PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

# SIXTH SESSION OF THE SUBCOMMITTEE ON PROGRAM, BUDGET, AND ADMINISTRATION OF THE EXECUTIVE COMMITTEE

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## PRELIMINARY PROGRAM AND BUDGET 2010–2011 END-OF-BIENNIUM ASSESSMENT/SECOND INTERIM PAHO STRATEGIC PLAN 2008–2012 PROGRESS REPORT

### Introduction

1. As established in the PAHO Strategic Plan 2008–2012, the Pan American Sanitary Bureau (PASB) is required to present progress reports to the Governing Bodies on the Plan's implementation every two years. This report covers the 2010–2011 biennium and represents the second progress report being presented to PAHO's Governing Bodies.

2. The report relies on information provided by the Performance Monitoring and Assessment (PMA) process conducted across the PASB at the end of the 2010–2011 biennium. It consists of programmatic and budgetary implementation analyses of the Organization's performance, including an analysis by organizational level (country, subregional, and regional entities) and by Strategic Objective (SO). The report also includes information on PASB's resource mobilization efforts to cover the funding gap of the 2010–2011 Program and Budget, and on the allocation of resources by organizational level and by SO.

3. The report will incorporate the recommendations provided by Member States on the first progress report of 2008–2009, presented to the 50th Directing Council in September 2010, and the input obtained from the SPBA and Executive Committee Members during 2012.

### Update on the Current Situation

4. The 2010–2011 end-of-biennium assessment was conducted in December 2011. It involved all PASB entity managers and their teams, as well as the Executive

Management (EXM). During this exercise the performance of each of the 69 PASB entities and the progress toward achievement of the 16 Strategic Objectives (SOs), 90 Region-wide Expected Results (RERs), and 256 RER indicators of the PAHO Strategic Plan 2008–2012 were reviewed. This exercise provided the main input for preparation of the progress report that will be presented to PAHO's Governing Bodies during 2012.

5. According to the preliminary results of the assessment, the Organization continues to make steady progress toward achieving the targets set for 2013 in the Strategic Plan. The end-of-biennium assessment shows that of the 16 SOs, 12 are on track (green) and 4 are at risk (yellow); 78 (87%) of the 90 RERs are on track, 11 are at risk, and 1 is in trouble (red); and 231 (90%) of the 256 RER indicator targets were achieved. Regarding funding, the Organization obtained US$ 599 million, which represents 93% of the total approved Program and Budget ($643 million) for 2010–2011. The overall budget implementation rate was 86% ($513.5 million of $599 million available for the biennium). It is important to note that, overall, there is a very good correlation between the program and budget implementation rates: 90% of RER indicator targets were achieved with 86% budget implementation of the funds available for the biennium.

6. The end-of-biennium assessment information is under review and validation as part of the end-of-biennium closure process. Once the analysis of the results is complete, the full report will be prepared. The complete report will be presented to the 150th Session of the Executive Committee in June 2012 and, subsequently, to the 28th Pan American Sanitary Conference in September 2012.

7. The proposed outline of the report and a brief description of each section is presented below for consideration and input from the SPBA Members.

I. **Executive Summary:** Includes highlights of the main findings of the end-of-biennium assessment.

II. **Introduction:** Presents background, purpose, and overview of the contents and structure of the report.

III. **Methodology:** Provides an overview of the Performance Monitoring and Assessment (PMA) process employed across the PASB.

IV. **Programmatic Performance:** Includes the assessment of the overall program implementation of PAHO and the achievement of Strategic Objectives, Region-wide Expected Results, and RER indicator targets. This section will also outline the principal achievements, challenges, and lessons learned during the biennium. Special attention will be given to documenting lessons learned in order to promote replication of successful outcomes in future plans.

V. **Budget and Resource Mobilization:** Provides an analysis of the funds available and implemented during the biennium, by organizational level and by

Strategic Objective. An analysis of the mobilization and allocation of resources by programmatic priority of SOs will also be included.

VI. **Strategic Objective Reports:** A detailed report for each SO, including its RERs and respective RER indicators, will be included. As recommended by Member States previously, for each indicator of the type "number of countries," the report will list the countries that achieved the target by the end of 2011.

VII. **Conclusions and Recommendations:** This section will present the main conclusions and recommendations of the end-of-biennium assessment.

8. Drafts of sections III, IV, and V are included as Annexes A, B, and C, respectively, to provide SPBA Members an overview of the methodology employed for the assessment and of the preliminary results of the Organization's programmatic and budget performance during 2010–2011. A sample Strategic Objective progress report is included in Annex D so that Members can see the proposed level of detail that will be included in the complete report.

**Action by the Subcommittee on Program, Budget, and Administration**

9. The Subcommittee is asked to issue recommendations on the proposed outline for preparation of the full "Program and Budget 2010–2011 End-of-Biennium Assessment/ Second Interim PAHO Strategic Plan 2008–2012 Progress Report."

Annexes

# ANNEX A

## METHODOLOGY

1. This report reflects the assessment conducted by the 69 Pan American Sanitary Bureau (PASB) entity managers and the Strategic Objective teams according to the progress toward achievement of the 16 Strategic Objectives (SOs), 90 Region-wide Expected Results (RERs), and 256 RER indicator targets at the end of the 2010–2011 biennium. The assessment includes both quantitative and qualitative methods, described below.

2. First, the achievement of the RER indicator targets set for the end of 2011 is evaluated based on the information provided by the entity managers. This part of the methodology is quantitative—the target was either met or not—and the entity managers are accountable for achievement of the results under their responsibility and for the information they provide. For indicators of the type "number of countries," the reports of the country entity managers are aggregated to find out whether the number of countries required to meet the RER indicator target was achieved. Subsequently, a qualitative analysis of the RERs is undertaken, and finally, on the basis of this information, a qualitative analysis of the SOs is done. In both cases the number of targets of the RER indicators that were achieved is addressed.

3. The following rating criteria have been applied for the programmatic and budgetary monitoring of the RERs and SOs:

- 90-100% implementation rate = Green, or "on track": no impediments or risks are expected to significantly affect progress.
- 75-89% implementation rate = Yellow, or "at risk": progress is in jeopardy and action is required to overcome delays, impediments, and risks.
- <75% implementation rate = Red, or "in trouble": progress is in serious jeopardy due to impediments or risks that could preclude the achievement of targets.

4. Rates of 75% and above for programmatic implementation and 90% for budgetary implementation are considered an acceptable performance at the end of the planning period, as established in the Strategic Plan 2008–2012.

5. A brief description of the methodology used in each component of the report is included below.

**Programmatic Assessment**

6. *Analysis by SO:* Progress toward the achievement of the Strategic Objectives (SOs), set for the end of the Strategic Plan, is assessed by SO Facilitators. The Facilitators analyze the aggregated level of achievement of the respective RERs and factors contributing to the progress or hindrance of the SO achievement (qualitative assessment), taking into consideration the RER indicator targets achieved (quantitative assessment). The SO Facilitator rates the status of the SO at the end of the biennium and determines whether it is on track, at risk, or in trouble with respect to its achievement by 2013.

7. *Analysis by RER:* The assessment of RERs is done by the RER Facilitators. They assess the level of achievement of the RER indicator targets (quantitative assessment) and factors contributing to or hindering RER achievement (qualitative assessment). The RER Facilitator rates the status of the RER at the end of the biennium with respect to its achievement by 2013, determining whether it is on track, at risk, or in trouble.

8. *Analysis by RER indicator target:* Achievement of the RER indicators is measured by the attainment of their respective targets set for each biennium; that is, they are either achieved or not achieved.

**Budgetary Assessment**

9. *Budgetary implementation:* This is assessed for the Organization as a whole; by organizational level (country, subregional, and regional entities); by SO; and by source of funds, including both regular budget (RB) and other sources (OS). The budgetary implementation rate is obtained by dividing expenditures over the total amount of funds available for the biennium.

