Addendum I

to the proposed Program and Budget 2012–2013
Pan American Health Organization

JUSTIFICATION FOR THE PROPOSED INCREASE IN ASSESSED CONTRIBUTIONS

CONTENTS

INTRODUCTION

1. The proposed Program and Budget for 2012–2013 is being presented with a $16.2 million[1] reduction with regard to the 2010–2011 Program and Budget (from $642.9 million to $626.7). This proposed Program and Budget is the last within the PAHO Strategic Plan 2008–2012 and the commitments of the Organization to achieve the 2013 targets agreed to in the Strategic Plan. It also considers the Results-Based Management (RBM) approach and recognizes the resource mobilization scenarios for the upcoming biennium.

2. In developing the proposed Program and Budget, the following criteria were considered to establish the total budget and distribute it among the Strategic Objectives (SOs) (Annex 5 shows the detailed analysis):

(a) Programmatic implementation in 2008–2009 and up to December 2010. In 2008–2009, the Organization achieved 85% of its RER indicator targets for that biennium, using 84% ($525 million) of the 2008–2009 Program and Budget ($626 million).

(b) Alignment of the budget with the programmatic prioritization as established in the PAHO Strategic Plan. Member States also requested this alignment during the 50th Directing Council in September 2010.

(c) Contribution of the SOs to the Millennium Development Goals (MDGs) and the Health Agenda for the Americas. The priorities in the Country Cooperation Strategies were also considered.

(d) The budgetary implementation rate and resource mobilization (measured by the reduction in the funding gap) by SO.

3. This document presents five aspects of the Bureau's justification. The first part presents the value that the Organization adds to its Member States. The second presents the overall need for an increase in the assessed contributions, showing three scenarios and their relative impact on the non-FTP budget.

4. The third part provides an overview of the expected impact on PAHO's technical cooperation programs if a 0% increase in assessed contributions is considered. This scenario will put several important interventions at risk, which are presented within the context of the Strategic Objectives (SOs).

5. The fourth part presents PASB's systematic effort over time to exercise budget discipline by reducing the number of posts (especially fixed-term posts). The analysis shows an increase in productivity compared to the previous biennium, despite an ongoing workforce reduction.

6. The fifth part presents PASB's programmatic and budgetary performance efforts to apply the Results-Based Management (RBM) Framework requested by the Member States, especially in ensuring that the targets approved for the Strategic Plan are met. The 2012–2013 biennium is particularly important: because it is the last two-year period within the PAHO Strategic Plan 2008–2012, it represents the last opportunity to make any necessary adjustments, based on analysis and evidence, to ensure that the Region-wide Expected Results and targets are achieved by 2013.

[1] Unless otherwise indicated, all monetary figures in this document are expressed in US dollars.

I. PAHO's VALUE-ADDED TO ITS MEMBER STATES

7. Since it was founded in 1902, PAHO has served as a forum for defining and unifying efforts and reaching consensus among the countries of the Region of the Americas in regards to public health issues.

8. As the premiere intergovernmental agency in matters of health, PAHO can effectively mobilize resources from assessed contributions and from voluntary contributions from different sources. Assessed contributions from quotas established for each Member State are transferred to the countries to implement technical cooperation programs, as stipulated in the Regional Program Budget Policy approved by PAHO's Governing Bodies. The Budget Policy proportionately grants more resources to countries that have greater needs to improve the health and well being of their populations.

9. Given the Organization's credibility and its transparent management of resources, it also is able to mobilize voluntary contributions from various sources to bolster its technical cooperation with Member States. In addition, PAHO can harness expertise from the Bureau and from Collaborating Centers and other specialized agencies to support Member States in addressing issues of shared interest.

