guía para el análisis y la cuantificación del SARS-CoV-2 en aguas residuales*, was published in 2021.

104. Action on healthy settings included progress on healthy schools through the production of guidance documents addressing the topic both in general terms and in the COVID-19 context (such as return to school for populations in situations of vulnerability). Paraguay is one of the early adopters of global standards on health-promoting schools. Guidance on markets and COVID-19 was produced and implemented in Peru, and Nicaragua carried out activities around healthy markets.

Challenges

105. The pandemic has intensified preexisting barriers to progress on child survival and well-being with equity. It has also demonstrated the importance of PAHO working systematically and consistently with critical non-health sectors such as education and social protection. Inequities within countries are a recognized concern, and addressing them implies continuous support to each country's subnational and local levels, using an intersectoral approach.

106. Health and social protection systems have been overloaded with service demands, resulting in several cases of ageism and discriminatory decisions affecting older persons, mainly the most vulnerable ones. The lack of trained human resources, especially those

providing long-term care, has affected the capacity to protect older adults. In addition, the poor coordination between social and health services has also negatively impacted the care of older people.

107. Health services still lack a people-centered approach in primary care, hindering their efforts to deliver comprehensive care that fully meets the needs of older adults. This undermines the implementation of self-care and self-management programs in the community, which are important for successful care of older adults.

108. Weak occupational health and safety services available in countries required additional efforts to address workplace contagion and spread of the coronavirus. Countries need to strengthen occupational health and safety policies and programs, giving workers' health a higher level of attention and commitment.

109. Roles and responsibilities of the health sector with respect to climate change and environmental determinants of health are limited and suffer from a lack of clarity, due in part to weak governance mechanisms in environmental public health. The trained environmental public health workforce in the Region is limited as well. To tackle this challenge, PASB intensified technical cooperation with countries to clarify and strengthen the roles and responsibilities of the health sector on climate change and environmental determinants of health through the essential environmental public health functions, aligned with PAHO's essential public health functions renewed for the 21st century.

110. Countries have not prioritized health promotion, intersectoral action, and community participation in planning processes, in part because of their cross-cutting nature. This means that their relevance is diluted and not always visible. However, in the context of the COVID-19 pandemic response, these areas emerged as priorities that should be strengthened during the pandemic and beyond.

Using an evidence-based information system to strengthen maternal and child health services in Dominica



Nurse filling out the take-home card of the Perinatal Information System.

Photo credit: Ms. Anneke Wilson, country specialist for Dominica.

The Government of Dominica prioritized the elimination of mother-to-child transmission of HIV and syphilis as a strategic policy initiative to improve the quality of maternal and child health services. Inadequate availability of quality, timely, and reliable health information on pregnant women and newborns had long hindered the achievement of this milestone.

In 2021, in the midst of the COVID-19 pandemic, the combined efforts of Dominica's Ministry of Health and PAHO teams across all levels paid off when Dominica was certified by WHO for the elimination of mother-to-child transmission of HIV and syphilis. Dominica joined the ranks of seven other Caribbean countries that have received dual validation. Critical to achieving certification was the introduction and roll-out of the Perinatal Information System, developed by CLAP/WR. PAHO provided technical and financial support for the system, including in-country training, monitoring, software installation, consultations, design of the antenatal record, updating data in the system, and discussions of the roll-out strategy.

The Perinatal Information System was put in place to improve monitoring of maternal and child health data, including reporting on vertical transmission of syphilis, HIV, Chagas, and hepatitis B. Ten countries in the Region

use this system, which allows health administrators to learn about the factors related to maternal and neonatal deaths and follow up to improve maternal and neonatal health. In Dominica, actions were focused on:

- **National-level commitment.** The effort to ensure that no child is born with HIV or congenital syphilis must be rooted in antenatal care, equitable access to care for women with HIV, and human rights. The Ministry of Health took ownership of the Perinatal Information System with a view to strengthening the area of perinatal care.
- **Roll-out of the Perinatal Information System Plus.** The roll-out enabled maternal and child health data to be collected in a systematic way and used to inform planning and programming and to monitor and improve maternal and child health care. The system is low-cost and easy to use.
- **Health worker capacity building.** Training on use of the system involved health workers in data collection and analysis, enabling them to improve maternal and child health through monitoring and evaluation, quality of care assessment, and diagnostic procedures.

Challenges encountered in rolling out the system included:

- **Unreliable internet connection.** This can be addressed by having nurses update information at clinics, and the Ministry of Health outlined a plan to have all clinics connected to internet services.
- **Regular rotation of health care workers.** Continuous training is needed.
- **Absence of a unique identification number in the Perinatal Information System Plus system.** This was addressed by developing a coding system. The Perinatal Information System Plus will be added to an immunizations software package on an open platform, using a unique identifier for all services.

Dominica's success in ensuring that no child will be born with HIV or syphilis brings the country one step closer to achieving an AIDS-free generation and ending the disease. The success was the result of strong government leadership and the technical and resource contributions of PAHO, in particular, to develop, implement, and ensure the smooth operation of the Perinatal Information System Plus.

Noncommunicable Diseases and Their Risk Factors, Malnutrition, Mental Health, Violence, and Injuries

Outcomes 5, 6, and 13-16

Access to services for NCDs and mental health conditions	Response capacity for violence and injuries	Risk factors for NCDs
Malnutrition	Intersectoral response to violence and injuries	Intersectoral action on mental health

Achievements

111. New knowledge was generated on the links between noncommunicable diseases (NCDs) and COVID-19, and technical guidance and educational materials were provided to help health providers address NCDs in the context of the COVID-19 pandemic. This included information on service adaptations to ensure continuity of care for persons with NCDs, use of telemedicine and digital health to minimize disruption in NCD services, prioritization of cancer services, and provision of palliative care during COVID-19. A series of factsheets directed to the public were also developed and widely disseminated to provide authoritative advice on managing NCDs during the pandemic. In addition, a series of high-level webinars were held with senior government officials to showcase effective and innovative NCD and mental health care strategies used in the Region and to demonstrate how NCDs and mental health have been incorporated into health system transformations during COVID-19.

112. Thirty-four countries and territories now have a mental health policy or plan approved by government, with emphasis on the development of community-based mental health care. The integration of mental health services into primary care through the WHO Mental Health Gap Action Programme (mhGAP) has continued. Providers from 34 countries and territories participated in training initiatives aimed at highlighting the importance of decentralizing mental health services, which are still often exclusively available in specialized facilities. Due to the increasing suicide rate in the Region, suicide prevention is a focus, and suicide prevention activities were implemented in five countries (Argentina, Costa Rica, Guyana, Suriname, Trinidad and Tobago). These activities include a situation assessment as well as development of plans and improvement of surveillance mechanisms.

113. Substance use has also been an area of increased attention, and PASB has mobilized financial resources for the implementation of substance use management programs in eight countries. PASB developed and deployed the first digital health specialist on alcohol-related topics to educate the public on alcohol harms and health. The female digital health worker, named Pahola, chats with users in English, Spanish, and Portuguese to help them

assess their individual alcohol risk and develop a plan to reduce consumption. Pahola also provides country-specific resources to facilitate access to treatment and support for alcohol use disorders. The associated communication campaign potentially reached 61 million people during the two months in which it was implemented, and over 236,000 people landed on the online page, showing that Pahola has the potential to become an effective health literacy and risk communication tool for countries. The top five countries accessing Pahola were (in decreasing order) the United States, Canada, Colombia, Argentina, and Haiti.

114. As part of the expansion of the HEARTS in the Americas Initiative, 21 countries implemented the evidence-based tools in the HEARTS technical package during the biennium. A total of 1,045 primary care centers are participating in the program, including 306 new health centers added in 2021. These centers cover an aggregate population of 8.2 million in the catchment areas, including an additional 2.1 million persons in 2021. Technical tools such as the clinical pathway, cardiovascular disease risk calculator, and regulatory framework for blood pressure devices were developed. Together with the HEARTS virtual courses, these tools benefited over 182,000 users during 2021.

115. Diabetes modules have been integrated into the HEARTS Initiative and into the tuberculosis programs in three countries (Brazil, Mexico, Peru). A regional analysis on diabetes prevalence and control was completed and has informed two reports: *Panorama of Diabetes in the Americas* (awaiting publication) and *Country Snapshot of Diabetes Prevention and Control in the Americas*. A regional stakeholders' group was established to expand the partnerships and collaborations on diabetes in the Region, and a communications campaign with social media messages and other communications products was disseminated widely throughout the Region to raise awareness of the disease. Diabetes programs were strengthened with guidelines, supplies, and monitoring in three countries (Bolivia, Honduras, Paraguay).

116. The regional cervical cancer elimination strategy was launched in November 2020 with great support from ministries of health throughout the Region, along with professional associations and nongovernmental organizations. PASB has provided various technical tools and assistance to Member States, including a virtual monthly tele-mentoring program to support interventions aimed at reaching the cervical cancer coverage targets of 90% HPV (human papillomavirus) vaccination, 70% screening, and 90% treatment. A communications campaign was developed with Chile, and HPV testing is being introduced, with support on procurement and training, in Antigua and Barbuda and Paraguay.

117. On childhood cancer, PAHO has implemented the CureALL Americas initiative in collaboration with St. Jude Children's Research Hospital to support the development of national plans, organize multi-stakeholder dialogues, and help improve the organization and delivery of childhood cancer care. This initiative has been rolled out in more than a dozen countries (Brazil, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru). Peru has been the flagship country and established a new cancer law in September 2020, ensuring

universal access and coverage for childhood cancer. Several tools were developed to support capacity building, including a manual on psychosocial support for children with cancer and a virtual course on early diagnosis of childhood cancer.

118. An innovative approach was developed to continue NCD surveillance during the COVID-19 pandemic using mobile phone surveys. These were implemented in five countries (Antigua and Barbuda, Belize, Bolivia, Honduras, Paraguay), generating data on how people with NCDs have been affected by COVID-19. Anticipating the initiation of NCD surveys in the post-COVID era, technical assistance was provided to several countries to plan future STEPS surveys on NCD risk factors (Grenada, Paraguay, Saint Lucia, Suriname).

119. National assessments of rehabilitation and assistive technology services took place in Bolivia, the Dominican Republic, and El Salvador, implementing PAHO/WHO tools and with PAHO support. These assessments will lay the foundation for the development of new plans and policies for rehabilitation and assistive technology in 2022. The assessments also integrated learning on how the COVID-19 pandemic has impacted rehabilitation services and implications for building back better. Two important regional forums have been established: a rehabilitation leadership roundtable with the focal points for rehabilitation in the ministries of health of 12 countries, and a Disability Community of Practice (CoP). This CoP is made up of people with disabilities and their representative organizations and works to ensure that PAHO's programming on disability is directly guided and informed by members of the disability community in the Region.

120. Following the publication and dissemination of new health system tools by PAHO/WHO, several Member States have shown an interest in updating their clinical guidance on response to violence (Argentina, Bolivia, Grenada, Jamaica, Paraguay, Peru, Trinidad and Tobago). Examples include new guidance in Bolivia on integrated responses to sexual violence, completion of a situational service assessment and new standard operating procedures in Grenada, initiation of the adaptation process for the WHO clinical handbook in Argentina, and revisions of the interpersonal violence protocol in Jamaica.

121. In the context of COVID-19, there is a renewed push to strengthen the skills of health workers, especially frontline providers, in the identification of survivors of violence and provision of first-line support. PAHO's partnership with UNFPA was strengthened to develop a new e-learning course for health workers in Latin America in collaboration with counterparts in countries, with a similar partnership established in the Caribbean to assess and advance health institutional capacity building in late 2021.

122. The COVID-19 pandemic has also reaffirmed the need for better administrative data on violence, including the collection, analysis, and use of data from health information systems. In Peru and Trinidad and Tobago, work advanced to strengthen the development of a data collection methodology and related tools. This included efforts to develop an online clinical record for survivors of violence against women and its incorporation as a new module within the PAHO Perinatal Information System.

123. Bolivia created a single toll-free emergency number with national coverage for road safety. This is a key mechanism for the centrally coordinated dispatch of ambulances and other emergency responders to care for road crash injuries and other acute medical conditions that require rapid intervention. It is an essential action to improve post-crash response and is included in the recently launched UN Global Plan for the Decade of Action for Road Safety 2021-2030.

124. South America became smoke-free during the biennium. Despite the challenges posed by COVID-19 and by tobacco industry efforts to use the pandemic as an opportunity to interfere with policy processes, several Member States developed stronger tobacco control regulations aligned with the WHO Framework Convention on Tobacco Control (FCTC). Among these advances, Bolivia passed a new law in February 2020 and Paraguay and Saint Lucia approved new regulations, all establishing smoke-free environments in indoor public places and workplaces and increasing the total number of countries with such regulations to 23 in the Americas. With new regulations issued in Paraguay in December 2020, all the South American countries are now in compliance with the WHO FCTC, a huge milestone for the Region. Additionally, the Mexican Congress approved a bill to amend Mexico's tobacco control law and establish 100% smoke-free environments in public places and workplaces along with a total ban on tobacco advertising, promotion, and sponsorship, in line with the WHO FCTC mandates.

125. Progress continued in the use of excise taxes to reduce consumption of tobacco, alcohol, and sugar-sweetened beverages. Peru established the annual automatic indexation of its amount-specific ISC tax on cigarettes and alcoholic beverages. This measure will help ensure that the effectiveness of the ISC in reducing the affordability of cigarettes and alcoholic beverages does not decrease as prices rise. PAHO also led pioneering work on calculating a tax share for sugar-sweetened beverages and alcoholic beverages, learning from and adapting the well-established WHO protocol for monitoring tobacco taxes. A standardized tax share indicator for sugary drinks and alcoholic beverages will enable countries to better assess their own situation related to tax rates, allow comparisons with other countries, and propose tax changes with the goal of reducing the consumption of these products, thus contributing to the achievement of health objectives.

126. There was progress on front-of-package labeling (FOPL) in the Americas. Mexico and Uruguay joined the three countries in the Region (Chile, Ecuador, Peru) that are already implementing FOPL to discourage the consumption of processed or ultra-processed products high in sugar, fat, and/or salt. Argentina approved a healthy eating law, incorporating the highest recommended standards for FOPL and food marketing and school food environment regulations.

127. Guidance on breastfeeding was completed with the provision of up-to-date technical guidance on protection, promotion, and support for breastfeeding during the COVID-19 pandemic. Dissemination of technical guidance on implementation of the Baby-Friendly Hospital Initiative (BFHI) was sustained and expanded to take into account

the pandemic context, in particular through the Latin American and Caribbean BFHI networks.

128. Multi-sector and multi-stakeholder partnerships remain essential to advance the work on violence and injuries. There was strengthened collaboration on INSPIRE, a package of seven evidence-based strategies to reduce violence against children and young people. This included a series of workshops for policymakers from 10 South American countries (Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, Venezuela), organized under the auspices of the Colombian government and in collaboration with INSPIRE partners.

129. Evidence was strengthened to inform action on violence, including development of two draft papers on the impact of COVID-19 on violence, a scoping study on ethnicity and violence against women, and a policy brief on alcohol and violence.

130. Multiple countries advanced in the development and strengthening of their legal frameworks for road safety, considering PAHO/WHO recommendations on best practices. This included the establishment of a lead agency on road safety in Suriname (published in September 2019, incorporated in August 2021); improvement of vehicle safety standards in Argentina and Mexico; and changes to the legislation on road safety risk factors in Brazil (regulation on child restraint systems). These measures have great potential to improve road safety in these countries and to encourage other countries to move forward on these important aspects. As part of the Bloomberg Initiative for Global Road Safety, PAHO and other partners worked with city-level authorities to implement a multi-pronged road safety program in five countries (Argentina, Brazil, Colombia, Ecuador, Mexico). Evidence is also being collected to monitor and evaluate the impact of all these activities.