10. *Mobilization of resources:* The Program and Budget (PB) establishes the estimated amount of funds (planned cost) required to implement the program of work approved by the Governing Bodies for a given biennium. The PB also establishes the estimated amount of funds required for each SO. During the biennium, the PASB mobilizes resources to fill the funding gap of each SO. In line with Results-based Management (RBM), each entity plans the cost of its biennial work plan (regardless of the source of funds) according to the estimated amount of resources required to achieve its expected results and outputs during that biennium. During the biennium, resources are mobilized to fill the funding gap of SOs and entities, which in turn contribute to filling the Organization-wide funding gap. (At any point in the biennium, the difference between the original estimate and the current available resources from any source to fulfill the program is the funding gap.)

# ANNEX B

## PROGRAMMATIC PERFORMANCE ASSESSMENT

(Please note that these are preliminary figures pending final reconciliation.)

1. *Progress toward the achievement of the SOs:* At the end of the second period of implementation of the Strategic Plan (2010–2011 biennium), 12 of the Strategic Objectives (SOs) were on track (green) and 4 were at risk (yellow: SO1, SO3, SO9, and SO14). It is worth noting that there was no SO in trouble (red). As shown in Table 1, the overall performance of SOs improved compared to 2008–2009; the number of SOs at risk decreased from 5 to 4 at the end of the 2010–2011. It is worth noting that while SO2, SO6, and SO11 went from being at risk to on track, the opposite occurred with SO1 and SO14. The assessment of the Region-wide Expected Results RERs and RER indicators also indicates an overall improvement in the progress made toward achieving the targets set under each SO. The complete analysis, including achievements, challenges, and lessons learned, will be included in the complete report that will be presented to the Executive Committee in June 2012.

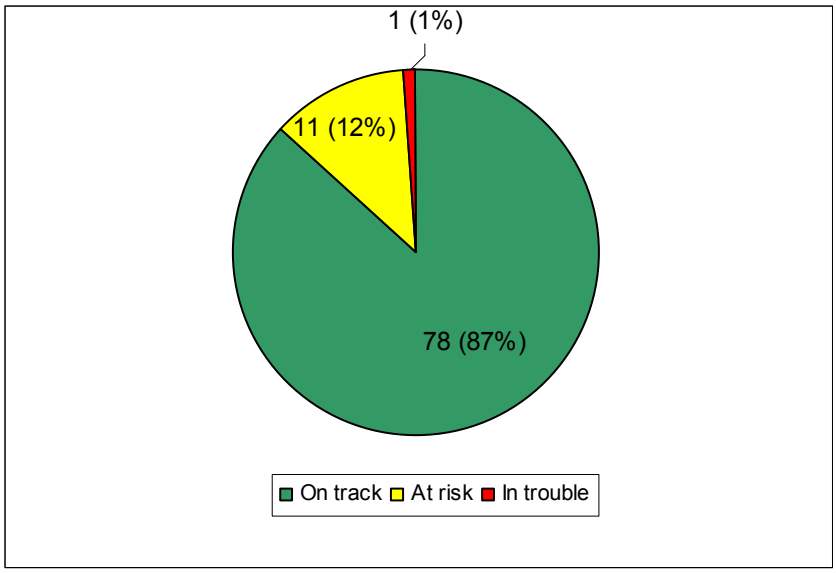
**Table 1. Progress toward Achieving Strategic Objectives, 2008–2009 and 2010–2011 Biennia**

| Strategic Objectives | | 2008–2009 | 2010–2011 |
|---|---|---|---|
| SO1 | Communicable diseases | On track | At risk |
| SO2 | HIV/AIDS, TB, and malaria | At risk | On track |
| SO3 | Chronic noncommunicable diseases (CNCD) | At risk | At risk |
| SO4 | Maternal, child, adolescent, and elderly health | On track | On track |
| SO5 | Emergencies and disasters | On track | On track |
| SO6 | Health promotion and risk factors | At risk | On track |
| SO7 | Social and economic determinants of health | On track | On track |
| SO8 | Healthier environment | On track | On track |
| SO9 | Nutrition, food safety, and food security | At risk | At risk |
| SO10 | Health services | On track | On track |
| SO11 | Health systems leadership and governance | At risk | On track |
| SO12 | Medical products and technologies | On track | On track |
| SO13 | Human resources for health | On track | On track |
| SO14 | Social protection and financing | On track | At risk |
| SO15 | PAHO/WHO leadership and governance | On track | On track |
| SO16 | Flexible and learning organization | On track | On track |
| PAHO | | 69% on track | 75% on track |

On track  At risk

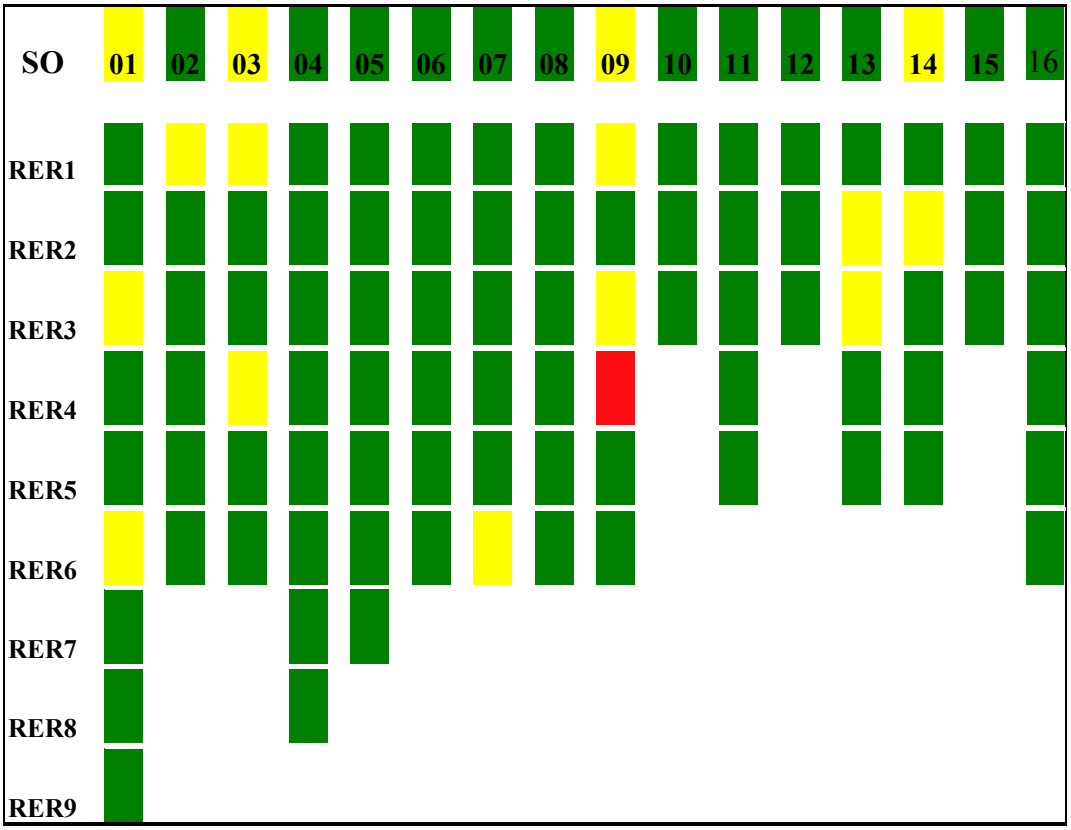
2. *Progress toward the achievement of the RERs:* As shown in Figure 1, of the 90 RERs, 78 (87%) were on track (green) and 11 (12%) were at risk (yellow). One was assessed as being in trouble (red); this was RER 9.4, "development, strengthening and implementation of plans and programs for improving nutrition through the life-course." Figure 2 shows the color rating for each RER, and Table 2 contains the 11 RERs rated at risk. Compared to 2008–2009, there was a reduction of 10 in the number of RERs rated at risk. However, of the 11 RERs rated at risk, 8 were at risk in 2008–2009 as well. These are marked with asterisks in Table 2 for ease of reference. Close attention needs to be paid to these RERs and their indicators in 2012–2013 in order to improve the progress being made on the respective topics.