10. The Organization also adds value in the following areas:

(a) Influence on the global health agenda to assert its perspective and interest, as well as to share its experiences;

(b) Export the image of well-being and good performance of the health systems of the Region in order to foster a climate of investments and promote tourism;

(c) Timely and permanent access to good quality vaccines, drugs, and other supplies at the best possible prices through the Revolving Fund for Vaccines Procurement, the Regional Revolving Fund for Strategic Public Health Supplies and the Reimbursable Procurement Mechanism;

(d) Access to databases and scientific forums worldwide;

(e) Participation in inter-country initiatives that have achieved historical successes in the elimination and control of several diseases at the hemispheric and global level;

(f) Support with immediate responses to disasters, emergencies, and epidemic outbreaks to strengthen the surveillance systems and health services, reducing the vulnerability to the population and mitigating the effects of the natural or man-made catastrophes and epidemics;

(g) Participation and benefits from the world surveillance systems, reporting and control of diseases;

(h) Development of policy and research agenda that addresses priority public health issues in the Region;

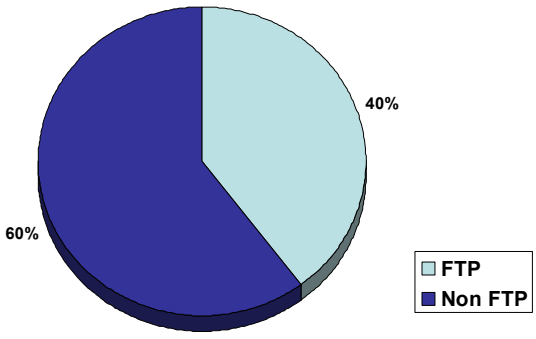
(i) PAHO has a long history of supporting the development of human resources for health in the Region. The Organization provides direct technical cooperation to Member States with its own human resources but it also facilitates the mobilization of national human resources from Member States, Specialized Collaborating Centers and from other Regions of WHO to address gaps at national level, while building the national capacity in key areas.

II. BUDGET ASSESSMENT AND JUSTIFICATION FOR AN INCREASE IN ASSESSED CONTRIBUTIONS

11. The proposed Program and Budget is presented with a view to meeting the targets set in the Strategic Plan by 2013. The budget is based on the costing of the work that needs to be done to meet these commitments. In Scenario D, the Program will be funded with 46% from the Regular Budget (RB) and 54% from other sources (OS), with most of these (about 90%) being highly earmarked. This RB/OS ratio is critical to maintaining the equilibrium that guarantees the collective Organization's mandates while responding to Member States' priorities. Although it is difficult to predict the level of resources that will be mobilized in light of the prevailing economic crisis, and bearing in mind that there may be an overall reduction in the AMRO component of voluntary contributions, the Bureau will do its utmost to mobilize the level of resources required to effectively implement its 2012-2013 Program. It should be emphasized that the proposed RB level is essential for maintaining the Organization's governance, including its core and enabling functions, flexibility for addressing priorities, and ability to mobilize the additional resources required to effectively implement the Program.

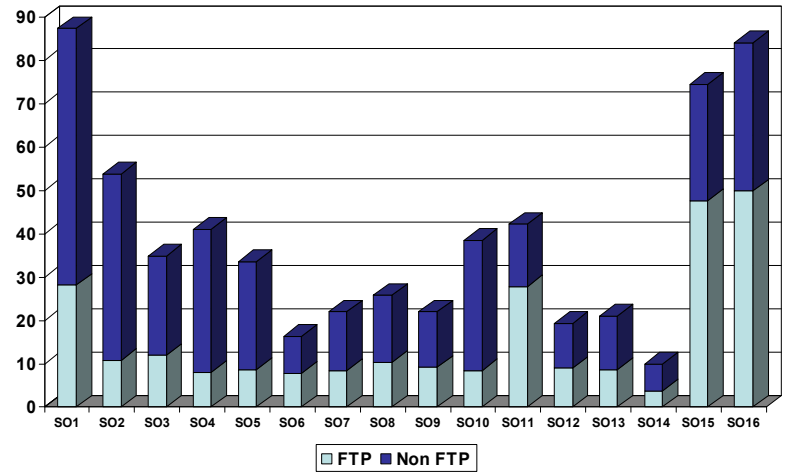
12. Figure 1 shows that the total estimated cost of fixed-term posts (FTPs) for 2012-2013 is 40% and for non-FTP, 60% of the entire Program. This includes FTPs funded from Regular Budget as well as Other Sources. This ratio indicates that the Bureau will have an adequate balance of operating funds to implement activities (non-FTP) for technical cooperation.