131. With the ongoing “mental health pandemic” and increasing concern about the impact on vulnerable groups, support to countries on the development and implementation of mental health policies, plans, laws, and capacity building have been intensified throughout the Region. Working with the Central American Parliament (PARLACEN) and the Executive Secretariat of the Council of Ministers of Health of Central America (COMISCA), PAHO developed model legislation for mental health, promoting a rights-based perspective and setting out a broad conceptual framework to promote mental health and well-being for all. The model law incorporates important principles of the Convention on the Rights of Persons with Disabilities. It was approved by the plenary of the Parliament, and Nicaragua has presented it as an initiative to their National Assembly. In addition, ORAS-CONHU (Andean Health Agency-Hipólito Unanue Agreement) has published a new mental health policy. Both initiatives are based on PAHO/WHO recommendations.

Challenges

132. The COVID-19 response resulted in extensive disruptions to NCD services. Only one-third of Member States reported that outpatient NCD services were functioning normally, and only one in four countries reported no disruptions. Ministry of Health staff

were largely redirected to work on the pandemic response, either full-time or part-time, reducing the human resources available for NCD services. Six countries reported stockouts of essential NCD medicines and/or diagnostics at health facilities that affected service continuity. NCD activities, most commonly screenings for cancer, diabetes, and other NCDs, were adversely affected in half of the countries. Mitigation strategies to ensure continuity of care for people with NCDs were deployed in many countries and included triaging patients, telemedicine and teleconsultations, and electronic prescriptions and other novel prescribing practices.

133. Population-based NCD surveillance through household surveys came to a halt. Governments faced difficulties in making the necessary investments and system changes to improve services and quality of care for NCDs, mental health, disabilities and rehabilitation, substance use, and palliative care. The need to strengthen mental health services is increasing since the COVID-19 pandemic has raised levels of depression, anxiety, and other mental health conditions, particularly among vulnerable populations, youth, and health workers.

134. The health system response to violence has long been a core pillar of the broader prevention agenda. Access to quality response services addresses the immediate needs of the violence survivor and is also a key step in preventing secondary victimization or revictimization. Disruptions in services due to the COVID-19 pandemic have exacerbated the need for action while introducing new challenges and risks, including an increase in the risk of domestic violence. Sexual violence services are likely to be particularly affected, necessitating a renewed emphasis on this area of work. Drawing on data before the pandemic, the regional status report on violence against children also warns of major barriers in access to services, with substantial differences noted across population groups. This calls for greater attention to specific groups in conditions of vulnerability to ensure their access to adequate support, taking into account the increased risk and barriers to access faced by migrant groups, ethnic minorities, indigenous groups, women and children with disabilities, the urban poor, and rural populations, among others. Moreover, while many countries have developed and are able to rely on clinical guidelines and tools to improve health system responses to violence, momentum must be maintained in the context of the pandemic and financial constraints. Limitations in capacity-building resources have slowed progress and addressing this is a major priority for the new biennium.

135. Regarding road safety, the health services response has traditionally received less attention than the broader prevention agenda. As a result, post-crash care remains limited in many countries, and there has been little progress on establishing national emergency telephone numbers. In close coordination with broader efforts to strengthen health systems, more targeted and practical guidance is needed to improve post-crash care, adapted to the regional context. It is important to note that the technical work in this area is complicated by major gaps in information on post-crash care, including data on time intervals for accessing care as well as quality of care for survivors.

136. Prior to the COVID-19 pandemic, salt reduction and elimination of industrial trans-fatty acids were relatively new topics that had not been prioritized. NCD staff in ministries of health focus more on control and management of disease than on prevention and health promotion. Nutrition staff still focus heavily on educational interventions and do not have the mandate or support needed to establish intersectoral agreements on interventions like food reformulation. Regarding physical activity, most countries do not have plans in line with the WHO Global Action Plan on Physical Activity, which calls for wide participation from different sectors, nor do they have a specific focal point for physical activity. Responsibilities are shared among NCD, nutrition, and health promotion departments, and are mostly uncoordinated.

137. It has been a challenge to support continuous capacity building for PAHO country and subregional staff on nutrition, healthy diets, and physical activity, and to carry out the activities needed to reach the regional scale required. There is also limited capacity to communicate in virtual spaces in a timely and effective manner and to develop and maintain online tools for capacity building and technical cooperation on nutrition, healthy diets, and physical activity.

138. Information needed to monitor progress on road safety comes from the WHO Global Status Report on Road Safety, which has been delayed because of the pandemic. Information on violence similarly draws on data reported by countries in relation to the regional strategy on violence against women. A mechanism to systematically receive progress updates at regular intervals might make information on road safety and violence available in a timelier manner. There continue to be major gaps in data and information in both areas, hindering effective progress monitoring and impeding the broad implementation of evidence-based policy and programs.

139. Due to the pandemic, violence prevention and road safety received less attention than other issues from country counterparts, and activities were sometimes rescheduled or delayed. While the pandemic has shined a spotlight on the increased risk of violence, there is a need to strengthen advocacy in favor of prevention. The health sector has an important role to play in convening partners, advocating for a public health approach, and guiding responses based on best available evidence. However, the limited engagement and institutional capacity of the health sector on these topics in many countries continues to pose barriers to progress.

Prevention, Control, and Elimination of Communicable Diseases

Outcomes 4, 12, and 17

Response capacity for
communicable diseases

Risk factors for
communicable diseases

Elimination of
communicable diseases

Achievements

140. In Latin America and the Caribbean (LAC), 91% of people with HIV on antiretroviral therapy (ART) reached viral suppression in 2020. Overall, seven countries have achieved over 90% of people on ART with viral suppression (Brazil, Canada, Chile, Dominican Republic, Panama, Trinidad and Tobago, Uruguay). Nine other countries are close to achieving the indicator. Dominica was certified as having eliminated maternal and child transmission of HIV and congenital syphilis. Nineteen countries and territories have achieved 95% coverage of appropriate syphilis treatment among pregnant women.

141. Thirty-four out of 35 Member States adopted the WHO “treat all” policy, and 71% (25/35) use a DTG-based first-line regimen for HIV treatment, as recommended by WHO. Fourteen Member States have adopted PrEP (pre-exposure prophylaxis) as a public policy, although implementation is still low. In LAC, 81% of persons with HIV have been diagnosed, up from 77% in 2018. Ten countries implemented HIV self-testing in 2021, and this strategy has the potential to further increase the number of people with HIV who know their status.

142. El Salvador was certified free of malaria. The Regional Malaria Elimination Initiative in Central America and three other countries is advancing elimination efforts in this subregion with support from the IDB, the Global Fund, the Bill and Melinda Gates and Clinton Foundations, and PAHO.

143. Thanks to the well-established PAHO Latin American and Caribbean Network for Antimicrobial Resistance Surveillance network (ReLAVRA+), countries were able to successfully detect the emergence of extensively antimicrobial-resistant microorganisms. The Organization has worked with countries to strengthen infection prevention and control practices with appropriate use of antimicrobials and to build the capacities of food analysis laboratories for the detection of antimicrobial resistance through the Inter-American Network of Food Analysis Laboratories.

144. A resolution on reinvigorating immunization programs in the Region was approved by the 59th Directing Council in 2021. The related policy includes a strategic line of action, “Strengthen the integration of immunization programs into the primary health care system toward universal health,” which highlights the importance of maternal and neonatal care and offers a platform for the integration of immunization into primary health care.

145. The new Plan of Action 2021-2025 for the Hemispheric Program for the Eradication of Foot-and-Mouth Disease was approved by the Hemispheric Committee for the Eradication of Foot-and-Mouth Disease. Its implementation is underway.

146. Thirty-three of the 35 Member States have sustained the elimination of measles, and all Member States have sustained the elimination of rubella and congenital rubella syndrome. Implementation of the first phase of a tuberculosis (TB) elimination project was carried out in three low-incidence countries (Costa Rica, Cuba, Jamaica).

147. Fifteen of the 17 countries with vectoral transmission of *T. cruzi* were able to maintain control of the main vectors. PASB intensified efforts in Bolivia and Colombia, where the number of municipalities with interruption of domiciliary vectoral transmission increased during the biennium.

148. New tools for virtual technical collaboration were developed, including but not limited to automated epidemiological bulletins for the regional and national levels and epidemiological dashboards with real-time information. Guidelines for clinical diagnosis and treatment of dengue, chikungunya, and Zika were finalized, published, and launched through a webinar, and 15,000 health workers have been trained.

149. Codex Trust Fund beneficiary countries (Bolivia, El Salvador, Guatemala, Guyana, Honduras) conducted assessments of the Food Safety Risk Analysis framework to identify strengths and weaknesses.

150. The regional system for Surveillance of Events Supposedly Attributable to Vaccination or Immunization (ESAVI) is progressing well. Sixteen Latin American countries are transferring data to the regional database, and eight countries and 20 hospitals are part of the ESAVI and AESI (Adverse Events of Special Interest) regional surveillance network.

151. PASB provided technical assistance to countries to prepare them for the introduction of COVID-19 vaccines. For instance, quality control tests were carried out to verify compliance with International Organization for Standardization (ISO) standards for syringes acquired through the PAHO Revolving Fund for Access to Vaccines (Revolving Fund) to meet the demand for the administration of COVID-19 vaccines. Effectiveness studies of the vaccines were developed in Argentina, Brazil, Chile, and Colombia.

Challenges

152. The changing political contexts in many countries caused personnel changes and affected leadership and governance for the prevention, control, and elimination of communicable diseases. There has been high staff turnover in priority programs within ministries of health, causing significant disruption and loss of continuity in the provision of essential services for all public health programs.

153. A challenge faced by programs targeting elimination was the allocation of insufficient resources, including infrastructure in countries and, within PWR Offices, human resources. There were funding disruptions from important donor agencies. In addition, the cost of interventions, including community-based interventions, increased due to COVID-19 and its requirements. This also affected procurement and transport costs of medicines, vaccines, supplies, and equipment. The COVID-19 pandemic affected access to life-saving treatments for diseases that are on the path to elimination, such as HIV, viral hepatitis, sexually transmitted infections, TB, and neglected infectious diseases.

154. Attention to migrants' health issues, including treatment of infectious diseases, was disrupted by COVID-19. Differences in treatment protocols among countries further impacted treatment coverage among migrants.

155. Travel restrictions and limited mobility due to COVID-19 impacted interventions for the prevention of communicable diseases, which is expected to drive an increase in cases in the near future. In addition, multidrug-resistant organism outbreaks in intensive care units affecting COVID-19 patients have been notified in several countries. Overall, reports of emerging antimicrobial resistance are on the rise, and certain multidrug-resistant pathogens have spread to areas where they had not been detected previously.

156. Sustaining the epidemiological surveillance of arboviral and other diseases in the context of the pandemic has been a continuing challenge, since the national epidemiological teams often include the same personnel working on COVID-19 at national and local levels.

157. Strong social determinants in contexts with weak public health structures continue driving the transmission of malaria. The COVID-19 pandemic disrupted early access to malaria services, aggravating the situation.

158. Brazil has continued to experience the circulation of measles for almost four years and therefore the reestablishment of the endemic transmission of measles for three years. Venezuela interrupted the circulation of measles after two years, but it will not be recertified by the regional committee for monitoring and reverification of elimination until after the measles and rubella campaigns planned for 2022.

159. The vaccination rates for first and second MMR (measles, mumps and rubella) doses have declined due to COVID-19, and there has been a negative impact on the epidemiological surveillance of measles and rubella. This might trigger outbreaks of both diseases if the vaccination program is not strengthened.

Addressing socioeconomic hardship associated with Tuberculosis in Brazil

People with tuberculosis (TB) often incur substantial costs related to seeking and receiving diagnosis, treatment, and care, and this may create barriers to access that adversely affect health outcomes and increase the risk of disease transmission. Eliminating catastrophic costs for people with TB and their households with effective mitigation strategies and policies is at the center of the WHO End TB Strategy.

PAHO, in collaboration with the WHO Global Tuberculosis Program, provided direct technical assistance for a national survey of TB patient costs in Brazil. The National TB Program of Brazil, in collaboration with the University of Espírito Santo and with technical assistance from WHO/PAHO, conducted the survey between 2019 and 2021. It reached a total of 603 people diagnosed with TB, despite interruptions in data collection due to the COVID-19 pandemic.

WHO/ PAHO provided extensive support to implement the survey and address COVID-related bottlenecks. This included providing technical support and policy recommendations, securing survey funding, monitoring survey implementation, and hosting post-survey events, which aimed to highlight research leading to policy development.

The results of the survey showed that about half (48%) of TB-affected households face catastrophic costs, defined as costs above 20% of their annual household income, during their TB episode. The average amount among respondents was \$1,573 from onset of symptoms to treatment completion. To mitigate such costs, one-third of TB-affected households in the survey had to borrow or sell assets to cope with economic hardship.



A TB patient holds the medicine he must take as part of his treatment.
Photo credit: PAHO/WHO Representative Office for Brazil.

Poverty levels almost doubled in respondent households, with one in four TB-affected patients living below the international poverty line. The risk of being unemployed was significantly higher for TB patients who had HIV co-infection, were self-employed, and/or had lower levels of education.

TB has social, income, employment, and poverty consequences, some of which may be long-lasting, and all of which require a multisectoral response. Findings from the Brazil survey and associated policy recommendations are being disseminated among a wide range of stakeholders in collaboration with WHO/PAHO. The evidence stemming from this survey is being used to design interventions, provide evidence-based case studies for health and social policy changes, and promote multisectoral collaboration to alleviate the burden of disease on TB patients and their households.

Information Systems for Health, Evidence, and Research

Outcomes 20-22

Integrated information
systems for health

Data, information,
knowledge, and
evidence

Research, ethics, and
innovation for health

Achievements

160. Information systems for health (IS4H) maturity assessments were conducted and completed in all countries and territories of the Region. Based on these assessments, specific roadmaps were developed. They include the revision and modernization of legislative frameworks and regulations for IS4H, focusing on the collection of data from the private sector and on privacy, confidentiality, and security. A majority of the countries included strategies for capacity building and change management at all levels in national roadmaps for the implementation of digital health solutions and strategies.

161. With the aim of positioning PAHO as the leading public health agency in the age of digital interdependence, Member States developed and adopted two regional policies: the Roadmap for the Digital Transformation of the Health Sector in the Region of the Americas, and the Policy on the Application of Data Science in Public Health Using Artificial Intelligence and Other Emerging Technologies. With these, the Americas became the first region to accelerate innovative processes for the digital transformation of the health sector. In support of policy implementation, a comprehensive digital transformation toolkit was developed. Significant progress was made in the provision of technical cooperation on legal frameworks to support the digital transformation of the health sector. Additionally, steps were taken toward the adoption of international standards for ensuring interoperability, cybersecurity, data management, ethical use of artificial intelligence (AI), among others.

162. Efforts were made to improve the infrastructure for IS4H and information and communication technology more broadly. The emphasis was on increasing bandwidth and connectivity with a view to avoiding digital divides and improving access to both structured and unstructured data, using the most effective digital health solutions. Particular attention was given to finding digital AI-based solutions for supporting Member States in the fight against infodemics.

163. In support of Member States, three critical platforms advanced: *a)* Health in the Americas,¹⁵ with an analysis of potentially avoidable premature mortality using data at the regional, subregional, and national levels for 33 countries; *b)* Core Indicators update for all

¹⁵ More information available at <https://hia.paho.org/en>.

countries and territories;¹⁶ and *c*) the SDGs monitoring portal.¹⁷ The portal includes a regional dashboard with subregional and country data, country profiles for 25 countries, and specific methodological tools and a repository of evidence to keep track of regional, national, and subnational progress toward the SDGs.