**Figure 1: Progress toward the Achievement of RERs, End-of-Biennium, 2010–2011**




3. Figure 2 displays the rating of SOs and their respective RERs. The majority of RERs at risk are in SO1 (communicable diseases), SO3 (noncommunicable diseases), SO9 (nutrition, food safety, and food security), and SO13 (human resources for health). SO9 is the only one with an RER in trouble (red), as noted above.

**Figure 2: Progress toward the Achievement of SOs and RERs, End-of-Biennium, 2010–2011**




On track At risk In trouble

SO1 - Communicable diseases
SO2 - HIV/AIDS, TB, and malaria
SO3 - Chronic noncommunicable diseases (CNCD)
SO4 - Maternal, child, adolescent, and elderly health
SO5 - Emergencies and disasters
SO6 - Health promotion and risk factors
SO7 - Social and economic determinants of health
SO8 - Healthier environment
SO9 - Nutrition, food safety, and food security
SO10 - Health services
SO11 - Health systems leadership and governance
SO12 - Medical products and technologies
SO13 - Human resources for health
SO14 - Social protection and financing
SO15 - PAHO/WHO leadership and governance
SO16 - Flexible and learning organization

4. As shown in Table 2, most of the RERs at risk are related to high-level policy and macro interventions to scale up and sustain achievements, requiring continued political commitment of Member States and advocacy from the Secretariat to raise their priority within national agendas. Some of these RERs also include new commitments that require additional effort and resources from within and beyond the health sector. These considerations should inform future operational and strategic planning.

**Table 2: Region-wide Expected Results "At Risk," 2010–2011**

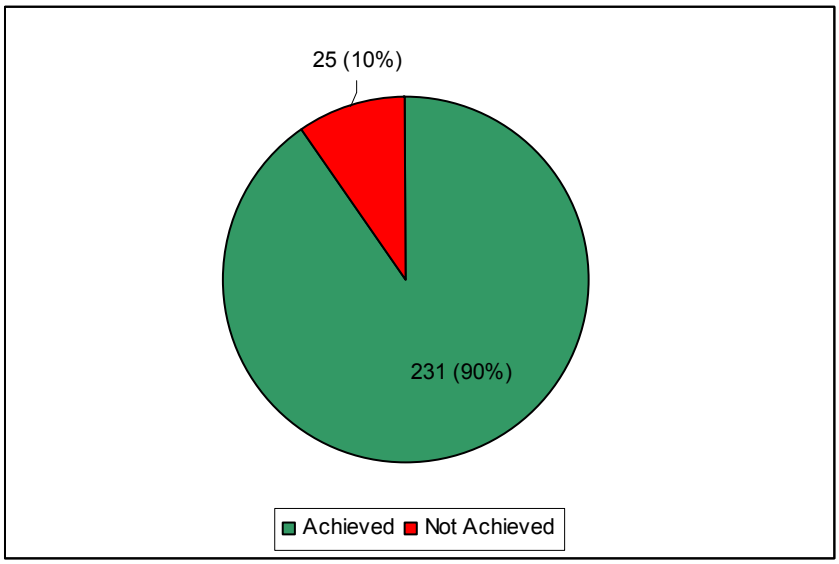
| Strategic Objective | RER No. | RER |
|---|---|---|
| SO1 - Communicable diseases | 1.3 | Prevention, control, and elimination of neglected diseases communicable diseases ** |
| | 1.6 | International health regulations and epidemic alert and response ** |
| SO2 - HIV/AIDS, TB, and malaria | 2.1 | Prevention, treatment, and care of HIV/AIDS, TB, and malaria ** |
| SO3 - Chronic noncommunicable diseases (CNCD) | 3.1 | Increased political, financial, and technical commitment for CNCD conditions ** |
| | 3.4 | Improved evidence on the cost-effectiveness of interventions for CNCD conditions ** |
| SO7 - Social and economic determinants of health | 7.6 | Policies, plans, and programs that apply an intercultural approach based on primary health care, and strategic alliances and partnerships to improve the health and well-being of indigenous peoples and racial/ethnic groups |
| SO9 - Nutrition, food safety, and food security | 9.1 | Partnerships, alliances, and intersectoral actions to increase investment in nutrition and food safety and security ** |
| | 9.3 | Surveillance, monitoring, and evaluation of food security, nutrition, and policy options ** |
| SO13 - Human resources for health | 13.2 | Establishment of a set of basic indicators and information systems on human resources for health |
| | 13.3 | Formulation and implementation of strategies and incentives to recruit and retain health personnel based on primary health care |
| SO14 - Social protection and financing | 14.2 | Evaluation of the relationship between catastrophic expenses in health and poverty, and public policies to reduce financial risks associated with diseases and accidents** |

** At risk since 2008–2009.
*Note:* Short titles for RERs are used for ease of reference.

5. *Status of RER indicators:* The assessment of the RER indicator targets shows that of a total of 256 indicators, 231 (90%) were achieved and 25 (10%) were not achieved (Figure 3). This marks a 5 percentage point increase in targets achieved compared to

2008–2009. It should be noted that considerable progress was made in the nonachieved indicators. However, the methodology used only considers those that fully met their target as achieved; there is no allowance for partial achievement. The details for each RER indicator will be included in the final report, including the list of countries that achieved the targets by the end of 2011 for the indicators of the type "number of countries."

**Figure 3: Achievement of RER Indicator Targets, End-of-Biennium, 2010–2011**



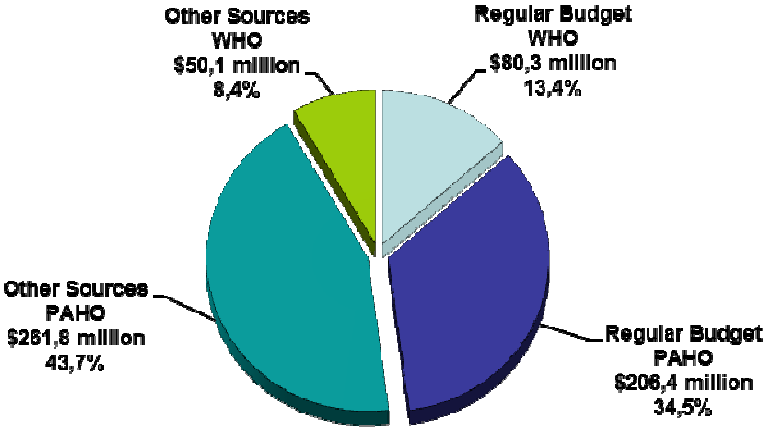
# ANNEX C

## BUDGET AND RESOURCE MOBILIZATION

(Please note these are preliminary figures pending final reconciliation.)

1. *Budget overview:* The approved Program and Budget was $643million[1] for base rograms, of which $599 million (93%) was available for the biennium. This represents an increase of $40 million over the amount of funds available in 2008–2009 ($559 million). As shown in Figure 4, of the total amount of funds available for the biennium, 48% or $287 million came from the regular budget (RB: $206.4 million from PAHO and $80.3 million from WHO—the AMRO share), while 52% or $312 million came from other sources (OS: $261.8 million from PAHO and $50.1 million from WHO). It should be noted that budget figures included in this document do not include funds from national voluntary contributions (formerly referred to as government-financed internal projects), the Revolving Fund, the Strategic Fund, funds for Outbreak Crisis and Response (OCR), or any other funds that are not directly funding the Strategic Plan.