Figure 1
Ratio of FTP and Non FTP of Proposed Program and Budget
(All funding sources)



13. Figure 2 shows the funding by SO and the ratio of FTP to non-FTP budget. The FTP/non-FTP budget ratio by SO varies as shown in Figure 2, demonstrating that depending on the nature of the SO, targets could be met with different FTP to non-FTP budget ratios. All SOs, with the exception of SOs 11, 15, and 16, have a major portion of non-FTP funding, thereby demonstrating that sufficient funding would be available for operational purposes. It should be noted that SOs 15 and 16 require less non-FTP funds because they cover enabling functions that support implementation of the core functions covered under SOs 1-14. In the case of SO 11 (health systems leadership and governance), a significant portion of the non-FTP is complemented with funds under SOs 10, 13, and 14, which cover areas related to health systems and services.

Figure 2
FTP and Non FTP Ratio of Proposed Program and Budget
(All funding sources in US$ Thousands)



The Cost Impact of Fixed-term Posts on the Regular Budget

14. The regular budget (RB) is comprised of two major components: a fixed-term post (FTP) budget and a non-fixed-term post (non-FTP) budget. The FTP budget includes all costs associated with fixed-term posts approved for a particular budget period. The non-FTP budget includes all other costs not related to FTP. These could be: **a) cost of non-FTP activities**—program and operational activities, such as expenditures for travel, meetings, publications, courses and seminars, and general operating expenses), and **b) cost of non-FTP personnel**—personnel hired through any mechanism other than fixed-term posts.

15. A key step in accurately projecting future budget requirements is to estimate the total cost of the fixed-term posts (FTP) required to carry out the desired program of work. Increases in the cost of FTPs are based on current data and foreseeable trends.

16. The cost of FTPs is subject to the following factors:

(a) Statutory increases due to normal succession patterns (changes in staff grade or annual step increments; annual step increases granted subject to satisfactory performance).

(b) Statutory increases due to higher costs for staff health insurance, pension contributions, cost-of-living supplements approved by the United Nations International Civil Service Commission (UNICSC), and other costs over which the Bureau has no control. These increases do not consider increases in salaries, which have remained virtually frozen in real terms for the past 12 to 15 years.

(c) Inflationary increase or decrease due to exchange rate impact, manifested by the conversion to U.S. dollars of salaries denominated in local currencies, or through post adjustment changes for professional staff salaries.

(d) Inflationary increases or decreases due to absolute FTP number changes at duty stations.

17. An analysis performed for actual costs incurred during 2010 for FTPs funded with the Regular Budget revealed that the budget for FTPs is under-budgeted by 6.1%. In the 2010–2011 biennium,

$206,200,000 will be needed. Table 1 below compares the amount budgeted for regular budget FTPs included in the approved budget for 2010–2011 with the current projection for 2010–2011 based on actual costs for 2010.

Table 1: Comparison of FTP Approved Budget versus Actual Costs for 2010-2011

2010–2011 FTP Regular Budget	2010–2011* Actual Cost for FTPs	% Change
$194,300,000	$206,200,000	6.1%

* Calculated with December 2010 payroll data and projected until the end of the biennium 2010–2011

18. However, an additional 2% increase to the actual cost of FTPs is needed for expected statutory increases during 2012-2013 bringing up the FTP budget to $210.3 million. (See Table 2)

Table 2: Comparison of FTPs Actual Costs for 2010-2011 versus Estimated Costs for 2012–2013

2010–2011 Actual Cost For FTPs	2012–2013 Estimated Cost for FTPs	% Change
$206,200,000	$210,300,000	2%

19. In recent years, the falling price of the US dollar worldwide has been the major contributing factor in the increased dollar-based cost of FTPs. This is true for general service posts, particularly in countries where salaries are denominated in local currencies other than the US dollar, and for professional-level posts, where significant compensatory increases in the post adjustment have been mandated by the UNICSC for most duties stations in the Region.

20. During the 2010–2011 biennium, in keeping with budgetary discipline, PASB's Director has further reduced 18 fixed-term posts (20 that were abolished at the regional level and 2 new posts that were created at the subregional level), representing a saving of $4.9 million. Despite this effort, real FTP cost has increased 6.1% (to $206.2 million) as mentioned above. The Bureau is monitoring and managing the situation carefully to ensure that the program implementation is balanced between the FTP and non-FTP components of the budget, in order to minimize any negative impact on achieving the current biennium's expected results**.** (Note: Given current trends in the U.S. dollar, actual costs for 2012–2013 are likely to be higher than estimated; as mentioned previously, however, added cost increases based on speculation of future economic indicators are not factored in the FTP cost figure).