164. The Institutional Repository for Information Sharing (IRIS), also known PAHO's Digital Library, and an intranet-based COVID-19 Institutional Knowledge Repository (IKR) provided easy and constant access to institutional and scientific-technical literature and documents. PAHO IRIS is a dynamic and ongoing repository and a continued valued asset for the Organization. During the biennium, it made available 2,834 documents which received more than 39 million accesses/interactions. Of these documents, 2,101 were on COVID-19, including the papers of the Pan American Journal of Public Health. The COVID-19 IKR became a searchable platform and a hub for collective work among the three levels of the Organization in response to the pandemic. Implemented in March 2020, it contained a total of 2,947 items as of December 2021. The Pan American Journal of Public Health, which completes 100 years of uninterrupted publication in 2022, has increased its impact factor to 1.46 (source: Web of Science, 2021). The Journal received a record number of manuscripts in the biennium, 2,900, of which around 300 were accepted and published. A fast-track process was implemented to expedite the peer review of COVID-19-related papers, allowing the Journal to be an important instrument for the production and dissemination of public health evidence in the Region of the Americas.

165. The Organization once again implemented innovative ways to engage with the PAHO/WHO Collaborating Centers to better respond to priorities and mandates as well as share and disseminate best practices on delivering technical cooperation and responding to COVID-19. In April 2021, a regional webinar was held with more than 340 participants from 183 Collaborating Centers.

166. The e-BlueInfo 2.0 application offers health personnel access to new collections of documents and scientific evidence in the Virtual Health Library in support of decision making, using the codes of the International Classification of Diseases (ICD-10) and the unique identifier or term of the DeCS/MeSH. The DeCS/MeSH 2021 edition was developed and published, highlighting COVID-19-related terms. The DeCS/MeSH Finder was developed as an innovative online service for researchers, editors, and librarians in the field of health sciences, allowing users to locate any descriptor, synonym, or qualifier of the DeCS/MeSH controlled vocabulary in any given text in a fraction of a second.

167. During the biennium, the scientific community and governments accelerated research and innovation aimed at containing the spread of the COVID-19 pandemic, facilitating optimal care, strengthening health systems, and protecting health care and essential workers. A considerable number of COVID-19 studies, including clinical trials, were conducted in most countries of the Region. PASB provided technical support for the

¹⁶ More information available at <https://opendata.paho.org/en/core-indicators>.

¹⁷ More information available at <https://www3.paho.org/ods3/en/home/>.

prioritization of ethical research, development and implementation of standards, coordination and harmonization of research, and development and integration of research results into health systems, among others. Multinational and international collaborative research studies on COVID-19, including the WHO Global Clinical Platform, the COVID-19 respiratory study (WHO O2CoV2), and the WHO Solidarity trials, were promoted and supported by PASB in the Region.

168. Coordination of research, evidence synthesis, and knowledge translation to respond to the COVID-19 pandemic has facilitated the implementation of the global and regional response. This includes the harmonization of norms and standards, development of public goods (evidence-informed policies and recommendations), strengthening of capacity building in evidence use for decision making, and support for the conduct of cross-country collaborative research. PASB reinforced the development of networks of health professionals and health facilities to support the characterization, diagnosis, and management of acute COVID-19 and post-COVID-19 conditions. The Bureau also developed capacity-building activities for health professionals in clinical management and health systems issues related to the disease; supported the provision of treatment for patients through the ACT Accelerator and other mechanisms; and provided technical support for health systems preparedness. PAHO provided technical support for the implementation of the WHO Global Clinical Platform for COVID-19 in countries of the Region, with more than 500,000 global COVID-19 cases.

169. PASB provided technical support for the development of timely, demand-driven evidence research synthesis and public health recommendations on COVID-19, the SDGs, and other health priorities. The Organization also supported stakeholder engagement processes to understand and shape policy, practice, political, and system dynamics, particularly in strengthening health systems and improving the implementation of programs and services. During the biennium, the Organization produced and continually updated evidence and recommendations for the management of patients infected with COVID-19. More than 40 PAHO evidence publications on COVID-19 and other priorities were developed and proved essential for technical cooperation with countries.

170. In support of PAHO Member States, critical databases and resources were developed to advance the transformation of evidence synthesis and knowledge translation. They included *a)* BIGGREC, a database incorporating all evidence-informed recommendations that have been formulated by WHO and PAHO, classified according to SDG3 targets; *b)* BIGG, a database of all evidence-informed guidelines that have been produced by different international organizations; *c)* EVID@EASY, a guided evidence search tool in the Virtual Health Library, which offers paths to locate scientific evidence according to the stage of the decision-making process; and *d)* a PAHO evidence synthesis collection of health recommendations produced by PAHO/WHO.

171. In partnership with Health Systems Global, PAHO developed webinars in Spanish and English to increase the capacity of LAC countries to produce and disseminate research evidence on health systems' response to the pandemic. In addition, four research

documents examining structural aspects of health systems resilience in LAC were developed. They addressed *a)* the politics and policies of health system performance; *b)* the intersection of health and social policies and the need to strengthen the intersectoral approach; *c)* the changing dynamics of health provision models and the central role of human resources for health; and *d)* the role of primary health care in securing sustainability, improving health financing, and promoting equity.

172. Mobility of health professionals, especially nurses, from the English-speaking Caribbean to North America, Europe, and Australia was exacerbated by the COVID-19 pandemic. To generate solutions and evidence to improve health and reduce health inequalities in the Caribbean subregion, PASB, in collaboration with the University of the West Indies and 18 English-speaking Caribbean countries and territories, developed a study to quantify human resources for health in the subregion and understand the magnitude and patterns of health professional emigration before and during the pandemic. This project seeks to produce the necessary evidence to inform decisions and policymaking on health human resources, migration, and health systems and policy.

173. The COVID-19 pandemic focused attention on the urgent need to catalyze ethical research. Seven original documents on COVID-19 ethics guidance were developed by PAHO and published in English and Spanish. They have been accessed more than 50,000 times from IRIS and are being widely implemented across the Region. PAHO's ethics guidance regarding the use of unproven interventions for COVID-19 continues to be the global reference on this topic. Eleven countries (including Bolivia and Guatemala) received direct support to strengthen their research ethics systems, using an indicators-based approach published in 2021 that was used to complete an evaluation of 22 countries. In addition, 18 regional bilingual discussion sessions and virtual ethics training activities were held, with almost 2,379 participants and more than 19,400 additional views on YouTube.

174. The PAHO Ethics Review Committee (PAHOERC) held 38 committee meetings during the biennium to meet the increasing demand for ethics review of research, which included 49 COVID-19 submissions. PAHOERC is supporting the WHO COVID-19 Research Ethics Review Committee in the implementation of PAHO's ProEthos platform, which was adapted to meet WHO's new cybersecurity standards.

175. Crowdsourcing calls made it possible to identify social innovations for health across LAC that have supported the response of health systems to COVID-19 and the continuity of regular services as well. Research is showing the impact of these innovations and ways in which they can be adapted and replicated in other settings. A crowdsourcing call in 2021 received over 100 eligible applications from 17 countries, including five priority countries; eight applications were recognized as winners or given a special mention. An analysis done in 2021 of the innovations previously recognized in LAC showed how these have scaled up in support of health systems, spearheading local responses to the pandemic and ensuring the continuity of care.

176. PAHO collaborated with the WHO Global Observatory on Health R&D (GOHR&D) and reached out to counterparts in UNESCO, the Ibero-American Network of Science and Technology Indicators, and the Organisation for Economic Co-operation and Development (OECD) to enable streamlined reporting on shared indicators. This enhanced consistency and reduced the reporting burden on countries. It has also allowed the updating of data on financial flows for research on health and human resources for health, mapping focal points and institutions in countries. Updates to the GOHR&D show that by the end of 2021, information on financial flows for research had been reported by 13 countries. Eight of them (Argentina, Chile, Costa Rica, El Salvador, Guatemala, Paraguay, Trinidad and Tobago, Uruguay) updated their data during the biennium.

177. An assessment of national policies and agendas on research for health was completed. It identified an increase in the number of countries and territories with an active national policy (11: Canada, Colombia, French Guyana, Guadeloupe, Haiti, Martinique, Mexico, Panama, Paraguay, Puerto Rico, United States of America) or agenda (10: Argentina, Brazil, Canada, French Guyana, Guadeloupe, Martinique, Mexico, Panama, Peru, United States of America). Thirteen countries have an active policy or an agenda on research for health as part of their national policy framework. To support countries developing or updating policies or agendas, a checklist with good practices was produced.

178. Pooled procurement of essential medicines and strategic public health supplies has been critical for the countries of the Region, both for control of the pandemic and to ensure ongoing provision of essential medicines. In addition, pooled procurement is key to improving equity of access to medicines and supplies and eliminating diseases. PAHO has documented these efforts and has published on the importance of using the PAHO Strategic Fund to strengthen health systems. A recent article published in *The Lancet* looks at pooled procurement, and specifically the PAHO Strategic Fund, as a means to minimize COVID-19 disruption by ensuring the supply of essential health products for health emergencies and routine health services.

Challenges

179. Establishing effective public health measures while leaving no one behind requires that all people enjoy good connectivity and bandwidth. This enables them not only to continue their work or educational activities but also to access health services and maintain continuity in care via telemedicine and other available technologies. However, connectivity and bandwidth are still some of the most critical aspects to be solved with respect to information access.

180. Although countries generate, analyze, and disseminate health data, information, knowledge, and evidence disaggregated by social determinants of health and other sociodemographic stratifiers, improvements are needed in availability, accessibility, and use of this information.

181. The COVID-19 pandemic accelerated innovation, research, and use of evidence for decision making. Nonetheless, prioritization of the COVID-19 response also caused delays and difficulties in the implementation of planned activities across the Region and in the uptake and appropriate use of scientific evidence. Some countries faced challenges related to the distortion or misuse of evidence, the negation of the scientific process generating the evidence, the questioning of scientific institutions generating evidence, and lack of a COVID-19 integrated scientific authority in-country. A related problem is lack of public trust in government to communicate and implement policies based on evidence, as well as excessive use by the public of information from untrustworthy sources.

182. Personnel changes in national administrations and relevant teams caused lack of continuity, while pandemic demands at times overwhelmed the work of research ethics committees and oversight entities. This hampered the completion of key initiatives such as, for example, the adoption of Guatemala's national research ethics policy.

183. Assessing financial flows on research for health requires intersectoral collaboration, as various sectors (e.g., health, science, technology, development) provide data that must be integrated. Given the pandemic, such intersectoral collaboration was difficult to achieve in this specific area. A mapping exercise done in 2021 identified institutions and focal points, and analysis has highlighted opportunities and challenges in using the Frascati Manual of the OECD or the PAHO SHA 2011. This has led to recommendations to advance the field during the 2022-2023 biennium.

184. As a result of changes in national priorities triggered by the COVID-19 pandemic, the development of national policies and agendas on research for health stalled in some countries. This made it difficult to monitor progress at country level in the implementation of the Policy on Research for Health (Document CD49/10). For example, Dominica, El Salvador, Guatemala, Guyana, Paraguay, and Uruguay did not renew or extend their research policy or agenda.

Cross-cutting Themes: Equity, Gender, Ethnicity, and Human Rights

Outcome 26

Achievements

185. During the 2020-2021 biennium, PASB ensured that the cross-cutting themes were strategically positioned within the context of the COVID-19 pandemic. In collaboration with the Incident Management Support Team (IMST), PASB produced a first-of-its-kind publication, *Gendered Health Analysis: COVID-19 in the Americas*. The report reviews morbidity and mortality from the coronavirus in specific populations, the mitigating national responses, and socioeconomic impacts of COVID-19, all through a gender equality lens. This work provides a foundation for new inequality analyses, for example, on vaccination coverage.

186. Outreach to women's groups across the Region was established with the Latin American and Caribbean Women's Health Network (LACWHN) through "Let's Talk among Women" dialogues on the impact of COVID-19 on women, targeting gender networks, women's equality advocates, and civil society. Over 20,000 people benefited from these PAHO webinars on gender-based violence, vaccination, and adolescent health.

187. As part of a WHO/UN-wide initiative to develop an LGBTI+ organizational strategy, a social media campaign was developed and implemented with the PAHO Communications Department. Multiple social media messages were prepared and disseminated widely throughout the Region, promoting the rights (including the right to health access) of LGBT persons and calling for an end to stigma and discrimination. Several countries, including Bolivia, Chile, Trinidad and Tobago, and Uruguay, have advanced related national plans and initiatives with PASB's support, including campaigns, virtual courses, LGBT-friendly clinics, and inclusive data registration.

188. In late 2020, subregional consultations and high-level meetings were held with indigenous peoples and Afro-descendant representatives and leaders in the context of the pandemic. The recommendations emanating from these meetings were published and are being used as frameworks for follow-up actions at country level with the different organizations representing diverse ethnic groups.

189. Responding to a request from Roma organizations across countries of the Region, a technical consultation was conducted on the impact of COVID-19 on Roma people in the Americas. A report on outcomes of the meeting is being finalized, highlighting recommendations for technical cooperation relevant to these groups in the context of the pandemic.

190. Significant training was provided on the use of knowledge dialogues as an innovative tool to make health services accessible and culturally appropriate for indigenous peoples and Afro-descendant groups. The methodology has promoted interprogrammatic collaboration, including in the fields of communicable diseases and maternal health (where

it has been aligned with use of the culturally safe birth tool developed previously). A document, *La salud de la población afrodescendiente en América Latina*, was published and launched at a high-level meeting with the participation of Afro-descendant leaders. It highlights some of the inequities faced by Afro-descendants and issues a call to action for Member States.

191. A database and online dashboard were developed to map the existing legislation, policies, and programs addressing the intersection between health and migration from a human rights perspective.

192. In Costa Rica, support was provided to the Vice Ministry of the Presidency, the Ministry of Health, and the Indigenous Development Associations in the indigenous territories for the response to COVID-19, promoting intercultural dialogues for recovery and social insertion. PAHO worked with other United Nations agencies on the economic recovery and health of migrant women and refugees in priority areas of the country. The Ministry of Health received support in evaluating and updating its Health Plan for People of African Descent, coordinating with the subregional initiative on Afro-descendant and indigenous issues.

193. In Paraguay, coordination actions were reactivated with the National Directorate for the Health of Indigenous Peoples (DINASAPI) and the National Commission for the Health of Indigenous Peoples (CONASAPI) with a view to institutionalizing and strengthening dialogues with representatives of indigenous peoples in the country. This coordination also makes it possible to identify the health needs of indigenous peoples and discuss strategies and plans to improve the health of these groups in compliance with the country's Indigenous Health Law.

194. In Colombia, in coordination with the departmental secretariats of health and indigenous affairs of La Guajira and with the Ai Hospital program of the Ministry of Health, a project is underway to guarantee the right to health of all people who inhabit a territory, using an ethnic and cultural diversity approach. The “gestores” model responds to the needs of widely dispersed rural populations that have serious difficulties in accessing health care. It has a strong focus on social mobilization and community participation, basic for any primary health care intervention.

195. In Haiti, PASB supported the Ministry of Public Health and Population (MSPP) in developing a national framework document and guidelines on the organization of District Health Services in line with the primary health care approach and with the Integrated Health Services Delivery Networks strategy. The guidelines will allow the development of a primary health care -based health system at the first level of care, increasing accessibility, equity, and efficiency in health at the community level.

196. A country channel for Suriname was added to the OpenWHO portal to host a series of COVID-19 online courses that have been translated into Dutch by PAHO Suriname. This represents a step toward building the capacity of frontline workers, using online

courses translated into Suriname's official language. These courses have also been included in the national requirements that health workers need to complete prior to being deployed to respond to COVID-19 at health facilities in Suriname.

197. In Panama, technical and strategic support was provided to expand access to health services for refugees, asylum seekers, and migrants through mobile units for primary and comprehensive medical care with a preventive approach. This was an interagency project with the UN Refugee Agency and the Panamanian Ministry of Health.

Challenges

198. While countries have taken some steps toward disaggregating health data by sex, ethnicity, and age, support for this essential task has been limited in scope. The limited availability and reporting of such data in and from countries has impeded the generation of evidence-based recommendations on COVID-19. Much greater effort is required to include ethnic variables in health registries and to conduct gender-based analysis to determine, address, reduce, and eventually eliminate the causes of gender, ethnic, and other inequities in health, including but also going beyond COVID-19.

199. There is a need to further develop competencies related to the cross-cutting themes at all levels of the Organization. Efforts to meet the demand from Member States for activities such as knowledge dialogues, among others, have been constrained by the limited number of staff trained and available for their sustainable implementation.