**Figure 4: Funds Available for the Biennium, 2010–2011, by Source**




2. Table 3 shows the distribution of funds available by Organizational level. It is noted that the distribution of funds available by Organizational level (as percentage of the total funds available for the biennium) complied with the Regional Program Budget

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

Policy (RPBP).[2] While the Policy applies only to RB funds, it also guided the allocation of OS funds.

**Table 3: Budget Overview by Organizational Level, Biennium 2010–2011**

| Organizational Level | Approved Program and Budget 2010–2011 (US$ thousands) | Funds Available for the Biennium (US$ thousands) | Funds Available for the Biennium as % of Program Budget 2010–2011 | Distribution of Funds Available (as % of total funds available) |
|---|---|---|---|---|
| Country | 234,860 | 232,566 | 99% | 39% |
| Subregional | 43,699 | 30,425 | 70% | 5% |
| Regional | 364,392 | 336,004 | 92% | 56% |
| Total | 642,951 | 598,994 | 93% | 100% |

3. *Overall budgetary implementation:* The total budgetary implementation was $513.5 million (86% of $599 million available for the biennium). As shown in Table 4, the implementation rate was consistent across the different levels of the Organization.

**Table 4: Budgetary Implementation by Organizational Level and Source of Funds, End-of-Biennium, 2010–2011**

| Organizational Level | Funds Available for the Biennium (US$ thousands) | Expenditure (US$ thousands) | Implementation Rate (%) |
|---|---|---|---|
| Country | 232,566 | 193,008 | 83% |
| Subregional | 30,425 | 25,447 | 84% |
| Regional | 336,004 | 295,014 | 88% |
| Total | 598,994 | 513,469 | 86% |

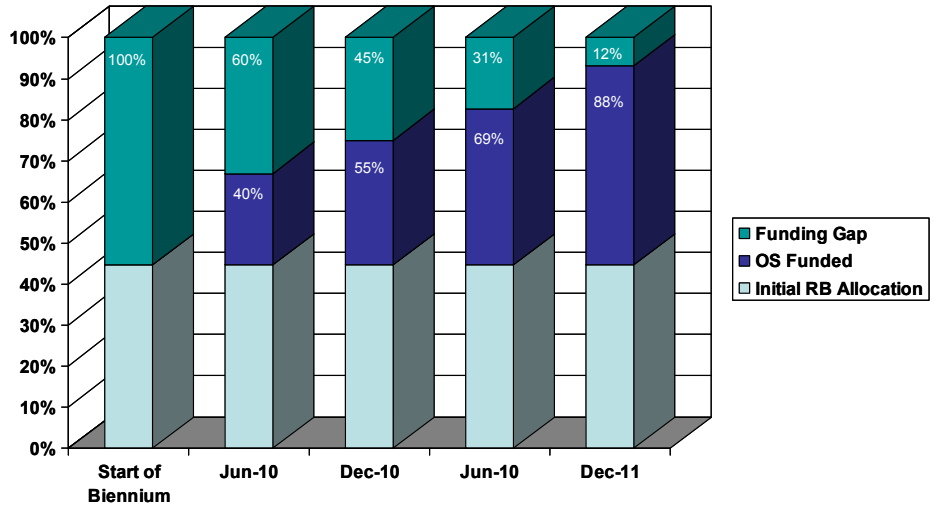
4. *Resource mobilization:* Of the $643 million approved Program and Budget, $287 million was expected from the regular budget ($206.4 from PAHO and $80.7 from WHO). The difference, $356 million, was the initial funding gap expected from other sources. During the biennium, the Organization was able to mobilize $312 million, reducing the funding gap to $44 million or 12%. Table 5 shows the funding gap at the beginning and at the end of the biennium, and Figure 5 shows the progressive reduction of the funding gap during the biennium. The Organization was successful in mobilizing about 10% ($31 million) more funds from other sources compared to 2008–2009.

[2] The RPBP stipulated the following distribution of RB funds for the 2010–2011 biennium: country 40%, subregional 7%, and regional 53%.

**Table 5: Status of the Funding Gap, End-of-Biennium, 2010–2011**

| Funding Type | Beginning-of-Biennium (US$ thousands ) | End-of-Biennium (US$ thousands) |
|---|---|---|
| Approved Program and Budget 2010–2011 (PB 10–11) | 642,951 | 642,951 |
| Regular Budget | 287,100 | 286,697 |
| Resources mobilized | 0 | 311,894 |
| Funding gap | (355,851) | (44,360) |

**Figure 5: Status of the Funding Gap During the Biennium, 2010–2011**




5. *Funding by Strategic Objective:* Figure 6 and Table 6 show the budget by SO, according to the approved Program and Budget, funds available for the biennium, and expenditure. Of the 16 SOs, 13 obtained over 75% of their expected level of funding. Of the 14 core technical cooperation SOs (SO1–SO14), SO9 (nutrition, food safety, and food security) had the highest funding. It was followed by SO12 (medical products and technologies), SO11 (health systems leadership and governance), SO1 (communicable diseases), and SO4 (maternal, child, adolescent, and elderly health). SO15 and SO16 (enabling functions) also had high funding levels. A complete analysis of the funding by SO will be included in the final report.

6. As shown in Table 6, all SOs had an overall budgetary implementation rate of 75% or above, with the exception of SO4 and SO12, which had 68% and 69%, respectively.