21. The continued trend in the devaluation of the US dollar, which has played a large part in the excessive cost increases experienced during the past biennia, continues to reverse against most Latin American and Caribbean currencies. The total effect of the inflationary and US dollar devaluation factors on PAHO's non-FTP regular budget for the current biennium is estimated at approximately $3.6 million, which is being absorbed within the current biennium's budget.

Assessed Contributions

22. In determining the level of the proposed 2012–2013 regular budget, three funding scenarios were considered: Scenario A - full cost recovery (a 10.5% increase in assessed contributions); Scenario B - partial cost recovery (a 6.7% increase in assessed contributions); and Scenario C - no increase in

assessed contributions. During the 148th session of the Executive Committee, an additional scenario was requested that included an intermediate level of assessed contributions between scenarios B and C, maintaining 0% nominal growth in the overall regular budget and a further reduction in FTP cost. Hence, the Bureau is presenting a new Scenario D with a 4.3% increase in assessed contributions.

23. Scenarios A and B include an FTP budget of $210.3 million. This figure involves the reduction of 18 FTPs, representing a $4.9 million reduction in the FTP budget proposal. In both of these scenarios, the proposed funding from Miscellaneous Income is estimated at $15 million and the AMRO share remains constant at $80.7 million, as approved by the 64th WHA.

24. Scenarios C and D incorporate a FTP budget of $209.4 million. This figure involves the reduction of 21 FTPs, representing a $5.8 million reduction in the FTP budget proposal. In both of these scenarios, the proposed funding from Miscellaneous Income is estimated at $12 million, based on the most recent available financial forecast, and the AMRO share remains constant at $80.7 million, as approved by the 64th WHA.

25. **Scenario A.** This scenario (full cost recovery) considers a 10.5% increase in the assessed contributions; in it, all inflationary and statutory costs for both FTP and non-FTP components would be compensated, representing an overall budget of $301.7 million.

Table 3. Scenario A: Full Cost Recovery
(In thousands of US dollars)

	2010–2011		2010–2011 adjusted		2012–2013		
	Approved Program Budget	Cost increase	Total	% increase	Cost increase	Total	% increase
FTP	194,300	11,900	206,200	6.1%	16,000	210,300	8.2%
Non-FTP	92,800	3,600	96,400	3.9%	3,600	96,400	3.9%
Total	**287,100**	**15,500**	**302,600**	**5.4%**	**19,600**	**306,700**	6.8%
					Miscellaneous income reduction	(5,000)	
					Proposed 2012–2013 Budget	301,700	

26. With this level of increase in the assessed contributions, the non-FTP budget (cost of operational activities of the Organization, including personnel hired through any mechanism other than FTP) would be decreased by 15.5% overall, compared to the 2010–2011 biennium.

Table 4. Regular Budget Proposal for 2012-2013
Scenario A
(In thousands of US dollars)

	2010-2011 $	Change $	2012-2013 $	Percentage %
To be financed from:				
Assessed Contributions	**186,400**	19,600	**206,000**	**10.5%**
Miscellaneous Income	20,000	(5,000)	15,000	-25.0%
WHO/AMRO (Approved by WHA)	80,700	-	80,700	0.0%
Regular Budget Total	**287,100**	**14,600**	**301,700**	**5.1%**
By Major Cost type:				
FTP				
Mandatory Costs (Statutory/Inflationary)	194,300	16,000	210,300	8.2%
Post Occupancy Charges*	-	12,200	12,200	6.3%
Total FTP	194,300	28,200	222,500	14.5%
Non-FTP (incl. county variable)	87,800	(13,600)	74,200	-15.5%
Retirees' Health Insurance	5,000	-	5,000	0.0%
Regular Budget Total	**287,100**	**14,600**	**301,700**	**5.1%**
Other Sources Total	**355,851**	**(14,600)**	**341,251**	**-4.1**
Total Budget	**642,951**	**-**	**642,951**	**0.0%**

* Includes mechanism to charge all PAHO funded posts to partially fund PMIS as presented to the 50th Directing Council in Document CD50/7 and endorsed through resolution CD50.R10.

27. **Scenario B** (partial cost recovery) considers an increase of 6.7% in the assessed contributions. In it costs are recovered for PAHO-funded FTPs only; inflationary costs on the non-FTP budget are absorbed. This scenario represents an overall budget of $294.5 million.