200. While the pandemic has heightened attention to the cross-cutting themes and related issues, this attention is not always systematic, uniform, or aligned with longer-term institutional approaches.

201. Donor interests and the direction of negotiations can diverge from agreed priorities or may skew funding (and hence activities) to one technical area at the expense of another. Therefore, when funds are mobilized, these may not contribute directly or equitably to the implementation of the activities originally contemplated.

COVID-19 vaccination for indigenous populations in Colombia



A member of the indigenous community in Puerto Nariño, Amazonas, Colombia receives a COVID-19 vaccination.

Photo credit: United Nations OPS Colombia/Karen González Abr

In 2021, the Colombian media reported that many indigenous people in the country were declining to be vaccinated against COVID-19, based on their cultural practices and beliefs. With 1.9 million indigenous Colombians, there was an urgent need to change attitudes toward this life-saving intervention.

In August 2021, the health minister stated that only 6% of the indigenous population had been vaccinated. To address this situation, PAHO designed and rolled out a communications strategy, tailored specifically to indigenous communities, to promote acceptance of COVID-19 vaccines. Drawing from indigenous peoples' customs, the strategy emphasized the use of oral communication. Vaccination brigades included indigenous translators; training of trainers involved cultural leaders, creating a multiplier effect for dissemination of information; and free phone applications were distributed to vaccinators in remote areas, facilitating connectivity.

This communications strategy produced the desired results as measured by increased vaccine uptake. In prioritized areas of the Amazonia region, for example, 34% of the indigenous population was vaccinated by the end of 2021.

To encourage acceptance of the COVID-19 vaccine in indigenous communities in Colombia, it was necessary to demonstrate respect for indigenous cultures, their system of knowledge, and their understanding of the relationship between health and disease. It was also important to find appropriate ways to create dialogue that were aligned with their perceived reality of the pandemic. The community's trust in PAHO as an institution was key to the success of these interventions. The PAHO communications strategy for reaching indigenous populations led to behavior change because it included elements that appealed to both emotions and reason.

A key challenge in the near future will be to provide training to health workers in the indigenous regions, emphasizing intercultural and ethnic approaches to COVID-19 vaccination and health. Similar strategies may be adapted for other populations and other health challenges, especially those facing the most vulnerable populations.

Leadership, Governance, and Enabling Functions

Outcomes 27 and 28

Leadership and
governance

Management and
administration

Achievements

202. PAHO remained an authoritative voice in the Region with strong name recognition, providing political, strategic, and technical guidance on the COVID-19 pandemic at the highest levels of national governments and the UN and inter-American systems. Its agenda called for addressing the impact of the pandemic, ensuring an agile response to Member States, while simultaneously advocating for key foundational investments in public health in the Region. PASB presented policy options to Member States aimed at promoting the Region's recovery while protecting public health gains and building stronger in a context where economies have become fragile. Initiatives to foster the Region's self-sufficiency in vaccines and other health technologies included mechanisms for faster procurement of quality and affordable COVID-19 vaccines through the PAHO Revolving Fund and the COVAX Facility with Gavi and UNICEF. PASB continued to call for heightened attention to the Region's scientific and technological capabilities. The Organization also emphasized the pandemic's particularly damaging impact on priority health programs, on people living in conditions of poverty and vulnerability, and on mental health.

203. PAHO achieved consistently high visibility as an unrivaled authority and newsmaker on COVID-19 globally and across the Region through weekly press conferences and media outreach, including hundreds of interviews by spokespersons in Headquarters and PWR Offices. The media briefings helped raise awareness not only on COVID-19 but on other critical health challenges affecting the Region. Innovative communication approaches shared with nontraditional partners (e.g., Global Citizen, Sony Music Latin, Sesame Street, World Economic Forum, and Univision, among others) allowed PAHO to expand its outreach to broader audiences.

204. PASB developed a new policy to prevent and address the sexual exploitation and abuse of people who depend directly or indirectly on services that the Organization provides. Additionally, the ClearCheck process was adopted from the United Nations to identify individuals who have been involved in sexual harassment, sexual exploitation, and sexual abuse in order to prevent situations that could compromise the reputation or credibility of the Organization. A conflict of interest disclosure form was made mandatory for new hires. These measures have enhanced the selection process for new personnel in line with the recently launched WHO initiative Preventing and Responding to Sexual Exploitation, Abuse and Harassment.

205. PASB implemented a prudent financial management approach that took into account the Region's severe economic contraction over the past two years, during which a

number of countries were still in arrears on their payments of assessed contributions to the Organization. This was coupled with challenging resourcing scenarios at WHO. Cost containment measures put in place by PASB to strengthen collaboration among entities, as well as the arrival of funds in 2021 and advocacy with Member States, allowed the Organization to mitigate the most severe effects of the financial crisis while continuing to respond to its mandates and build resilience for the future.

206. The PAHO Resource Mobilization Strategy 2020-2025 was launched in December 2020, presenting a roadmap to enable the Organization to increase its resource mobilization efforts. In addition, the PAHO Roadmap 2021-2023: Working with the Private Sector was launched in 2020 to provide strategic guidance on private sector engagement, with an Organization-wide goal and three lines of action to help PAHO achieve expected results set forth in the Strategic Plan 2020-2025 and beyond.

207. The Report of the End-of-Biennium Assessment of the PAHO Program and Budget 2018-2019/Final Report on the Implementation of the PAHO Strategic Plan 2014-2019 (Documents CD58/5 and Add. I) was presented to the 58th Directing Council in September 2020. The report highlights successful practices that have led to the Organization's achievements at impact level and in countries. The PAHO Program Budget 2022-2023, with the theme *Protect, Recover, and Build Stronger*, was approved by the 59th Directing Council. PASB conducted a consultative and iterative process to develop this Program Budget, including bottom-up costing and planning with all PASB entities and a strategic review of priorities with Member States. This Program Budget was developed in a unique context during the COVID-19 pandemic.

208. The new PAHO Evaluation Policy was approved in 2021. The policy aims to strengthen PAHO's evaluation capacity and evaluation culture by aligning it with the Organization's results-based management approach. Accordingly, it promotes the identification of lessons learned from evaluations and their incorporation into corporate plans and strategies.

209. PAHO reached \$2.84 billion in procurement during the biennium, becoming one of the top 10 United Nations agencies carrying out procurement activities to support Member States in achieving their national and regional health goals.

210. Amid the pandemic, PASB implemented innovative ways of working and continued efforts to increase efficiency in order to mitigate major disruptions (including travel restrictions and supply chain issues) and remain responsive to the needs of Member States. Despite the cost containment measures made necessary by the financial crisis, the Organization continued to respond to the increasing demands for technical cooperation from Member States under the teleworking modality. Full implementation of a paperless initiative combined with the one-device strategy, cloud-based archives, and expanded use of Microsoft Teams and Zoom created a seamless telework environment and facilitated high-level meetings that enabled the Organization to remain fit for purpose. During the pandemic, the leadership and continuity of strategic, technical, and managerial operations

at country and subregional levels was ensured through virtual PWR Office and subregional program transfers and continuous communication and coordination at all levels.

Challenges

211. The Organization was challenged to respond in a timely and efficient manner to the pandemic while protecting health gains in the Region. The competing demands faced by PWR Offices and national authorities, which were mostly focused on the COVID-19 pandemic response, affected the timeliness of planned activities and corporate processes. For instance, the development and evaluation of Country Cooperation Strategies was delayed. This resulted in reliance on outdated strategic agendas to guide PAHO's technical cooperation as well as the joint assessment of results for the end-of-biennium assessment of the Program and Budget 2018-2019. The limited interest of donors in programs not directly related to the COVID-19 response also affected the financing of planned activities during the biennium.

212. The financial crisis stemming from significant delays in the receipt of assessed contributions from Member States and the cost containment measures taken in response to the crisis affected the delivery of technical cooperation to countries on topics related to leadership and governance. The Organization had to prioritize activities and implement cost containment measures on work plans that had already been disrupted by the COVID-19 pandemic. Once flexible funds became available in late 2021, some activities were implemented, but others needed to be cancelled or postponed.

213. PAHO's high-level advocacy and policy dialogue activities were affected since face-to-face meetings, including Governing Bodies meetings, were cancelled, while visits by the Director to countries and visits by national authorities to PAHO Headquarters were postponed. Additionally, the biennium saw an unprecedented turnover in health ministers and senior officials that affected the continuity of processes and agreements and resulted in loss of institutional memory on cooperation with the Organization at country level. The changes in health authorities and restrictions imposed by COVID-19 required PAHO to innovate and implement alternative ways to ensure business continuity for meetings and training workshops with Member States and other stakeholders.

214. Staffing levels remained a challenge as the demands from Member States and the volume of work continued to increase. For example, staff from different backgrounds were detailed to the IMST supporting the COVID-19 response. Although the Organization had to implement these measures to respond to the pandemic, this situation also contributed to a shortage of human resources that affected commitments and deliverables scheduled for 2020-2021. The shortage of staff due to hiring restrictions imposed by the 2020 financial crisis was especially challenging for enabling entities, which are mostly financed by flexible funds (i.e., assessed contributions).

215. The Organization is experiencing an increase in the proportion of small grants (value under \$100,000), from 34% of all grants in 2018-2019 to 50% in 2020-2021.

This is placing an increasing burden on the Organization to negotiate, review, implement, monitor, and report on small grants, at the cost of mobilizing grants in larger amounts and potentially over multiple years. Efforts should focus on higher-value grants with major flexibility for allocation as an important resource mobilization strategy.

Improving Accountability for Results and Financial Resources

216. In the context of the pandemic and the financial crisis of the Organization, PAHO's ability to demonstrate accountability for results and financial resources has become more important than ever. The end-of-biennium assessment report to Governing Bodies, including the joint assessment with Member States, represents one of four key mechanisms for the monitoring, assessment, and reporting of the PB20-21. The other three are:

- a) Internal monthly financial reviews by PASB Executive Management (EXM) and provision of monthly monitoring reports to entity managers.
- b) Internal PASB performance monitoring and assessment (PMA) reviews at the end of each semester (six months).
- c) Quarterly updating of the PAHO Program Budget Portal with information on Program Budget financing and implementation, disaggregated by country.

217. During the biennium, PASB scaled up efforts on each of these monitoring mechanisms. Important enhancements were carried out in the systems, reports, and presentations utilized for the internal PMA reviews with EXM, leading to more concrete discussions and actions to accelerate implementation of the Program Budget. These mechanisms were also crucial for management of the Bureau's response to the internal financial crisis.

218. During 2020-2021, PASB further strengthened the culture of results, evaluation, and learning by integrating the evaluation function into the Planning and Budget Department. The aim is to ensure that PASB's planning, reporting, and results-based management cycle includes lessons from both performance monitoring and evaluation. A new Evaluation Policy and Corporate Work Plan (CWP) for Evaluation were developed in 2021. In addition to the policy, setting up a new institutional and governance framework for the evaluation function in PASB included preparing a new handbook to guide the conduct of evaluations consistent with international standards and practices.

219. Some evaluations that had been planned to start during the early phases of the pandemic had to be postponed. In 2020 two regional evaluations commissioned by regional Headquarters entities, but with guidance from the evaluation function, were finalized: the Evaluation of the Sub-Regional Level of Technical Cooperation-Subregional Program Coordination-Caribbean, and the Evaluation of the Integrated Health Systems for Latin America and the Caribbean Project (IHSLAC). During the last quarter of 2021, terms of reference were drafted for select evaluations in the CWP, and the Evaluation of Human Resources for Health began. Terms of reference were drafted for three additional

evaluations: the evaluation of PAHO's response to COVID-19, PAHO's actions on noncommunicable diseases, and the state of results-based management in PAHO. These evaluations are in progress and will be finalized in the 2022-2023 biennium.

220. To build and enhance capacity to conduct quality evaluations and promote their use for institutional learning, the Planning, Budget and Evaluation Department (PBE) conducted webinars and provided technical backstopping and advice for decentralized, country-level evaluations. These include evaluations of the joint PAHO-FAO-UNDP programs in Guatemala's Ixil and Cuilco regions of San Marcos department, both finalized in 2021. Additionally, PBE advised on an evaluation commissioned by the PWR Office in Colombia regarding actions to address the health needs of Venezuelan migrants who lacked access to the health system amid COVID-19. Finally, PAHO also participated in five WHO corporate evaluations.

V. Implementation of the PAHO Program Budget 2020-2021

221. This section analyzes the implementation of the PAHO Program Budget for 2020-2021, comparing approved budget levels with financing and implementation, identifying funding gaps by outcome, and summarizing resource mobilization efforts during the biennium.

222. The total approved PB20-21 was \$650 million, comprising \$620 million for base programs and \$30 million for special programs. The budget for base programs was divided into 28 outcomes and 112 outputs in line with the programmatic structure of the PAHO Strategic Plan 2020-2025, adopted by the 57th Directing Council. The special programs segment included the Hemispheric Program for the Eradication of Foot-and-Mouth Disease, Smart Hospitals, Outbreak and Crisis Response (OCR), and polio eradication maintenance.

223. The overall Program Budget was overfinanced by 48%, or \$315 million over the total approved budget; however, the base programs segment was only \$16 million overfunded. The high level of budgetary financing is explained by the large quantity of resources received for special programs, more than 10 times the amount that was projected as a placeholder. Of this, 85% (\$280 million) went to OCR to address the COVID-19 pandemic and other health emergencies. The overfinancing is also explained by the projected payment in full of PAHO assessed contributions 2020-2021; by the inclusion of all voluntary contributions available in the 2020-2021 biennium (including those that were carried over into 2022, which amounted to \$97 million); and, finally, by funds from other sources that were not fully spent during 2020-2021.¹⁸

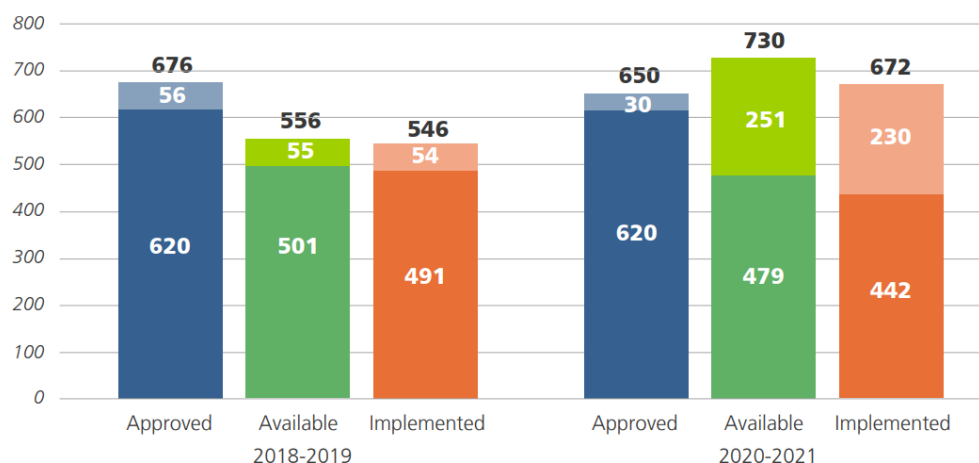
224. As shown in Figure 4, funds available to entities for implementation amounted to \$730 million (\$479 million in base programs and \$251 million in special programs). At biennium closure, implementation was \$672 million (\$442 million in base programs and \$230 million in special programs), or 103% of the total approved budget. This level of implementation is historic, representing 23% (\$126 million) more than in 2018-2019, an increase driven by implementation of the special programs segment. While the implementation of base programs was 10% lower than that of the previous biennium, implementation of special programs was more than four times that of 2018-2019.