**Figure 6: Budget Overview by Strategic Objective, 2010–2011**

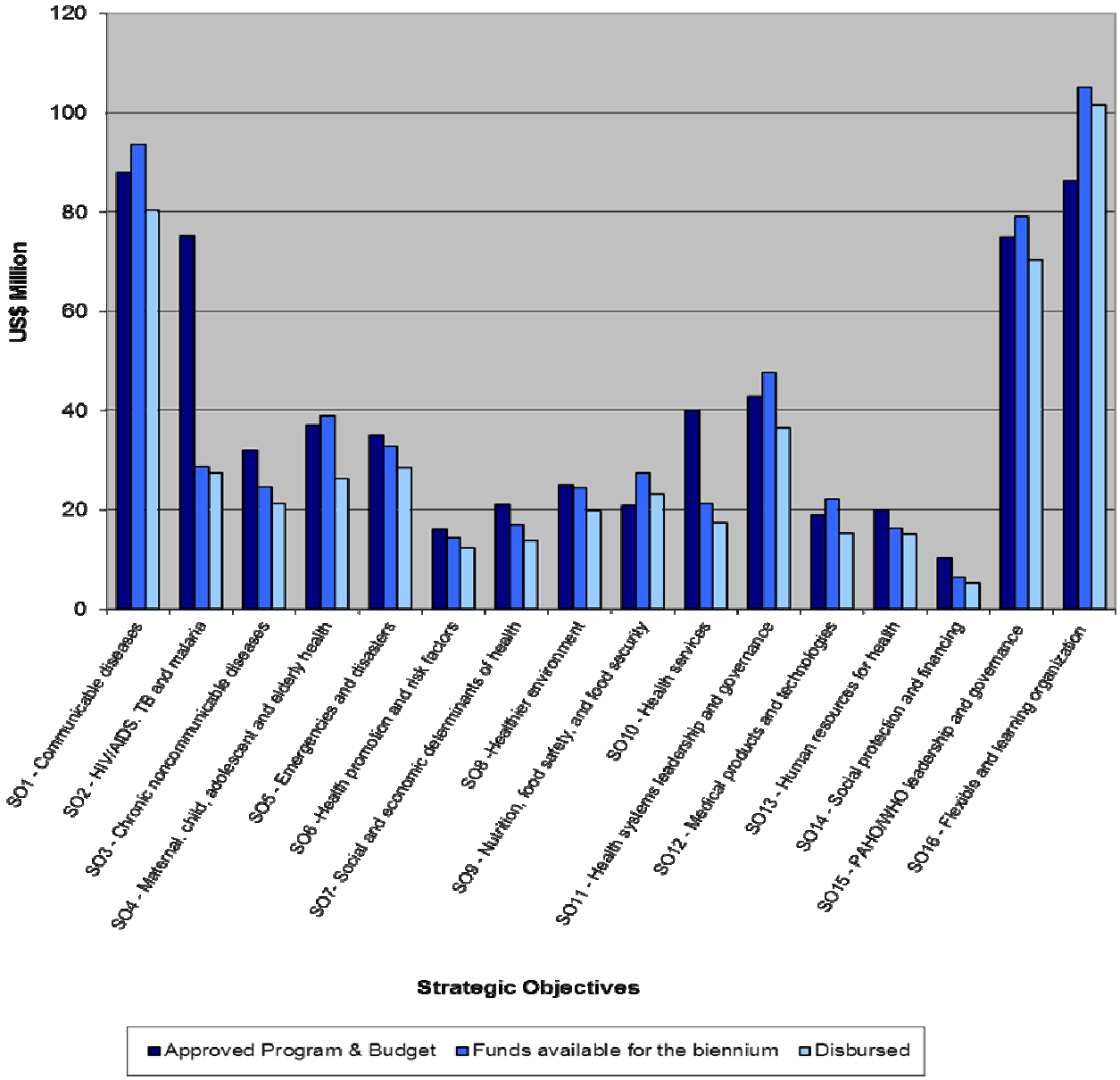


**Table 6: Budget by Strategic Objective, End-of-Biennium, 2010–2011**

| Strategic Objective | Approved Program and Budget (US$ millions) | Funds Available for the Biennium (US$ millions) | | Expenditure (US$ millions) | Implementation Rate (%) |
|---|---|---|---|---|---|
| | | Total | % | Total | Total |
| SO1 - Communicable diseases | 87.9 | 93.5 | 106% | 80.3 | 86% |
| SO2 - HIV/AIDS, TB, and malaria | 75.1 | 28.6 | 38% | 27.4 | 96% |
| SO3 - Chronic noncommunicable diseases | 31.9 | 24.6 | 77% | 21.2 | 86% |
| SO4 - Maternal, child, adolescent, and elderly health | 37.1 | 38.8 | 105% | 26.3 | 68% |
| SO5 - Emergencies and disasters | 35.0 | 32.7 | 93% | 28.4 | 87% |
| SO6 - Health promotion and risk factors | 16.0 | 14.4 | 90% | 12.2 | 85% |
| SO7 - Social and economic determinants of health | 21.0 | 16.9 | 80% | 13.8 | 82% |
| SO8 - Healthier environment | 24.9 | 24.3 | 98% | 19.8 | 81% |
| SO9 - Nutrition, food safety, and food security | 20.9 | 27.3 | 131% | 23.1 | 84% |
| SO10 - Health services | 40.0 | 21.2 | 53% | 17.3 | 82% |
| SO11 - Health systems leadership and governance | 42.8 | 47.7 | 111% | 36.4 | 76% |
| SO12 - Medical products and technologies | 19.0 | 22.2 | 117% | 15.3 | 69% |
| SO13 - Human resources for health | 19.9 | 16.2 | 81% | 15.0 | 93% |
| SO14 - Social protection and financing | 10.3 | 6.4 | 62% | 5.3 | 82% |
| SO15 - PAHO/WHO leadership and governance | 74.9 | 79.1 | 106% | 70.3 | 89% |
| SO16 - Flexible and learning organization | 86.3 | 105.0 | 122% | 101.5 | 97% |
| **Total** | **643** | **599.1** | **93%** | **513.5** | **86%** |

7. *Resource allocation versus prioritization of Strategic Objectives:* The Strategic Plan ranked the SOs by programmatic priority (excluding the SOs related to enabling functions SO15 and SO16) to guide resource mobilization and allocation during the implementation of the Plan.

8. Table 7 shows the SOs ranked according to their programmatic priority, from 1 (highest priority) to 14 (lowest priority), as approved in the Strategic Plan. It also shows the funds available for each SO for the 2008–2009 and 2010–2011 biennia. The percentage difference between the two biennia shows a positive shift in the allocation of resources among three of the five top priority SOs. It is worth noting that the two highest priority SOs (SO4 and SO1) had the greatest percentage increase among these five. In reviewing these figures, it should be noted that the alignment of resources with programmatic priorities is a complex process due to the limited flexibility in the allocation of most resources available to the Organization during a biennium. For instance, over 70% of RB funds are linked to fixed-term posts (FTP), which are not easily transferred or distributed to different SOs due to the technical association of the posts with their relevant SOs. Also, the majority of voluntary contributions received by the Organization continue to be highly earmarked, which restricts the Secretariat's ability to allocate resources to the priority SOs. While efforts will be made to continue improving the alignment between programmatic priorities and allocation of resources, this is a gradual process that will take several years to address.

**Table 7: Programmatic Priority Ranking vs. Resource Allocation in 2008–2009 and 2010–2011**

| Strategic Objective | Priority Ranking | Funds Available for the Biennium (US$ millions) | | % Difference 2008–2009 to 2010–2011 |
|---|---|---|---|---|
| | | 2008–2009 | 2010–2011 | |
| SO4 - Maternal, child, adolescent and elderly health | 1 | 24.7 | 38.8 | 57% |
| SO1 - Communicable diseases | 2 | 75.1 | 93.5 | 25% |
| SO2 - HIV/AIDS, TB, and malaria | 3 | 34.9 | 28.6 | -18% |
| SO3 - Chronic noncommunicable diseases | 4 | 21.0 | 24.6 | 17% |
| SO7 - Social and economic determinants of health | 5 | 17.5 | 16.9 | -3% |
| SO13 - Human resources for health | 6 | 14.8 | 16.2 | 9% |
| SO10 - Health services | 7 | 34.4 | 21.2 | -38% |
| SO8 - Healthier environment | 8 | 19.1 | 24.3 | 27% |
| SO6 - Health promotion and risk factors | 9 | 14.2 | 14.4 | 1% |
| SO14 - Social protection and financing | 10 | 4.9 | 6.4 | 31% |
| SO11 - Health systems leadership and governance | 11 | 31.1 | 47.7 | 53% |
| SO12 - Medical products and technologies | 12 | 19.2 | 22.2 | 16% |

| Strategic Objective | Priority Ranking | Funds Available for the Biennium (US$ millions) | | % Difference 2008–2009 to 2010–2011 |
|---|---|---|---|---|
| | | 2008–2009 | 2010–2011 | |
| SO5 - Emergencies and disasters | 13 | 49.3 | 32.7 | -34% |
| SO9 - Nutrition, food safety, and food security | 14 | 15.8 | 27.3 | 73% |

# ANNEX D

## SAMPLE STRATEGIC OBJECTIVE AND RER PROGRESS REPORTS

(Please note: These are examples of the Strategic Objectives (SOs) and Region-wide Expected Results (RERs) reports for illustration purposes only)

### (1) Sample Strategic Objective Progress Report

| **SO1: To reduce the health, social, and economic burden of communicable diseases** | | | | | SO Rating<br>At risk |
|---|---|---|---|---|---|
| **Approved Budget (PB 10–11)** | **Funds Available** | | | **Expenditure (%)** | **Funded (%)** |
| | **RB** | **OS** | **Total** | | |
| **$87,985,000** | **24,518,064** | **68,942,156** | **93,460,220** | **86%** | **106%** |

**Progress toward achievement of the SO in 2013**

**Progress toward achievement of the SO impact-level indicator targets as established in the PAHO Strategic Plan 2008–2012:**

**1. Reduction of the mortality rate in children under five years old due to vaccine-preventable diseases in the Region.**

**Baseline:** 47 per 100,000 children under five years old in 2002
**Target:** 31 per 100,000 by 2013

Although no specific data are available at this time, it is expected that there has been a significant reduction in the mortality rate in children under five years of age due to vaccine-preventable diseases (VPDs) in the Region. Hence, the target should be met by 2013. This result is expected given the high vaccination coverage among targeted cohorts achieved by the countries against those diseases most commonly associated with childhood death (such as rotavirus, pneumococcus, meningococcus, and haemophilus influenzae type b). Those countries which have not introduced the vaccines have expressed their commitment to do so in the near future. It is estimated that 174,000 lives of children in the Region of the Americas are saved each year as a result of immunization, and this number is expected to continue to increase with the introduction of new vaccines.