225. During 2020-2021, PAHO was able to maintain a high level of performance despite the combined challenges of a financial crisis due to the delayed payment of Member States' assessed contributions and the effects of the COVID-19 pandemic on planned activities. The Organization identified opportunities and mechanisms to mitigate the effects on implementation of base programs, enhancing the efficiency and effectiveness of technical cooperation. These included employing prudent financial management practices and cost

¹⁸ These other sources include the Special Fund for Program Support Costs, the Master Capital Investment Fund, Virtual Campus for Public Health services, PROMESS vaccines and medication sales, sales of PAHO publications, and the Special Fund for Health Promotion.

reduction measures, reprogramming and prioritizing, and accelerating implementation when possible. These efforts led to many innovations and cost efficiencies like paperless communications, virtualization, a one-device strategy for computer use, and reduced travel, all of which could become permanent as part of the Organization's future work.

**Figure 4. PAHO Program Budget 2020-2021:
Overview of Budget, Financing, and Implementation
(US\$ millions)**

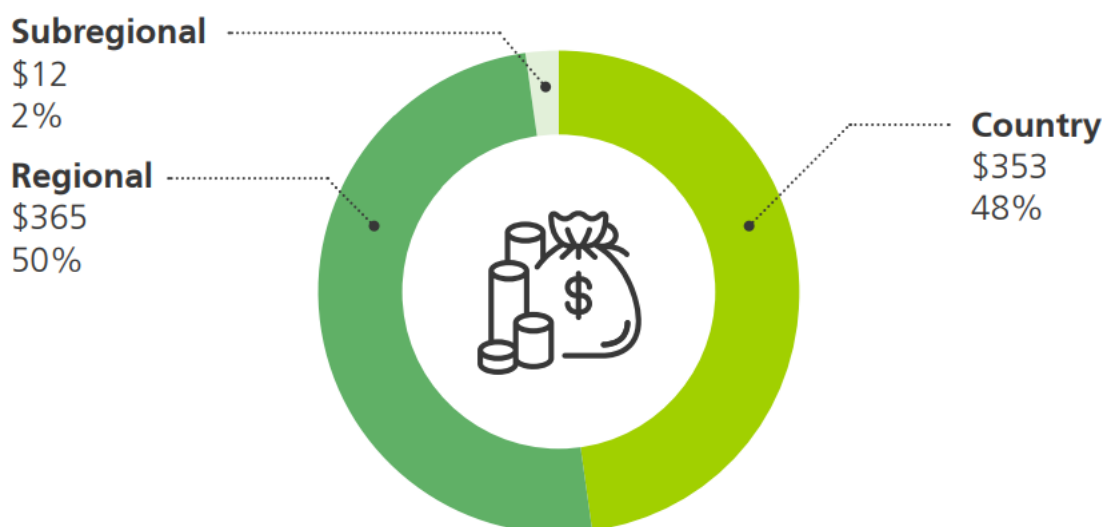


Bottom segments: Base programs
Upper segments: Special programs and emergencies

226. Figure 5 presents the distribution of funds available for implementation in all segments across the three functional levels of the Organization. In 2020-2021, PASB allocated \$365 million (50%) of its available resources at the country and subregional levels, an increase over the \$229 million (41%) allocated to these levels in the 2018-2019 biennium. The funds allocated to the COVID-19 response, mostly implemented at country level, were instrumental for this result, considering that 47% (\$172 million) of the \$365 million was allocated to the country level for OCR.

227. While the distribution of funds to the country level was above the 45% established by the PAHO Budget Policy, PASB has made a commitment to continue maximizing the allocation of funds to the country and subregional levels. It is also important to recognize that technical and enabling functions coordinated by the regional level directly benefit the country and subregional levels.

**Figure 5. PAHO Program Budget 2020-2021:
Funds Available by Functional Level
(US\$ millions)**



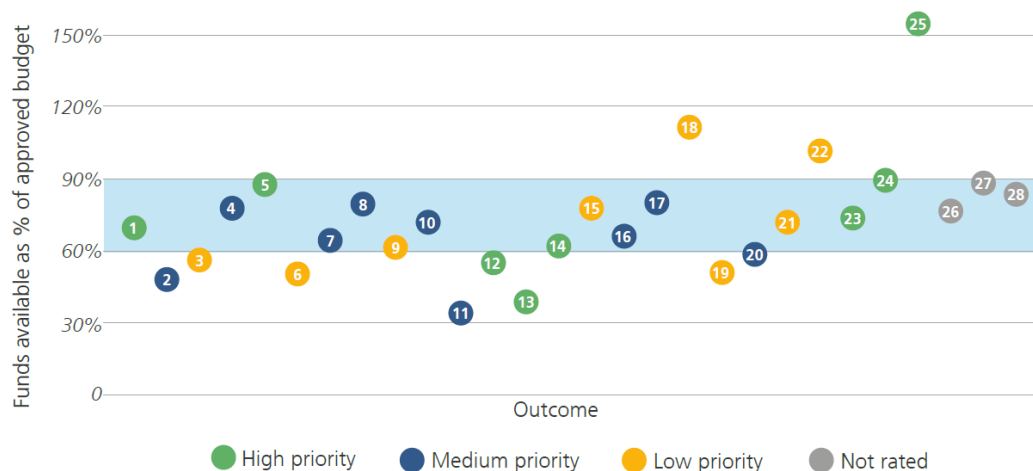
Base Programs

228. At the end of the 2020-2021 biennium, the available funds for base programs were \$479 million, of which 92% was implemented.

229. A deeper analysis by outcome shows that absolute and relative levels of financing varied greatly across the elements covered by the base programs, as shown in Figure 6. Of the 28 outcomes, three were overfunded with respect to their approved budgets: Outcome 25 (Health emergencies detection and response), with \$13.6 million (155%); Outcome 18 (Social and environmental determinants), with \$1.5 million (112%); and Outcome 22 (Research, ethics, and innovation for health), with \$29,000 (101%). Nevertheless, 17 of the outcomes were financed between 60% and 90%, and eight outcomes at less than 60%.

230. The outcomes with the lowest percentage of financing were Outcome 11 (Strengthened financial protection), with 34% of its approved budget; Outcome 13, (Risk factors for NCDs), with 39%; and Outcome 2 (Health throughout the life course), with 48%. Reasons for the observed underfinancing included the highly earmarked nature of some voluntary contributions and the limited interest of donors in certain priority areas. Due to the integrated nature of the outcomes in this Strategic Plan, funding for some outcomes would have supported the implementation of activities under other outcomes (e.g., NCD risk factors). It should be noted, however, that some outcomes were overbudgeted, as was the case of Outcome 2 (Health throughout the life course). This specific situation has been addressed in Program Budget 2022-2023.

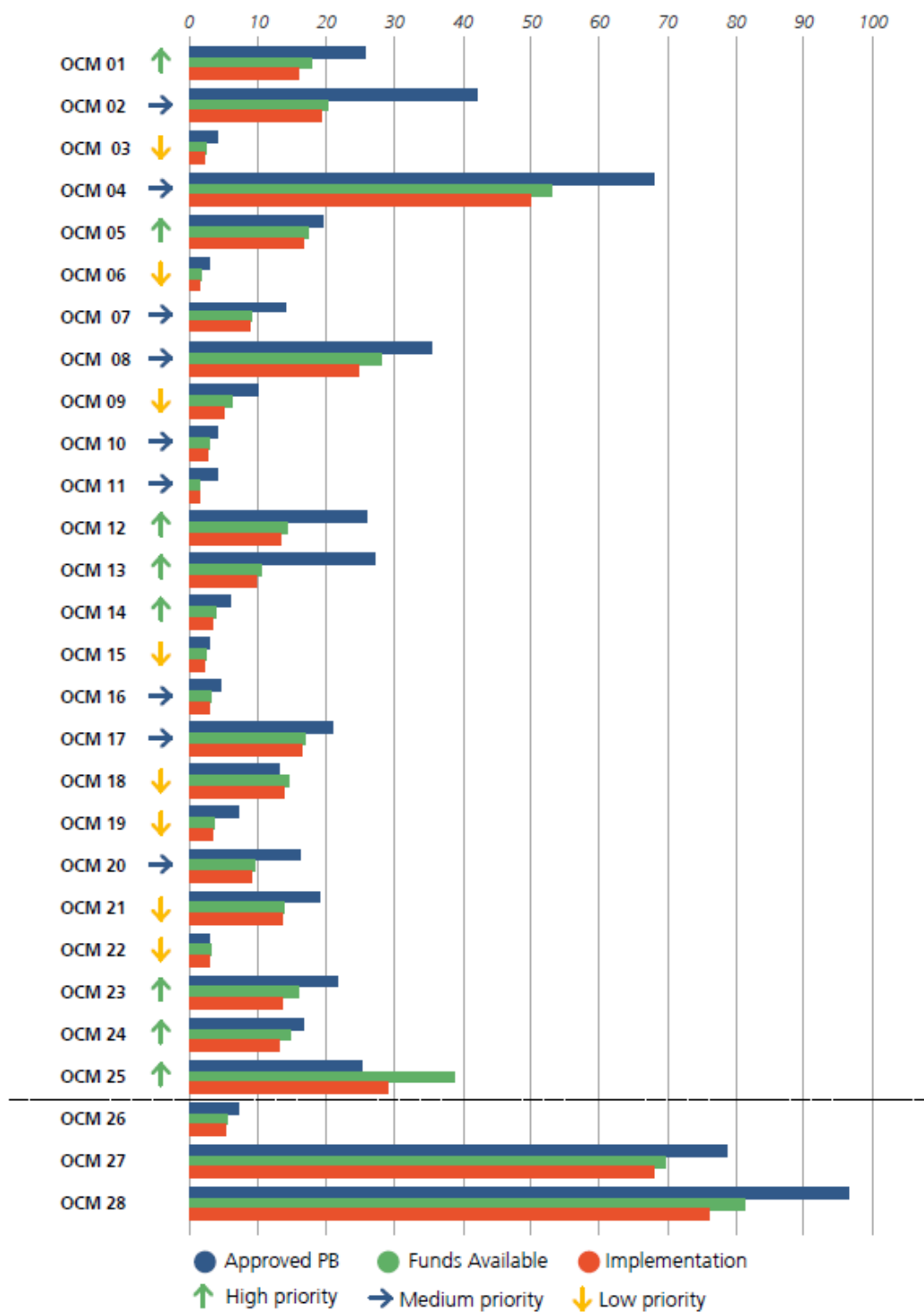
**Figure 6. Level of Financing and Priority by Outcome
2020-2021**



231. As expected, there was a direct correlation between funds available and implementation as measured against approved budgets. Outcomes with a high level of funding had a high level of implementation. In fact, Outcome 4 (Response capacity for communicable diseases), Outcome 27 (Leadership and governance), and Outcome 28 (Management and administration) had the highest levels of financing and implementation. Consistent with this, their corresponding financial gap was low (between 12% and 22%). On the other hand, Outcome 6 (Response capacity for violence and injuries) and Outcome 11 (Strengthened financial protection) had the lowest levels of implementation, limited funding, and gaps of 49% and 66%, respectively. In the cases of Outcome 25 (Health emergencies detection and response), Outcome 18 (Social and environmental determinants), and Outcome 22 (Research, ethics, and innovation for health), which received funds in excess of their approved budgets, the implementation levels were 116%, 105%, and 96% of their approved budgets, respectively.

232. When implementation is measured against funds available, as shown in Figure 7, 21 of the 28 outcomes (75%) exceeded 90% implementation, and six outcomes (21%) were between 80% and 90%. Only Outcome 25 implemented less than 80% of its funds available, reaching 75%, explained in part by the carryover of some of its funding into 2022. The other two overfunded outcomes had an implementation of 94% in the case of Outcome 18 (Social and environmental determinants) and 95% for Outcome 22 (Research, ethics, and innovation for health).

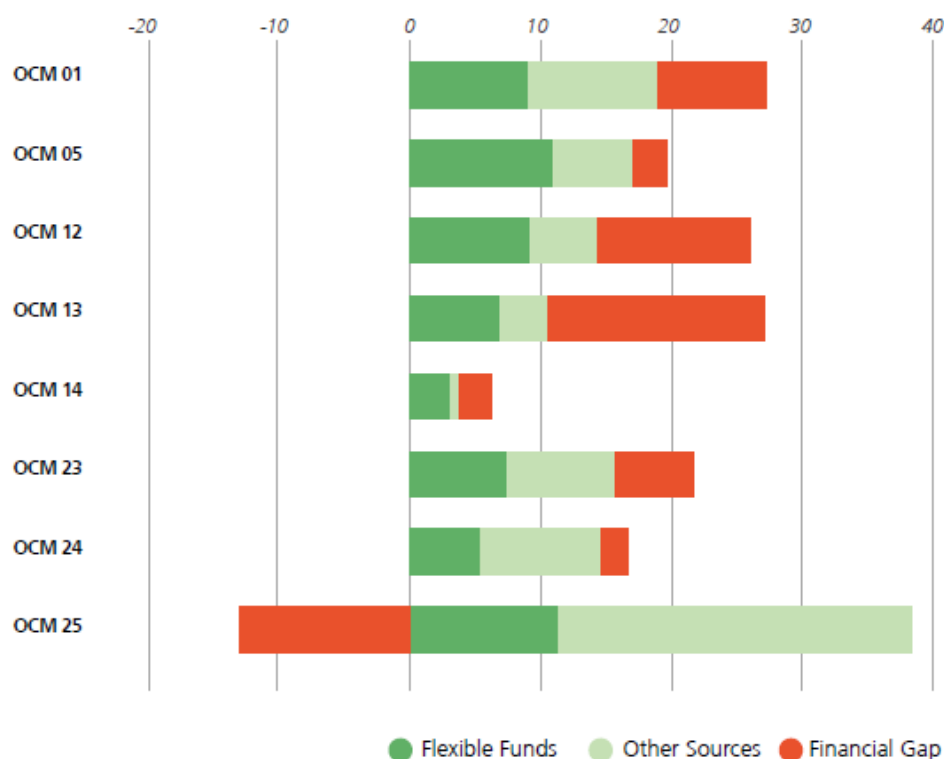
**Figure 7. PAHO Program Budget 2020-2021:
Approved, Available, and Implemented Funds, by Outcome
(US\$ millions)**



233. Figure 8 presents the level of funding for outcomes defined as highest priorities by Member States in the PAHO Strategic Plan 2020-2025. PAHO strives to reduce funding gaps in high-priority outcomes, using more flexible funds when needed, and to support cross-cutting themes and PAHO's leadership, governance, and enabling functions not funded by voluntary contributions. To illustrate this, Figure 8 presents a summary of approved budget levels, available funds by main type of fund, and financial gaps by high-priority outcomes, as defined with Member States for the 2020-2021 biennium.

234. Outcome 12 (Risk factors for communicable diseases) and Outcome 5 (Access to services for NCDs and mental health conditions) fall in the top tier of prioritization and are two of the technical outcomes that received the highest amount of flexible funding. Still, given the reliance on flexible funding in the case of many other outcomes, and with insufficient voluntary contributions for some other outcomes, the Organization has not been able to completely close the financial gaps for all high-priority (Tier 1) outcomes. The gaps for Outcome 13 (Risk factors for NCDs), Outcome 12 (Risk factors for communicable diseases), Outcome 14 (Malnutrition), and Outcome 1 (Access to comprehensive and quality health services) were 61%, 45%, 38%, and 30% of their approved budgets, respectively. Nevertheless, it is important to note that given the interprogrammatic nature of the PB, funding in one outcome may compensate for the lack of funding in another, contributing to PAHO's existing priorities in an integrated way.

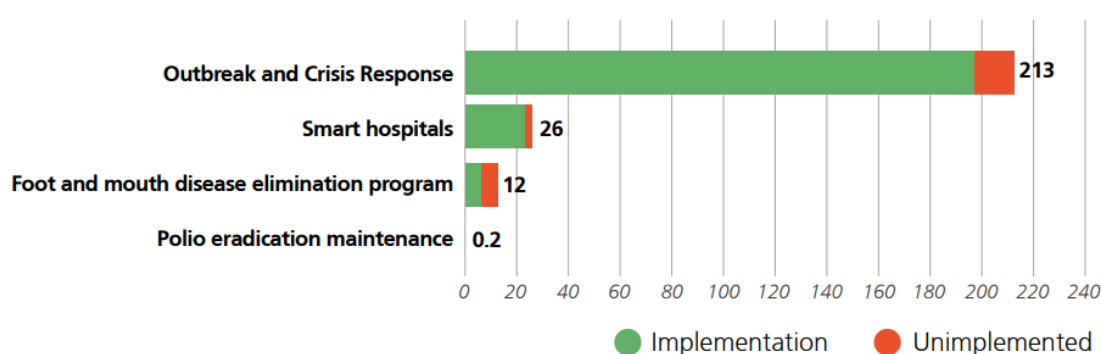
Figure 8. PAHO Program Budget 2020-2021: Approved and Available Funds for Implementation of High-Priority Outcomes, by Fund Type (US\$ millions)



Special Programs

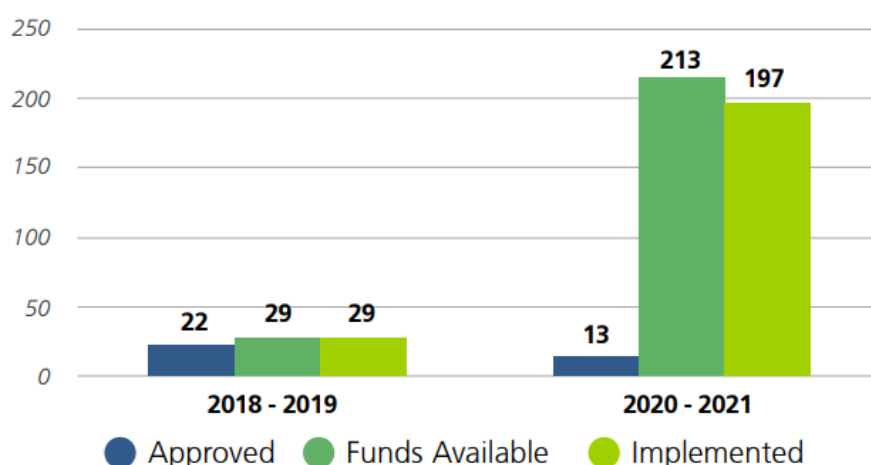
235. As defined in the approved PB20-21 document, the special programs segment is considered a placeholder, given the uncertainty about the needs and funding of this segment when the Program Budget was developed and approved. Because of the COVID-19 pandemic, PAHO received much more than the approved placeholder amount for the biennium (\$30 million). The available funding for special programs amounted to \$251 million in 2020-2021, of which \$213 million (85%) was concentrated in Outbreak and Crisis Response, mobilized to respond to the pandemic. The Smart Hospitals initiative represented 10% (\$26 million), and the remaining 5% (\$12 million) funded foot-and-mouth disease eradication. The amount received for polio eradication maintenance was \$200,000 (Figure 9).

**Figure 9. Special Programs:
Funds Available and Implementation
(US\$ millions)**



236. Figure 10 illustrates the available funding and implementation of the OCR component only, over two biennia: 2018-2019 and 2020-2021. In 2020-2021, OCR had an estimated placeholder of \$13 million. Because of the COVID-19 pandemic, however, PAHO received a total of \$213 million for this component, more than seven times the amount of OCR funds available in 2018-2019. In 2020-2021, 92% of available funds were implemented. Most funds mobilized for OCR in 2020-2021 were COVID-19-related funds, which were allocated for the most part in the special programs segment of the budget. In addition to COVID-19, OCR funds supported PAHO's efforts to maintain an effective humanitarian response to the situation in Venezuela and to hurricanes in Central America, the earthquake in Haiti, and other emergencies in the Region.

**Figure 10. Outbreak and Crisis Response:
Overview of Budget, Funds Available, and Implementation
(US\$ millions)**



237. The case of funds received to respond to the COVID-19 pandemic deserves special attention. In total, PAHO PB20-21 received \$232 million for this purpose. Most of these funds (\$194 million, or 84%) financed the special programs segment of the Program Budget. The remainder (\$38 million, or 16%) was received to complement the funding for base programs and was instrumental for the integrated response to the pandemic. This in turn ensured that technical cooperation continued, focusing on the protection of essential health services in the Region. Many plans were adapted to enable the Organization to rise to the historic moment while continuing to deliver on the commitments set in the Program Budget by Member States.

238. Additionally, \$16 million was implemented through national voluntary contributions in countries like the Dominican Republic, Haiti, Honduras, and Nicaragua. These funds fall outside the Program Budget but are programmatically linked to emergencies.

Main Sources of Financing for 2020-2021

239. As described in the approved PAHO Program Budget 2020-2021, the Program Budget was financed through *a)* assessed contributions from Member States, Participating States, and Associate Members; *b)* budgeted miscellaneous revenue (e.g., interest earned on bank deposits); *c)* PAHO voluntary contributions; *d)* funding allocated by the World Health Organization to the Region of the Americas (consisting of both WHO flexible funding and voluntary contributions; and *e)* other PAHO financing sources, including special funds.

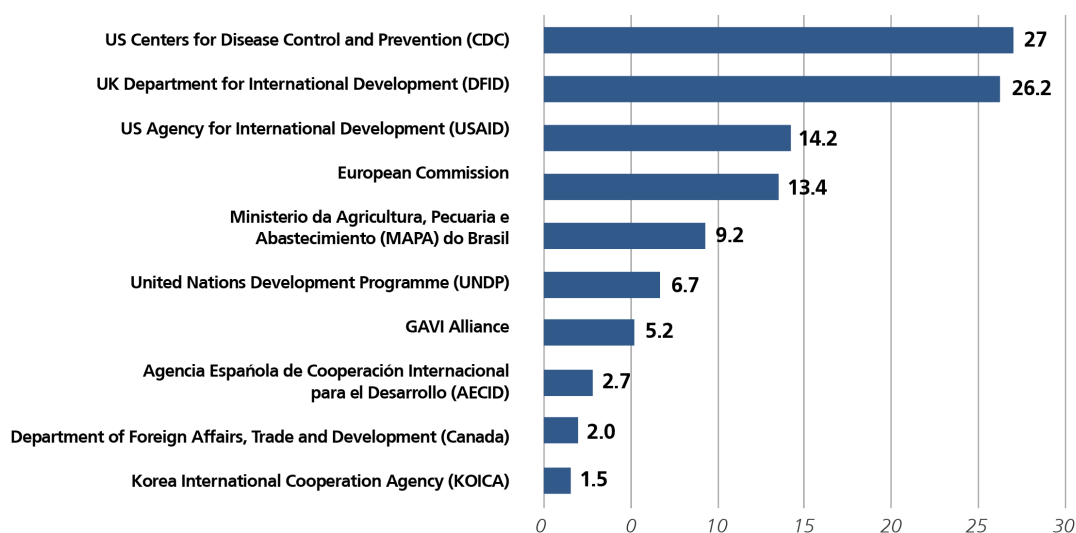
240. **Assessed contributions and budgeted miscellaneous revenue** constituted 33% of total funds expected to finance the Program Budget. Since PAHO assessed contributions are considered financial commitments from Member States, they are counted as “funds

available” in full at the start of the biennium. However, PASB needs timely payment by Member States in order to respond to the commitments in the approved Program Budget and its operational plans.

241. In 2020, PAHO suffered a financial crisis due to a delay in the payment of assessed contributions from several Member States, which created financial uncertainty and a backlog in implementation. This situation, compounded by the effects of the COVID-19 pandemic, forced PASB to establish cost containment measures and reprogram work plans to preserve its core operational capacity. These measures, most of which were phased out in early 2021, included a reduced Human Resources Plan for the 2020-2021 biennium, with a freeze on all vacant positions and reductions in funds for activities and short-term staff. Thanks to the prudent and adaptive measures put in place by senior management, the resolve and commitment of staff, collaboration across the three levels of PAHO, an increase in resource mobilization, and advocacy with Member States, the Organization was able to navigate through these storms. These efforts allowed PAHO to continue responding to its mandates while building resilience for the future, achieving a high level of performance.

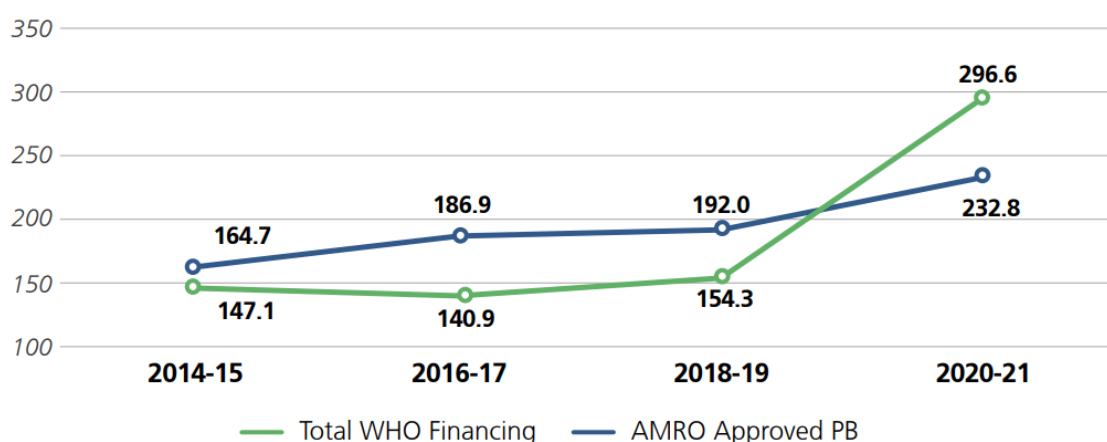
242. Resource mobilization efforts yielded \$210.6 million in **PAHO voluntary contributions** during 2020-2021, though some of these funds correspond to multi-year agreements that go beyond that specific biennium. As shown in Figure 11, 86% of all voluntary contributions available for implementation in 2020-2021 came from 10 donors to PAHO. PASB greatly appreciates the trust of its partners and their commitment to support the Program Budget; at the same time it calls for improved flexibility of funds and strategic alignment with priorities as set out in the Organization’s mandates. Compared to the 2018-2019 biennium, the contribution of the 10 main donors increased by 45% (\$33.5 million) in 2020-2021.

**Figure 11. Top 10 Donors to PAHO Program Budget 2020-2021
(US\$ millions)**



243. The funding received as the **WHO allocation to the Regional Office for the Americas (AMRO)** reached \$296.6 million in 2020-2021. This was 27% more than the initially approved budget for AMRO and the highest level of financing in the last four biennia (Figure 12). Of this total, 35% or \$105.3 million was flexible funds,¹⁹ and \$191.3 million corresponded to WHO voluntary contributions, the largest share of which, \$148.9 million, was allocated for emergencies.

Figure 12. WHO Approved Budget Levels and Financing for AMRO (US\$ millions)



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

244. **Other sources** of the PB20-21 comprise PAHO revenue from program support costs and all other PAHO special funds that finance the Program Budget. These accounted for \$245 million of available funds in 2020-2021, and 58% of these funds were to finance Outbreak and Crisis Response in special programs. It is important to note that some of these funds were utilized to cover the assessed contribution shortage that PASB faced in 2020.

245. Although they are not part of the Program Budget of the Organization, government-sponsored initiatives, known as **national voluntary contributions (NVCs)**, are an important funding modality that complements the financing of PAHO technical cooperation at country level. National governments provide NVCs to finance specific in-country initiatives that are aligned with the existing technical mandates of PAHO. Like Program Budget funds, NVCs are strictly managed following the PAHO Financial Regulations and Financial Rules; they are audited regularly and are reported in financial statements. This funding modality is becoming increasingly important for PAHO’s technical cooperation in many countries that do not qualify for traditional voluntary contributions due to their level of economic development. The programmatic achievements to which NVCs contribute are reported as part of the Organization’s overall results.

¹⁹ Considers WHO Core Voluntary Contributions as part of the flexible fund allocation to the Americas.

In 2020-2021, NVCs contributed mostly to Outcome 4 (Response capacity for communicable diseases), Outcome 8 (Access to health technologies), Outcome 23 (Health emergencies preparedness and risk reduction), and Outcome 25 (Health emergencies detection and response).

246. NVCs should be consistent with the PAHO Strategic Plan and Country Cooperation Strategies. However, the level of such funds is not easy to predict from one biennium to the next. Table 1 lists the governments that used this modality of technical cooperation and financing in 2018-2019 and 2020-2021. Compared to the previous biennium, five additional governments were able to implement funds through PAHO during 2020-2021: Guyana, Haiti, Honduras, Nicaragua, and Venezuela. This shows an expansion of PAHO's work in the Region. It is important to note that NVCs do not follow Program Budget timelines, and therefore the amounts financed during 2020-2021 are frequently not intended to be fully implemented in that same period. This is the case with countries like Jamaica and Trinidad and Tobago, which signed NVCs in late 2021 to be implemented during 2022-2023.

**Table 1. National Voluntary Contributions provided to PAHO
and implemented during 2018-2019 and 2020-2021
(US\$)**

Government	Implemented 2018-2019	Implemented 2020-2021
Argentina	1,655,751	3,404,330
Brazil	109,791,250	87,959,929
British Virgin Islands	148,627	161,726
Chile	13,083	-
Colombia	1,279,441	199,413
Costa Rica	739,001	886,687
Dominican Republic	15,024,133	14,575,160
Ecuador	52,810	27,626
Guatemala	142,894	-
Guyana	-	101,458
Haiti	-	6,250,590
Honduras	-	754,042
Mexico	2,270,748	1,633,607
Nicaragua	-	883,199
Panama	530,263	533,948
Paraguay	43,389	70,611
Trinidad and Tobago	303,036	-
Uruguay	88,700	4,173
Venezuela	-	10,576,782
Total NVCs	132,083,126	128,023,281

VI. Risk Analysis

247. Corporate risks and opportunities were identified as part of the PAHO Strategic Plan 2020-2025, and for that reason it was not necessary to establish risks separately for the 2020-2021 biennium. In the Strategic Plan, 11 key risks were identified, along with their potential adverse impacts on the achievement of the Plan's outcomes. Tools to mitigate these risks were noted.

248. The contextual environment in which the Organization operated during the 2020-2021 biennium was characterized by the COVID-19 pandemic emergency, a situation particularly challenging for PAHO. The pandemic tested core functions of the Organization in multiple areas, including procurement, business continuity management, funding sustainability, and, equally important, PAHO's capacity to support the emergency response and undertake relevant technical cooperation with Member States. It should be emphasized that the implementation of PASB activities has maintained the highest levels of accountability in an environment where risk levels are increasing due to the unstable social, political, and economic situation in PAHO Member States.²⁰ Even now, the course of the COVID-19 pandemic in the Americas remains highly uncertain. This means that control of the pandemic in the Region will continue to require a comprehensive response with sustained health services network capacities, sustained public health and social measures, targeted vaccination operations, and outbreak control actions, including early detection, investigation and isolation of cases, and tracing and quarantine of contacts.

249. While the pandemic was unfolding, PASB faced an unprecedented threat to Pan American solidarity and to the institution's very existence. Due to nonpayment of several Member States' assessed contributions and certain voluntary contributions, the Organization found itself on the brink of insolvency. A Special Session of the Executive Committee was held virtually to allow Member States to monitor and provide guidance on issues related to the internal financial situation and the response to the emergency. Nonetheless, the critical situation provided a stimulus for change management. Once the business continuity plans for every duty station were activated, administrative guidance was provided and regularly monitored.

250. The reality faced by the Organization during 2020-2021 showed that the Enterprise Risk Management system implemented by PASB, which is aimed at increasing transparency and improving governance and accountability, is an integral part of PASB's operations and decision making. It is also a critical component of results-based management. The risk management approach, considering the 11 key risks identified for the implementation of the PAHO Strategic Plan, increases managerial capacity, leverages the resources and knowledge of staff to better inform Executive Management, and optimizes the performance of the Organization and thereby the achievement of results.

²⁰ Pan American Health Organization. Financial Report of the Director and Report of the External Auditor, 1 January-31 December 2020 (*Official Document 362*). Washington, DC: PAHO, 2020.