**2. Number of countries maintaining certification of poliomyelitis eradication in the Region.**

**Baseline:** 38 countries in 2006
**Target:** 38 countries by 2013

Currently all countries of the Americas maintain their polio-free status and expect to sustain eradication through 2013 and beyond. A plan of action to maintain the Americas free of poliomyelitis during the transition from the pre- to post-eradication eras was developed. The plan includes a comprehensive strategy to enhance all aspects of community protection and epidemiologic surveillance. Considering that the Region of the Americas remains at risk of importing the virus from countries where it is still circulating, a regional analysis of risk was conducted, and specific strategies have been developed to maintain eradication in the global context. Finally, countries are expected to maintain certification standards for acute flaccid paralysis (AFP) surveillance, in compliance with surveillance indicators, and report periodically to the regional level.

**3. Number of countries achieving and maintaining the elimination of measles, rubella, congenital rubella syndrome, and neonatal tetanus in the Region.**

**Baseline:** 0 countries in 2006
**Target:** 38 countries by 2013

At the end of 2011, all 38 countries/territories in the Region had achieved the interruption of endemic transmission of measles, rubella, and congenital rubella syndrome. In an effort to maintain elimination, all countries are implementing PAHO-recommended interventions, including the periodic implementation of follow-up campaigns, strengthening of rapid response plans to quickly detect and respond to outbreaks, high-quality integrated measles/rubella surveillance that meets surveillance indicators, and targeted vaccination activities aimed at achieving >95% coverage in municipalities. All countries/territories have also established national commissions and are working to finalize country reports in order to submit them to the International Expert Committee during the first semester in 2012. At the Pan American Sanitary Conference (PASC) in September 2012, a progress report will be presented, as well as a plan of action to consolidate this goal.

With respect to the elimination of neonatal tetanus, Haiti is the only country that has not achieved the target, and it is unlikely to achieve it by 2013 unless a plan is developed and implemented in 2012. One major component of the country's plan to eliminate neonatal tetanus is to conduct a vaccination campaign.

**4. Number of countries that have fulfilled the core capacity requirements in surveillance, response, and points of entry, as established in the 2005 International Health Regulations (IHR).**

**Baseline:** 0 countries in 2007
**Target:** 35 countries by 2013

Twenty-six countries have submitted their annual reports to the World Health Assembly. Although the countries have achieved widely varying levels of core capacity, none has fully met all IHR requirements.

**5. Reduction in the lethality rate due to dengue (dengue hemorrhagic fever/dengue shock syndrome) in the Region.**

**Baseline:** 1.3% in 2006
**Target:** 1.0% by 2013

The current lethality rate is 0.071 under the new WHO classification.

**6. Number of countries with certification of Chagas disease vector transmission interrupted, in the 21 endemic countries in the Region.**

**Baseline:** 3 countries in 2006
**Target:** 15 countries by 2013

Fourteen countries are certified to have interrupted Chagas disease vector transmission (ARG, BLZ, BOL, BRA, CHI, COR, ELS, GUT, HON, MEX, NIC, PAR, PER, URU).

**7. Number of endemic countries in the Region with onchocerciasis elimination certification.**

**Baseline:** 0 of the 6 endemic countries
**Target:** 1 country by 2013.

Colombia officially requested the certification of onchocerciasis elimination.

| **2010–2011 SO Assessment** |
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| Strategic Objective 1 is assessed as at risk (yellow), but significant progress has been made at the RER level during the biennium. Of the 9 RERs, 7 were assessed as on track (green) and 2 as at risk (yellow); the two at risk are RER 1.3, related to neglected zoonotic diseases, and RER 1.6, related to the implementation of IHR. Of the 22 RER indicator targets, 18 were achieved and 4 were not. |
| **Main achievements:**<br>(1) Collaboration with Haitian authorities to develop a country plan of action for the upcoming measles/rubella/ polio follow-up campaign to protect the gains in elimination of these diseases while strengthening the routine vaccination services in the country.<br>(2) Hispaniola response to cholera outbreak.<br>(3) Steady work for infection prevention and control (IPC) in Caribbean countries: Trinidad and Tobago, Belize, and Guyana are consolidating their national plans and interventions.<br>(4) Early warning capacity in place at country offices and member states.<br>(5) Publication of book, *Thirty Years of the Immunization Newsletter: The History of the EPI in the Americas*, which highlights experiences and lessons learned that have made the Immunization Program of the Americas one of the most successful life-saving initiatives in the world.<br>(6) Advances toward achieving the regional elimination targets for neglected infectious diseases (NID) such as onchocerciasis, Chagas, and schistosomiasis.<br>(7) Regional consensus achieved in 2011 on IHR monitoring approach.<br>(8) Strengthened multidisciplinary and collaborative approach between the Regional Alert and Response Team, PAHO's technical experts, and PAHO/WHO Representative Offices, to detect, assess, and verify public health threats on a 24/7 basis.<br>(9) PAHO´s role as IHR focal point strengthened: 710 events were assessed, and 61 epidemiological alerts, 30 reports, 4 interactive maps, and 39 advisories and recommendations on international public health threats were issued.<br>(10) Lab capacity increased: new resistance mechanisms are detected, supported by the horizontal collaboration of the Antimicrobial Resistance Surveillance Network.<br>**Main challenges:**<br>(1) The impact of vaccination interventions targeting low-coverage municipalities is not easily demonstrated, given that data are still unavailable and countries continue to carry out plans of action for reaching these vulnerable populations.<br>(2) There is need to strengthen epidemiological surveillance of vaccine-preventable diseases and ensure the quality of data in periodic reports.<br>(3) Insufficient resources at the national and international levels endanger the achievement of neglected infectious disease elimination targets and make it difficult to achieve core capacities for IHR and alert and response activities for public health events of international concern (PHEIC) on a 24/7 basis.<br>(4) There is a limited number of specialized human resources who can respond to public health risks.<br>(5) Multidisciplinary collaboration across PAHO areas to assess and verify events needs to be strengthened to better comply with PAHO's mandate.<br>(6) A high level of advocacy must be maintained to guide ministries of health in making informed decisions about extension of the deadline for IHR implementation.<br>(7) There is a need to identify synergies and partnerships to review human resources policies to secure establishment and maintenance of competencies in field epidemiology and other public health–related disciplines. |

**Lessons learned:**

(1) Collaboration with strategic partners is critical to supporting the revitalization of the immunization program in Haiti.
(2) Advocacy for measles/rubella eradication must continue in global forums, and countries must remain vigilant to quickly address importations to the Region.
(3) Integration of NID activities in other public health programs is necessary to achieve targets.
(4) Research has been key to fostering a stronger and more targeted response for preventing and controlling priority infectious diseases.
(5) Advocacy communication is a cornerstone for the countries.
(6) World Health Day 2011 put antimicrobial resistance in the spotlight and facilitated technical cooperation activities at the country level.