251. Due to the particular conditions of the 2020-2021 biennium, the risks were systematically monitored, reviewed, and prioritized, including the level of risk tolerance.²¹ They were reported as part of the internal control statement that is part of the Financial Report of the Director and Report of the External Auditor.

252. The information contained in the corporate risk register is reviewed regularly, with the key findings reported to Executive Management during the corporate performance monitoring and assessment process. The list of risks was reviewed and prioritized with the PAHO Enterprise Risk Management and Compliance Standing Committee and with Executive Management for the purpose of monitoring the mitigation strategies and preparing the Program Budget 2022-2023. The review and prioritization considered aspects such as the use of risks as potential opportunities; programmatic and financial implications; identification of new and emerging risks; and decisions to strengthen the organizational risk culture. Based on this exercise, the concept of tolerance level has been incorporated as part of the corporate risk register in order to reinforce the linkage between internal controls and risks, and specific questions related to use of the corporate risk register are included in the quarterly compliance survey for cost center managers.

253. Table 2 shows the key risk areas managed during 2020-2021. Mitigation actions are described below and are applicable to one or more risks.

²¹ United Nations System, Chief Executives Board for Coordination, Guidelines on Risk Appetite Statements (Final), 38th Session of the High-Level Committee on Management (Document CEB/2019/HLCM/26, 15-16 October 2019). Annex 1: Risk tolerance is the “acceptable level of variation an entity is willing to accept regarding the pursuit of its objectives.” Page 23: “Risk tolerances can also be defined as quantitative thresholds that allocate the organisation’s risk appetite to specific risk types, business units, activities and segments, and other levels. Certain risk tolerances are policy limits that should not be exceeded except under extraordinary circumstances (hard limits), while other risk tolerances are guideposts or trigger points for risk reviews and mitigation (soft limits). Whereas risk appetite is a strategic determination based on long-term objectives, risk tolerance can be seen as a tactical readiness to bear a specific risk within established parameters.”

Table 2. Key Risk Areas and Scope Managed during 2020-2021

Risk Area	Scope
Dependence upon and need to ensure Member States' funding of their financial commitments ²²	<ul style="list-style-type: none"> • Failure of some Member States to comply with financial commitments (assessed contributions) • Insufficient resources or decline in investments to implement and achieve the PAHO Strategic Plan, including funds through voluntary contribution mechanisms • Governance collapse or crisis that may delay compliance with financial obligations or derail programmatic development
Ability to support Member States' needs through mobilization of resources and leveraging of partners and donors	<ul style="list-style-type: none"> • Lack of diversification of partners and donors • Failure to develop and implement resource mobilization plans
Failure to provide business continuity and duty of care for PASB personnel during pandemic	<ul style="list-style-type: none"> • Failure to follow workplace safety protocols to ensure health and well-being of personnel • Lack of updated business continuity plans in PAHO duty stations
Failure to respond rapidly to Member States' needs in emergencies and disasters (outbreaks and natural events)	<ul style="list-style-type: none"> • Failure to provide adequate support and technical cooperation to Member States in cases of outbreaks, pandemic events, or new diseases (COVID-19 pandemic) • Inability to strengthen and support responsive and adaptive health systems in the face of risks from the current pandemic situation • Lack of monitoring system in the Region for recurring epidemic waves and outbreaks • Failure to effectively and equitably make COVID-19 vaccines accessible and achieve appropriate population coverage
Competing national priorities that reduce attention to health priorities	<ul style="list-style-type: none"> • Increasing scale of the COVID-19 emergency and new humanitarian crises that may affect health outcomes • Information systems with limited disaggregated data and scarce data on the social determinants of health
System/technology infrastructure readiness to support digital transformation	<ul style="list-style-type: none"> • Insufficient resources to develop applications for workplace modernization and business continuity • Cybersecurity gaps
PASB reputation	<ul style="list-style-type: none"> • Potential for fraud, conflict of interest, and/or misconduct

²² Financial Regulations and Financial Rules of the Pan American Health Organization. In the Financial Regulations (latest update approved by Resolution CD58.R7, 29 September 2020), Regulation IV, para. 4.4, refers to the legal obligation of Member States to make available the assessed contributions for implementation on the first day of the budgetary period to which they relate.

254. To manage risks, several mitigation actions are integrated into the regular program of work of the risk owners and are regularly monitored by the Enterprise Risk Management Program, the Enterprise Risk Management and Compliance Standing Committee, the Executive Management team, and other entities. The range of mitigation actions with different levels and dimensions includes the development or review of policies and procedures, regular confirmation of compliance within specific business processes, monitoring of the implementation of donor agreements, training to build internal capacity in several areas of work, regular and ad hoc consultative processes with Member States, maintenance of communications with internal and external stakeholders regarding PASB progress and challenges, monitoring of the implementation of the PASB response during the emergency and duty of care, and conducting assessments or audits.

255. For the purpose of this report, mitigation actions can be classified by the level of intervention: strategic or operational/technical. The nature of the risk mitigation may be technical, financial, political, or administrative. However, it is important to highlight that the general understanding of mitigation actions is based on the root causes of the identified risks, the risk interactions due to common causes, and the scope of the Organization in terms of mandate, governance framework, and current policies in place. The following are among the main mitigation actions reported by PASB entities:

Strategic mitigations:

- a) Consult Member States regularly and promote dialogue to find regional solutions, respecting the specific needs and priorities of countries.
- b) Maintain open communication channels and keep internal and external stakeholders continuously informed about the progress and challenges.
- c) Promote dialogue and solidarity among countries to reduce inequities and better respond to emerging risks.
- d) Advocate at the national level for financing for health.
- e) Increase the role of PWR Offices and regional department directors in support of high-level political dialogue to ensure commitment of Member States and partners, giving priority to health programs with a focus on health equity.
- f) Create and promote opportunities for collaboration among Member States, United Nations agencies, and other nongovernmental organizations.
- g) Advocate for continuously strengthening and funding at national level the first line of response for emergencies.
- h) Continue advocating for investment and upgrading of integrated information systems for health with capacity to generate and analyze disaggregated health data.

Operational/technical mitigations:

- a) Monitor collection of assessed contributions and continue to explore mechanisms to increase the timely collection of assessed contributions.
- b) Identify other resources and funding mechanisms available to the Organization.
- c) Improve governance for projects funded by voluntary contributions (building lesson learned, risk management, and project management).
- d) Provide technical cooperation to strengthen *i)* leadership, stewardship, and governance; *ii)* epidemic intelligence; *iii)* health systems and service delivery networks; *iv)* emergency operations response and supply chain. Support Member States in procuring COVID-19 vaccines and public health supplies through the Revolving Fund and the Strategic Fund.
- e) Monitor the implementation at national level of the International Health Regulations (IHR) and Member States' acceleration of actions to strengthen information systems for health.
- f) Adopt digital solutions for access to timely (close to real-time) and disaggregated data to support decision making for responding to the COVID-19 pandemic.
- g) Adjust policies to enable the Organization to perform its mandate in an environment that promotes accountability, a respectful workplace, and duty of care.
- h) Monitor to ensure that donor agreements are implemented fully and on time, and build internal capacity in project management and donor engagement.
- i) Continue generating efficiencies in budgetary implementation.
- j) Ensure that PASB standard operating procedures are in place to organize support teams in cases of outbreaks, disasters, or other declared emergencies.
- k) Monitor, learn, and adapt business continuity management for all PASB duty stations to support the duty of care and COVID-19 response and to maintain the Organization's technical cooperation presence.
- l) Maintain and update the information security program and train PASB personnel to build awareness of and compliance with information security procedures.

VII. Lessons Learned and Recommendations

Overview

256. The 2020-2021 biennium will be remembered as one of the most critical periods during the first 120 years of PAHO. Therefore, documenting the lessons learned during this period and identifying recommendations for how to move forward becomes more relevant than ever. While these lessons are based on PAHO's experience during the 2020-2021 biennium, they should be seen in the broader context of the various reviews that are taking place at country, subregional, regional, and global levels. Although the full impact of the COVID-19 pandemic remains to be seen, this report contains important insights on how PAHO faced the pandemic and the financial crisis while simultaneously advancing in the first biennium of the Strategic Plan. This review seeks to ensure that during 2022-2023 and beyond, as the Region aims to protect, recover, and build stronger, actions are developed that take into account the knowledge and understanding gained over the past two years.

257. PAHO has identified lessons that can be seen from multiple angles, with political, strategic, technical, and managerial aspects, as described below. Lessons presented here include positive and innovative practices that should be promoted to enhance implementation of programs and ensure successful achievement of results. They also include adverse practices and experiences that need to be documented and shared to avoid recurrence as PAHO continues to implement the SP20-25 and SHAA2030. The review captures lessons learned and recommendations from the internal assessment by PASB and may be updated for the report to the 30th Pan American Sanitary Conference.

Political

258. If the pandemic has taught us anything, it is that health cannot be left out of development. The COVID-19 pandemic has highlighted the inextricable linkages between health, social development, and the economy, and the evidence suggests that controlling the health crisis is the key to a sustainable and equitable economic recovery. The pandemic resulted in important lessons learned on the political and strategic dimensions of health and the need to further strengthen PAHO's capacities to proactively analyze and foresee scenarios and trends in order to be better prepared. The capacity shown by PAHO Member States in sustaining the response to the pandemic also presents the opportunity to engage in strategic thinking to reshape the future of technical cooperation.

259. PAHO has proven to be of critical value to Member States in its role as catalyst, convener, and trusted broker during an unprecedented health emergency. While responding to the COVID-19 pandemic, the Organization also acted to protect essential health services in collaboration with Member States and partners and in line with its mission and values. Technical leadership and ongoing engagement with national authorities were crucial in enabling the Organization to maintain the validity of its mandate as lead agency in health for the Americas and to support countries in facing an emergency of such great magnitude and duration. Equally important was strategic communication, especially sharing evidence

and improved storytelling. Regular press conferences and op-eds have had a tremendous positive impact on PAHO's name recognition worldwide and have allowed the Organization to expand its outreach to broader audiences. Confronted with an "infodemic" of misinformation and disinformation around COVID-19, PAHO worked to expand access to and use of up-to-date evidence and information. In addition, annual country reports are being produced that illuminate PAHO's work and value-added at country level.

260. While PAHO as an institution has played a leading role in the Region and the world, contributions in global forums from the Region of the Americas, both PASB and Member States, were essential to the response at all levels. Coordination with WHO improved significantly and led to increased access to collaborative projects with funding, updating, and participation in global initiatives, as well as access to the experiences of other regions. Similarly, joint work with other agencies, programs, and funds of the UN system and other international organizations facilitated the mobilization of additional financial and technical resources. PWR Offices exercised a constant and strong leadership role in the UN system at country level. PAHO's engagement with multi-agency partnerships at all levels was critical to the pandemic response and provided opportunities for joint resource mobilization. Advocacy and presence in the global mechanisms (the ACT Accelerator and Consortiums) proved very productive and allowed PAHO to position the Region for the mRNA technology transfer project and others.

261. Confronting major public health threats requires strong public health institutions at national and international levels with clear mandates, good governance mechanisms, and adequate financial and human resources. Barriers to access, fragmentation, and segmentation in health systems must be addressed through comprehensive policy reforms and stronger legislation. As the pandemic response continues, countries will soon be required to envision a post-COVID-19 development era in which they prioritize, build, and embed resilience within societies and health systems and continue advancing toward the SDGs. Countries will need to prioritize the strengthening of health systems toward the achievement of universal health based on the regional strategy for resilient health systems. Pandemic preparedness and response will be a key component of this work.

262. South-South cooperation, cooperation among countries for health development, and subregional initiatives continue to provide opportunities to advocate for stronger health systems response, promote PAHO/WHO recommendations to countries, and increase engagement with national programs while creating spaces to share experiences. Collaboration and coordination between countries, donors, and external partners is even more essential in a context of competing priorities. This is illustrated, for example, by the rapid implementation of strategies and interventions in Central America through the Regional Malaria Elimination Initiative and the mobilization of Global Fund support to Venezuela.

Recommendations

- a) Intensify advocacy for health at the highest levels of government, ensuring linkages between health, the economy, social protection, and pandemic preparedness and response.

- b) Capitalize on the visibility that PAHO has earned through its response to COVID-19 and extend it to other areas and audiences (in particular as pandemic fatigue sets in).
- c) Continue providing technical cooperation and support to promote the higher positioning of the health sector in preparedness for and response to health emergencies, with the aim of placing health at the center of all policies.
- d) Use PAHO's unique position as lead agency for the COVID-19 response within the inter-American system to gather strategic intelligence to increase the Organization's influence and identify new partnership opportunities.
- e) Assess the effectiveness of the PASB response to COVID-19 and develop urgent strategies and plans to reorient the Bureau's technical cooperation in a post-pandemic world, ensuring better preparation for the next pandemic and intensifying efforts to achieve the full spectrum of health goals for the Region.
- f) Advocate for greater investment in human and financial resources to communicate the Organization's role and achievements and to face emerging political and diplomatic challenges in the changing political context of the Region.
- g) Continue to implement initiatives that promote collaboration between countries across the Region and its subregions.

Strategic

263. Despite the constraints of the pandemic and the financial crisis, PAHO was able to advance many planned activities during the biennium and achieve important progress in the technical cooperation agenda. This has shown that even in acute emergencies, the full spectrum of public health issues can be addressed. PAHO was able to use the pandemic as an entry point to advocate for strengthening essential health services and health systems and to accelerate actions on NCDs, mental health, nutrition, communicable diseases, and the social and environmental determinants. Agility, flexibility, responsiveness, and, in some cases, reprioritization were more important than ever as approaches to technical cooperation. At the same time, effective health diplomacy and regular, systematic, and persistent engagement with the national authorities at different levels were key to ensuring the delivery of work plans and the achievement of desired results.

264. Strong intersectoral work continues to be essential to the effectiveness of PAHO's technical cooperation. High-level coordination across sectors played a crucial role in the containment and mitigation of the pandemic. It should be recognized, however, that governments often create or activate intersectoral mechanisms at times of crisis, only to see them dissolve afterward. It is important to ensure that these mechanisms are maintained over time in order to support a Health in All Policies approach. For example, when it comes to the health system response to violence and injuries, including timely access to quality emergency care, there are many common challenges and opportunities, and thus a possibility for win-wins. This is an opportune moment to push forward, as governments, partners, and donors are increasingly approaching these topics in a coordinated and integrated manner that seeks to address their intersections.

265. Civil society organizations play a key role in the effort to advance on priorities. Providing close technical support and advice to these organizations can help ensure that evidence and recommendations on best practices promoted by PAHO/WHO are taken into consideration.

266. Working at the local level became very important during the pandemic. Local governments have a clear role to play in promoting and protecting health in the communities. Regional, national, and subnational networks of local governments have provided valuable platforms through which to disseminate information and have advocated for including health promotion on local government agendas. Similarly, health systems that involve community health workers have had better success than other systems in communicating public health measures. During the pandemic, local health teams demonstrated resilience and the capacity to integrate topics such as malaria and integrated vector management into routine health services. PAHO presence in the field, including through its satellite offices, was key to coordinating the response among prioritized groups in hard-to-reach locations.

267. Interprogrammatic work enabled an integrated approach in responding to Member States' demands, achieving better results during the pandemic than would have been achieved without such collaboration.. Such approaches were envisaged in the Strategic Plan 2020-2025, and past investments in this regard facilitated a timely, efficient, and effective response to the crisis. Coordinated activities by partners in the Incident Management Support Team, including PWR Offices and technical and enabling departments, drove the delivery of technical cooperation. Still, the crisis offers an opportunity to take stock and make changes to the model of work.

268. New modalities of technical cooperation were established, including partnerships, networks, and various modes of virtual training that were essential for a coordinated response. Resource mobilization efforts for COVID-19 facilitated the establishment of new partnerships and helped build relationships for long-term work in the post-COVID-19 era. The crisis presented an opportunity to expand strategies and innovations for bringing together partners around the health agenda—an opportunity that must not be missed.