**Budget implementation and resource mobilization analysis:**

Of the $93.5 million available for this SO, 26% was from the regular budget and 74% from other sources (or voluntary contributions). This SO was among the top five highest-funded SOs during the biennium, which corresponded with the level of priority given in the PAHO Strategic Plan.

| RER No. | RER Facilitator's Assessment | RER Facilitator's Progress Report |
|---|---|---|
| RER 1.1 - Member States supported through technical cooperation to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies; strengthen immunization services; and integrate other essential family and child health interventions with immunization. | On track | PAHO worked in collaboration with Member States and strategic partners to strengthen and maintain the credibility of immunization (IM) programs by providing equitable, quality services to all individuals. Technical cooperation provided during 2010–2011 supported vaccination coverage improvements at all levels while prioritizing effective interventions to reach at-risk areas and overcome challenges that continue to impede access to IM services. Continuous efforts have guaranteed that the PAHO Revolving Fund maintains visibility to procure quality, safe vaccines at the lowest cost. The vast experiences of the Americas in introducing new vaccines and strengthening surveillance have been shared with other regions. These achievements are made evident through the efforts of the countries and fulfillment of RER 1.1 indicators for 2010–2011. The indicator related to low-coverage municipalities continues to present challenges despite country efforts and resource mobilization with partners. Although it is expected that data available in 2012 will demonstrate marked improvements, countries will continue to implement interventions to increase vaccination coverage in these areas in the upcoming biennium. |

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| RER 1.2 - Member States supported through technical cooperation to maintain measles elimination and polio eradication; and achieve rubella, congenital rubella syndrome (CRS) and neonatal tetanus elimination. | On track | Technical cooperation was provided to complement country efforts in maintaining measles/rubella/CRS elimination and polio eradication in the Region. All countries have implemented vaccination and surveillance interventions to maintain these achievements. The Plan of Action to maintain the Americas free of polio during the transition from the pre- to post-eradication eras was developed to enhance community protection and surveillance. The implementation of this plan will also require that countries maintain certification standards for acute flaccid paralysis (AFP) surveillance. The Region achieved the elimination of endemic rubella/CRS in 2010 and is on track for achieving the documentation/verification of measles/rubella/CRS elimination in 2012. A primary challenge is the constant threat of importations, increasing the risk that endemic measles/rubella transmission will be reestablished. Countries must remain vigilant in order to quickly detect and respond to importations. |
| RER 1.3 - Member States supported through technical cooperation to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases. | At risk | Important advances have been made toward the achievement of this RER and its indicators. With respect to leprosy, 18 countries achieved targets for elimination or maintenance of baselines, but Argentina fell from baseline. For human rabies, the elimination target for the biennium was achieved in 2011. For zoonotic diseases, countries continue developing, updating, and testing preparedness plans. With respect to Chagas, three of four target countries achieved interruption of transmission and/or certification of elimination (Colombia did not). Argentina and Nicaragua recovered their baseline status, and elimination/ nterruption of transmission of secondary vectors was achieved in some baseline countries. The new guidelines on neglected infectious diseases (NID) have been disseminated and their implementation started in all target countries, significant progress has been made individually for trachoma, filariasis, schistosomiasis, and onchocerciasis; the most recent advance was the certification of elimination of onchocerciasis in Colombia. Mobilization of financial and human resources for NIDs remains a challenge to achieve the targets by 2015, as mandated by Resolution CD49.R19 (2009). |

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| RER 1.4 - Member States supported through technical cooperation to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system. | On track | Countries continue working to enhance their surveillance systems in the Region. The mandate of the International Health Regulations (IHR) requires countries to build, strengthen, and maintain capacities for surveillance of and response to communicable diseases. Therefore, multiple efforts across SO1 are contributing to the strengthening of this expected result. Countries are engaged in enhancing their surveillance systems at the national and local levels, and are progressing at different levels in their integration. Most countries and territories of the Region, including target countries, report on immunization surveillance, and PAHO ensures the provision of feedback to guarantee quality and timely information. The countries of the Region continue enhancing their infection prevention and control and antimicrobial resistance surveillance at the national and hospital levels. The enhanced detection capacity has been demonstrated by the more frequent detection and reporting of outbreaks in health care facilities. As countries advance in their surveillance systems, it is a challenge to refine the indicators to determine appropriate means of verification and close monitoring of countries that are falling behind in the process. |
| RER 1.5 - Member States supported through technical cooperation to enhance their research capacity and to develop, validate and make available and accessible new knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases. | On track | Despite some limitations of funding and human resources, particularly due to the TDR/WHO financial crisis, this RER was achieved. Capacity was strengthened and research performed in target countries as well as other countries of the Region. Tools such as quantitative real-time polymerase chain reaction (qPCR) as a biomarker of Chagas disease cure were evaluated using different methods. In addition, this technique was standardized with the participation of 20 countries of the Region and one country from Europe. Systematic reviews and priorities were defined for leishmaniasis, rabies, and leptospirosis. Networking between researchers on innovative vector control was also established. |

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| RER 1.6 - Member States supported through technical cooperation to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern. | At risk | The deadline for establishing IHR core capacity is June 2012. The definition of core capacity in IHR is very broad and covers all hazards; to date, no ministry of health (MOH) in the Region has achieved it. The at-risk status of this RER is also attributable to differing obligations, timelines, and means of verification set by IHR, making the determination of MOHs with core capacity possible only after June 2012. It is anticipated that countries will request a two-year extension in 2012, a decision that is both political and technical in nature. If the decision to request extension is based on a solid action plan, it should be regarded as positive, consistent with public health preparedness as an intrinsically dynamic process. Toward this end, PAHO should provide guidance to MOHs to help them make informed deadline extension decisions; mobilize resources to implement MOH action plans; identify procedures for IHR implementation and long-term monitoring (the regional consensus reached in 2011 on the monitoring approach is a main achievement); maintain high-level advocacy; communicate the public health benefits of IHR compliance; and identify synergies and partnerships to review human resources policies to secure establishment and maintenance of competencies in field epidemiology. |
| RER 1.7 - Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g., influenza, dengue, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox). | On track | With all Member States having put in place standard operating procedures within their influenza pandemic preparedness plans for rapid response teams since the second semester of 2010, PAHO continues working to maintain gains and strengthen countries' capacity for nationwide intensified surveillance of acute respiratory infections (SARI). This provides actionable information that national and local decision-makers can use to activate Regional Response Teams (RRTs). Detection of epidemic-prone viral pathogens has been achieved in Member States located in endemic areas for yellow fever and flavivirus and will be maintained. Work continues on achieving a standardized protocol for flavivirus diagnostic testing in the Americas; an expert meeting was held in August in Pergamino, Argentina, to facilitate this consensus. Interventions and control strategies for dengue have been achieved and continue on track. These center on establishment of integrated management strategies for dengue (EGI-dengue) in target countries, evaluation, and implementation in baseline countries, and trainings on new clinical guidelines for treatment of dengue patients. As the vector for Chikungunya and dengue virus are the same, and the two diseases have a similar clinical profile, joint regional trainings were implemented. |

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| RER 1.8 - Regional and Subregional capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern. | On track | In this biennium it has been possible to detect, verify, and evaluate 710 public health events of international concern (PHEIC) within the time recommended by IHR (no more than 48 hours). This collective achievement at all organizational levels allowed compliance with IHR requirements, and should be regarded as a priority in all involved areas. To alert Member States on public health risks, 61 epidemiological alerts were issued, as well as 39 notifications and recommendations, 30 reports. and 4 interactive maps. The Alert and Response team maintained its 24/7 operation to guarantee early detection and response to PHEIC. To verify the needed functionality for an opportune response by Member States, periodic communication tests were held with all 35 IHR Focal Points of the Region. An alert and response website was redesigned to make information more accessible to Member States and to facilitate the identification, evaluation, and dissemination of event information. |
| RER 1.9 - Effective operations and response by Member States and international community to declared emergencies situations due to epidemic and pandemic prone diseases. | On track | In order to promote a coordinated response from the Region, and in line with its IHR mandate, PAHO continues supporting countries during public health events. Technical cooperation was provided to several countries, especially to Haiti and the Dominican Republic on the island of Hispaniola during the cholera outbreak. Guidelines were issued and other preparedness efforts undertaken against potential outbreaks of diseases such as plague and leptospirosis and the possible occurrence of *E. coli*. Standard Operating Procedures (SOPs) for deployments in case of public health emergencies have been disseminated to partners of the Global Outbreak Alert and Response Network (GOARN) in the Region. Lessons learned and recommendations to move forward with regionalization of GOARN were agreed upon in June 2011 during a meeting in Brasilia, Brazil. Contingency funding is required, especially to facilitate a timely initial response during emergencies. |

## (2) Sample RER Progress Report

| **RER 1.1 - Member States supported through technical cooperation to maximize equitable access of all people to vaccines of assured quality, including new or underutilized immunization products and technologies; strengthen immunization services; and integrate other essential family and child health interventions with immunization.** | **RER Rating** |
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| | **On track** |

**RER Assessment** (3 of 4 RER indicator targets achieved and exceeded)

PAHO worked in collaboration with Member States and strategic partners to strengthen and maintain the credibility of immunization (IM) programs by providing equitable, quality services to all individuals. Technical cooperation provided during 2010–2011 supported vaccination coverage improvements at all levels while prioritizing effective interventions to reach at-risk areas and overcome challenges that continue to impede access to IM services. Continuous efforts have guaranteed that the PAHO Revolving Fund maintains visibility to procure quality, safe vaccines at the lowest cost. The vast experiences of the Americas in introducing new vaccines and strengthening surveillance have been shared with other regions. These achievements are made evident through the efforts of the countries and fulfillment of RER 1.1 indicators for 2010–2011. The indicator related to low-coverage municipalities continues to present challenges despite country efforts and resource mobilization with partners. Although it is expected that data available in 2012 will demonstrate marked improvements, countries will continue to implement interventions to increase vaccination coverage in these areas in the upcoming biennium.

| Ind. No. | Type of Indicator | RER Indicator Text | 2009 Baseline | Target 2011 | Target Achieved? | Comments/Recommendations[3] |
|---|---|---|---|---|---|---|
| 1.1.1 | Number of countries | Number of countries achieving more than 95% vaccination coverage at national level (DPT3 as a tracer) | 20 | 22 | Yes (exceeded) | **2009 Baseline:** ABM, ANI, ARG, BAH, BLZ, BRA, CUB, DOM, ECU, ELS, GRA, GUY, MEX, NIC, PAN, SAL, SAV, SCN, TRT, USA<br>**2011 Target:** HON, PER<br>Honduras, a 2011 target country, successfully reached 96% coverage with DPT3 vaccine. Peru, also a 2011 target country, identified coverage gaps at the municipality level and will continue to strengthen efforts to improve coverage in these target municipalities. During 2011, although 3 countries fell from the baseline (ELS, MEX, and USA), an additional 10 countries and territories |

[3] The list of countries included in this column correspond to the information available at the closing of the assessment.

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| | | | | | | (BOL, CHI, FDA, GUT, HON, JAM, PAR, SUR, TCA, VEN) achieved >95% coverage, resulting in a total of 27 countries and territories achieving this indicator target. Hence, the anticipated target of 22 countries for the end of 2011 was exceeded by 5 countries. Countries that did not achieve coverage goals have planned interventions to reach unvaccinated populations. It is recommended that countries continue to develop and implement Expanded Program on Immunization plans of action to ensure high coverage in 2012–2013. |
| 1.1.2 | Percentage | Percentage of municipalities with vaccination coverage level less than 95% in Latin America and the Caribbean (DPT3 as a tracer using baseline of 15,076 municipalities in 2005) | 44% | 34% | No | Although 2% improvement was observed, 42% of municipalities in LAC countries reported coverage <95%. It is expected that 2011 data (available in April 2012) will demonstrate a decline in the number of low-coverage municipalities, given that (1) technical cooperation was provided to countries with highest number of at-risk municipalities (BRA, COL, HAI, PER, VEN); (2) countries continue to develop and implement plans of action to ensure homogeneous coverage; and (3) partners continue to provide support prioritizing high coverage in these areas. |
| 1.1.3 | Number of countries | Number of countries that have included pneumococcal and/or rotavirus sentinel surveillance in their national epidemiologi-cal system | 5 | 10 | Yes (exceeded) | **2009 Baseline:** BRA, ECU, ELS, NIC, PAN<br>**2011 Target:** BLZ, BOL, COR, GUY, HON, MEX, PAR, URU<br>A total of 18 countries confirmed that pneumococcal and/or rotavirus sentinel surveillance had been established in their national systems during the biennium. They included all 5 baseline countries, the 8 target countries for 2011, plus 5 additional |

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| | | | | | | countries: COL, DOR, GUT, PER, and VEN. |
| 1.1.4 | Number of countries | Number of countries that purchase the vaccines for their National Immunization Program through the PAHO Revolving Fund for Vaccine Procurement | 32/38 | 33/38 | Yes (exceeded) | **2009 Baseline:** ABM, ANI, ARG, BAH, BAR, BLZ, BOL, BRA, COL, COR, CUB, DOM, DOR, ECU, ELS, FDA, GRA, GUT, GUY, HON, JAM, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, VEN |
| | | | | | | **2011 Target:** CHI, NEA |
| | | | | | | At the end of 2011 a total of 34 countries/territories are purchasing vaccines for their national immunization programs through the PAHO Revolving Fund (RF). The most recent addition is Chile, which purchased almost all of its vaccines through the RF in 2010 and plans to continue in 2012. In addition, the Netherlands Antilles confirmed that they obtain vaccines through the Revolving Fund |

**Countries and Territories**

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|---|---|
| ABM | Anguilla, British Virgin Islands, and Montserrat (United Kingdom Overseas Territories) |
| ANI | Antigua and Barbuda |
| ARG | Argentina |
| BAH | Bahamas |
| BAR | Barbados |
| BLZ | Belize |
| BOL | Bolivia |
| BRA | Brazil |
| CAN | Canada |
| CHI | Chile |
| COL | Colombia |
| COR | Costa Rica |
| CUB | Cuba |
| DOM | Dominica |
| DOR | Dominican Republic |
| ECU | Ecuador |
| ELS | El Salvador |
| FDA | French Departments in the Americas |
| FEP | United States–Mexico Border Field Office in El Paso, Texas |
| GRA | Grenada |
| GUT | Guatemala |
| GUY | Guyana |
| HAI | Haiti |
| HON | Honduras |
| JAM | Jamaica |
| MEX | Mexico |
| NCA | Northern Caribbean (Bermuda and the Cayman Islands) |
| NEA | Netherlands Antilles |
| NIC | Nicaragua |
| PAN | Panama |
| PAR | Paraguay |
| PER | Peru |
| PUR | Puerto Rico |
| SAL | Saint Lucia |
| SAV | Saint Vincent and the Grenadines |
| SCN | Saint Kitts and Nevis |
| SUR | Suriname |
| TCA | Turks and Caicos |
| TRT | Trinidad and Tobago |

**Countries and Territories**

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|---|---|
| URU | Uruguay |
| USA | United States of America |
| VEN | Venezuela (Bolivarian Republic of) |