Recommendations

- a) Strengthen the engagement of the Organization in high-level dialogue with health and finance ministries, international financial institutions, and donors, to continue advocacy for increased, improved, and sustainable public investment in health.
- b) Strengthen work with other sectors, listening to and involving communities and civil society, to better position health on national agendas and to address topics that involve actors outside the health sector.
- c) Continue to promote interprogrammatic work as an efficient and cost-effective approach to technical cooperation.

- d) Strengthen relationships with academia and PAHO/WHO Collaborating Centers to better respond to technical cooperation demands, and develop a targeted approach to increase the number of collaborating centers.
- e) Advocate for sustained investments in areas of work pertaining to health emergencies and leverage the lessons learned from the pandemic, recognizing that health emergencies can have extraordinary impact on all sectors.
- f) Strengthen competencies and acquired knowledge of processes and mechanisms to offer strong technical cooperation through virtual means and integrate programs and activities, giving them synergy and breaking down silos.

Technical

269. As indicated above, setbacks have put at risk progress toward the achievement of the targets in the Strategic Plan, SHAA2030, and the SDGs. There has been a greater effect on the most vulnerable populations, such as pregnant women and newborns in disadvantaged situations. Achieving impact requires sustained implementation of proven interventions and an integrated, Organization-wide approach that looks closely at the determinants of health and the access barriers, as well as at the impact of health systems and services interventions.

270. During this pandemic, it has been essential to negotiate, coordinate, and integrate emergency public and private services, the first level of care, hospitals, EMTs, and AMCSs to contain and mitigate the spread of COVID-19 and maintain access to quality essential health services. There were many positive experiences during the biennium that showed the potential of accelerated innovation in health services management. These included, most notably, reorganization toward integrated health services networks, with emphasis on strengthening the first level of care and incorporating telemedicine solutions.

271. The COVID-19 pandemic has put to the test virtually all provisions of the IHR. In this way the crisis offers unprecedented opportunities to identify, understand, and take stock of national core capacities, technical tools, legal instruments, and preparedness frameworks and to introduce legal, institutional, and operational changes to strengthen preparedness and response capacities. The IHR should cease to be portrayed as an end in themselves and should be seen instead as a means to exercise the essential public health functions (EPHF). By strengthening their health systems as a whole and the EPHF in particular, countries will be empowered to achieve compliance with the IHR. Similarly, ensuring that the IHR can be used to practice good public health will require a deeper knowledge of their articles at all levels, going beyond their selective application to date.

272. The institutionalization of emergency and disaster risk management programs in national health authorities has been recognized as a priority need. The COVID-19 response reinforced the role of national teams to serve as first responders and support life-saving actions, not only at the onset of an emergency, but also in the medium and long term to ensure sustainability of operations. Renewed focus must be placed on strengthening national response teams to assist their own countries during emergencies.

273. Collaborative networks of laboratories that existed before the pandemic made possible the timely deployment and adoption at scale of novel diagnostic methods for COVID-19 and influenza. At the same time, laboratory response to emerging pathogens has historically been concentrated in the national public health laboratories (NPHL). Countries that have decentralized laboratory capacities under the supervision of the NPHL were better able to respond to the pandemic. Similarly, increased investment in epidemiological and laboratory-based surveillance, including sequencing capacities, is needed to detect and report early emergence of pathogens and assess abrupt changes in transmission or disease severity.

274. Maintenance of a self-sustaining strategic stock, prepositioned for health emergencies, was critical to delivering life-saving responses during the pandemic. Propositioning helps mitigate delayed or blocked access to critical supplies that may result from the global dynamics of demand/supply, logistics constraints, transport delays, and/or production shortages during emergencies.

275. COVID-19 triggered innovation. Despite the need to accelerate adoption of new methods, however, countries have been slowed by the limited availability of human, financial, and technological resources and normative instruments. Research, evidence, and innovation, including the capacity for adaptation, early adoption of, and use of evidence for decision and policy making, are crucial in the context of public health emergencies. In addition, the pandemic has shown that quality, transparency, rigor, and effective communication and knowledge management are essential to ensure uptake of evidence.

276. Health workers are essential to the effort to expand services and build the resilience of health systems. However, given the widely reported burnout among health personnel, it is increasingly difficult to sustain and further expand capacity. Investment in health care workers needs to be prioritized to enable a comprehensive response to current and future pandemics, including maintaining access to quality essential health services. In their planning for pandemics and other public health emergencies, countries need to place greater emphasis on the health workforce, ensuring the availability, distribution, and necessary competencies of human resources for health at the different levels of care. Special consideration should be given to the personal health and safety of health workers, including their mental health. Psychosocial support for health workers is critical, and while remote training and virtual support are important service delivery modalities, they do not replace the effectiveness of face-to-face training and support.

277. Rapid increases in international health worker migration threaten the health emergency response and achievement of universal health in several countries. Continued support is required to enable Member States and relevant stakeholders to monitor and manage international health worker migration and mobility effectively and ethically.

278. The COVID-19 pandemic accelerated a transition to telemedicine that had been slowly underway for years. However, health systems must avoid simply layering telemedicine technology on top of current systems and should instead reimagine the entire

system, fully integrating telemedicine to ensure that access to care is safe, free from inequities, and truly responsive to the needs of patients, families, and the health workforce.

279. The PAHO Virtual Campus for Public Health constitutes a strategic resource for the Organization, enabling PASB to respond directly to the needs of countries and the health workforce with the virtual delivery of technical cooperation for emergency response and for capacity building toward priority program objectives. During the biennium, the Virtual Campus progressively expanded its capacity to host capacity-building courses and to serve as a repository for webinars. It is expected that this growth in the virtual modality of technical cooperation will continue after the pandemic subsides, even as in-situ technical cooperation activities return.

280. The achievement of equity and efficiency with sustainability in health outcomes depends to a large degree on how resources are planned, budgeted, and allocated. The pandemic demonstrated that flexibility in the reallocation and transfer of resources and agile payment mechanisms to frontline providers in emergency situations are crucial to ensure availability of testing and isolation strategies, deployment of vaccines, and operation of essential health services. Some countries responded better than others, demonstrating an ability to spend resources in a timely manner and allocating them where needed to ensure an efficient response to the demands imposed by the emergency.

281. Despite improvements in financial protection, the pandemic proved once again that any unpredictable event can produce substantial setbacks. Some financial protection mechanisms that rely strongly on contributory mechanisms (like social security-related health insurance) are too pro-cyclical and should be revised in the light of the economic downturn resulting from the pandemic. The creation of specific schemes to cover COVID-19-related expenditures should be seen as a temporary solution and undertaken with caution, as such schemes may undermine the continuity of care and a comprehensive approach to financial protection in health overall. Having accurate and timely information on the impact of out-of-pocket expenditures on households is key, and special emphasis should be put on disaggregating this impact by ethnicity, gender of the household head, and rural/urban context.

282. Health systems and services need to reinforce preventive and health promotion initiatives. Addressing the social determinants of health through a Health in All Policies approach at all levels of government has proven to be important for a more effective and equitable response to the pandemic. Moving forward, there is an opportunity to sustain momentum created by the crisis for continued health sector leadership on intersectoral action and community participation to address the social determinants.

283. Services for NCDs, mental health, rehabilitation, and palliative care all suffered significant disruptions during the biennium, and the long-term impact on people's health is not yet fully known. As countries strengthen and improve their health services, it is urgent that NCDs be prioritized and that services become more accessible, with adaptations such as teleconsultations, extension of prescriptions to 90 days, availability of mobile pharmacies, and apps for continuous care. The links between NCDs, risk factors, and

COVID-19 have underscored the urgency of taking action to effectively address the commercial determinants of NCDs. This includes setting up regulatory frameworks that are conducive to making the healthy choice also the easy choice (no tobacco use, reduced alcohol consumption, healthy eating, and more physical activity). However, it has been difficult to gain political commitment to put in place effective policies.

284. Mental health, too, must become a higher priority, with services adapted to be more accessible, advances in deinstitutionalization, and mental health coverage more firmly integrated into primary care. There is an opportunity to integrate mental health into emergency response as the pandemic has increased visibility and awareness of mental health problems and of the need to increase capacity in mental health promotion, prevention, and care. Suicide prevention activities that are evidence-based need to be implemented at country level. Mobilizing funds for suicide prevention and working with countries that have high suicide rates also creates the opportunity to improve mental health care and services.

285. In the context of COVID-19, action by governments, partners, and PASB on violence prevention and response has taken on new urgency. However, service disruptions have hampered the response and have exacerbated preexisting vulnerabilities in health services, such as inequity in access. Strengthening the health system response to survivors of violence is widely seen as an area where PAHO has a comparative advantage over other actors.

286. As with other areas, there is an opportunity to accelerate progress in the prevention, control, and elimination of communicable diseases. Some advances were seen even during the pandemic, such as the expansion of PrEP to mitigate the impact of HIV. In pursuit of the elimination agenda, community approaches and intercultural dialogue were important factors in helping with diagnosis and follow-up care.

287. Member States have agreed on the importance of reinforcing data management and information technologies, data governance, knowledge management and sharing, and innovation, following a lessons learned exercise convened by PASB. The adoption of international standards and principles for managing data, implementation of digital literacy programs, and information systems maturity assessment are key steps to that end.

Recommendations

- a) Readdress universal health with a view to strengthening and transforming health systems and services as the conduit for delivering essential public health programs and priorities, focusing on the health needs of vulnerable populations and on the social and environmental determinants of health.
- b) Undertake continuous indicator monitoring, explore methods to accelerate progress toward the targets, and take actions to protect past achievements, recover, and build stronger, to reach and maintain national, regional, and global goals.

- c) Provide the necessary technical, legal, and strategic support for health sector reform processes with a view to enhanced capacities for health systems strengthening and resilience, aligned with global and regional mandates.
- d) Define the key elements of a national health emergency preparedness and response system, including its expected *modus operandi* and necessary legislation, and work with Member States and partners to put them in place.
- e) Advocate for greater national investment in emergency preparedness, based on best practices in countries that responded effectively to COVID and prior emergencies and ensuring that the health needs of vulnerable groups are protected.
- f) Promote within PASB and among national authorities a shared understanding of the IHR as a tool to facilitate the practice of evidence-based public health and a cohesive and coherent approach to health systems strengthening.
- g) Continue to encourage Member States to comply with the provisions of the IHR, especially those related to the timely sharing of information, and to conduct and document reviews of their national response to the pandemic.
- h) Continue strengthening emergency response coordination mechanisms at all levels of PASB and Member States, including the level of political leadership.
- i) Highlight the importance of strengthening routine immunization across the life course, taking into account lessons learned on how to manage COVID-19 vaccination and integrate it into public health activities.
- j) Work in a coordinated manner to address challenges related to the lack of updated, reliable data on the impact of COVID-19 on health and well-being.
- k) Focus actions on the integration of service provision for priority programs, the formation of interprofessional health teams within health services networks, and the application of digital technology as tools to support the optimal organization of the health services.
- l) Renew the approach to workforce planning and education, increasing competencies for primary health care, in line with the regional strategy on human resources for health.
- m) Improve access to quality-assured, safe, and effective health technologies and essential supplies, oversee the integrity of the supply chain, and regulate the quality of health technologies and their rational use, based on evidence, to ensure future improvements in pandemic preparedness and response.
- n) Encourage intersectoral action and partnerships on research and innovation and ensure that health decisions and interventions are informed by the best available evidence to ensure their success.
- o) Advocate at the highest levels of government and partner organizations for political commitment to and prioritization of actions on NCDs, mental health, malnutrition, road safety, and violence, with intersectoral collaboration and increased investment in these areas.

- p) Continue to advocate for the elimination of communicable diseases in the Region, utilizing the platform of the Elimination Initiative.
- q) Strengthen efforts to address the social and environmental determinants of health and reinforce the importance of gender, equity, ethnicity, and human rights in strategic frameworks and in the context of pandemic response, with the aim of better responding to the pandemic and reducing health inequities.

Managerial and administrative

288. PAHO faced an unprecedented threat to its functioning in the first part of the biennium due to the nonpayment of quotas by some Member States. This financial crisis was compounded by the effects of the COVID-19 pandemic and forced PASB to establish cost containment measures and reprogram work plans to preserve its core operational capacity. The measures, most of which were phased out in early 2021, included a reduced Human Resources Plan for 2020-2021, with a freeze on all vacant positions and reductions in funds for activities and short-term staff. Thanks to these adaptive measures, plus the collaboration of teams across PAHO, an increase in resource mobilization, and advocacy with Member States, the Organization was able to mitigate the effects of the financial crisis, respond to the pandemic, and continue fulfilling its mandates while building resilience for the future.

289. The progress achieved in automating the corporate risk register and the review process for projects funded by voluntary contributions (VC) provided an enabling environment that allowed rapid advances in addressing key recommendations from the PAHO Governance Reform resolution to strengthen the integration of risk management into VC projects.

290. PASB invested during non-emergency times in information technology, including cyber security and migration to the new cloud-based Microsoft SharePoint online platform. This allowed the Organization to operate remotely during the pandemic, reducing accessibility problems and potential security issues. Innovations led to the development of new tools, such as mobile applications and virtual seminars and training, that allowed PAHO to reach a broader audience. The introduction of PAHO's first-ever digital workers, bots named "Mia" and "Max," has been a positive experience, enabling PAHO to handle an increase in procurement transactions.

291. The transition to virtual trainings and meetings has energized PAHO's work, allowing technical cooperation to be maintained without the excess time and costs that in-person meetings would require. Virtual platforms also facilitate expanded outreach to a wider range of target beneficiaries, increasing the impact of activities in Member States. Use of technology has made it possible to maintain an adequate level of coordination and communication across all levels of the Organization. Several innovative approaches and practices in preparing for and conducting Governing Bodies meetings have proven very useful and should continue.

292. Teleworking provided positive lessons and opportunities for strengthening a country focus approach by *a)* broadening and facilitating the interaction of the three functional levels of the Organization, resulting in further inclusiveness, transparency, and diversity; *b)* facilitating knowledge-sharing and capacity-building activities that reduced the impact of the extended no-travel declaration on the delivery of technical cooperation; *c)* fostering innovative approaches to ensure PAHO's positioning as regional health leader and technical expert; and *d)* reducing regional transaction costs.

293. Nevertheless, not all activities can be implemented virtually. Technical cooperation implies sharing challenges and successes with country counterparts, which requires deep contextual understanding. Virtual exchanges, while practical and convenient, will still need to be complemented with face-to-face encounters once COVID-19 restrictions are lifted.

294. The special procedures for emergency response that were put in place enabled the Organization to respond to the pandemic and other health emergencies and to meet Member State demands. This was accomplished by enhancing its agility while remaining in compliance with procedures and requirements.

295. Finally, the political climate has changed, and there are now stronger expectations that organizations will adhere to sound ethical policies and practices that also consider the rights and needs of victims of abuse and improper conduct. The ways in which organizations investigate allegations of sexual exploitation and abuse, sexual misconduct, and other forms of harassment must reflect the new realities. Investigations need to be streamlined and timely, provide personnel with the right of recourse, and hold perpetrators accountable.

Recommendations

- a) Continue building on existing efficiencies and increasing effectiveness of core activities in ways that maximize the use of resources.
- b) Continue to streamline administrative processes to increase agility and enhance risk management, compliance, and internal controls in ways that optimize staff time and the hybrid work environment, drawing on good practices and innovations that proved valuable in the pandemic response.
- c) Evaluate technologies and processes to determine which can feasibly be automated to strengthen PAHO's ability to provide technical cooperation.
- d) Strengthen recruitment processes to attract and retain well-qualified personnel in a job market and work environment that continue to undergo changes as a result of the pandemic.

Annex

Annex

1. This section is under development. The complete Annex will be included in the document that will be presented to the 30th Pan American Sanitary Conference in September 2022.
2. This annex will present detailed findings from the review of impact indicators of the Strategic Plan of the Pan American Health Organization 2020-2025. An overview of the main findings to be presented in this annex is available in Section III of the present report.

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