Table 5. Scenario B: Partial Cost Recovery
(In thousands of US dollars)

	2010–2011		2010–2011 adjusted		2012–2013		
	Approved Program Budget	**Cost increase**	**Total**	**% increase**	**Cost increase**	**Total**	**% increase**
FTP	194,300	8,300	202,600	4.3%	12,400	206,700	6.4%
Non FTP	92,800	3,600	96,400	3.9%	-	92,800	0.0%
Total	**287,100**	**11,900**	**299,000**	**4.1%**	**12,400**	**299,500**	4.3%
					Miscellaneous income reduction	(5,000)	
					Proposed 2012–2013 Budget	294,500	

28. With this level of increase in the assessed contributions, the non-FTP budget (cost of operational activities of the Organization, including personnel hired through any type of mechanism other than FTP) would decrease by 23.7%, overall, compared to the 2010–2011 biennium.

Table 6. Regular Budget Proposal for 2012-2013
Scenario B
(In thousands of US dollars)

	2010-2011	Change	2012-2013	Percentage
	$	$	$	%
To be financed from:				
Assessed Contributions	**186,400**	12,400	**198,800**	**6.7%**
Miscellaneous Income	20,000	(5,000)	15,000	-25.0%
WHO/AMRO (Approved by WHA)	80,700	-	80,700	0.0%
Regular Budget Total	**287,100**	**7,400**	**294,500**	**2.6%**
By Major Cost type:				
FTP				
Mandatory Costs (Statutory/Inflationary)	194,300	16,000	210,300	8.2%
Post Occupancy Charges*	-	12,200	12,200	6.3%
Total FTP	194,300	28,200	222,500	14.5%
Non-FTP (incl. country variable)	87,800	(20,800)	67,000	-23.7%
Retirees' Health Insurance	5,000	-	5,000	0.0%
Regular Budget Total	**287,100**	**7,400**	**294,500**	**2.6%**
Other Sources Total	**355,851**	**(7,400)**	**348,451**	**-2.1%**
Total Budget	**642,951**	**-**	**642,951**	**0.0%**

* Includes a mechanism to charge all PAHO-funded posts to partially fund PMIS, as presented to the 50th Directing Council in Document CD50/7 and endorsed through Resolution CD50.R10.

29. **Scenario C** involves no increase in the assessed contributions; neither inflationary nor statutory cost compensation is included. Scenario C involves a 2.8% reduction with respect to the overall 2010-2011 regular budget, from $287.1 to $279.1 million. It also includes an adjusted Miscellaneous Income estimated at $12 million, reflecting the most recent financial forecast. In addition, it eliminates 3 more FTPs for a total reduction of 21 FTPs, representing an additional savings of approximately $1 million in the FTP budget. Considering the increasing statutory and inflationary costs, a reduction in the overall Regular Budget poses a tremendous challenge to the Organization in its efforts to mobilize the level of additional resources required to implement its Program as originally proposed in Scenario B. For this reason, a $26.2 million reduction in the Other Sources budget over the 2010-2011 biennium is proposed: from $355.9 to $329.7 million. Therefore, the overall budget proposal is also decreasing from $643 million in 2010-2011 to $608.8. In line with the RBM approach, this reduction requires a corresponding reduction in the Program, which means that an estimated 19% of the Strategic Plan targets will not be met by 2013, as reflected in Section III.

Table 7. Scenario C: No Increase in the Assessed Contributions
(In thousands of US dollars)

	2010–2011		2010–2011 adjusted		2012–2013		
	Approved Program Budget	Cost increase	Total	% increase	Cost increase	Total	% increase
FTP	194,300	12,400	206,700	6.4%	-	194,300	0.0%
Non FTP	92,800	3,600	96,400	3.9%	-	92,800	0.0%
Total	**287,100**	**16,000**	**303,100**	**5.6%**	**-**	**287,100**	0.0%
					Miscellaneous income reduction	(8,000)	
					Proposed 2012–2013 Budget	279,100	

30. If there were to be no increase in the assessed contributions, the non-FTP budget (cost of operational activities, including personnel hired through any mechanism other than FTP) would decrease by 40.2% overall, compared to the 2010–2011 biennium.

Table 8. Regular Budget Proposal for 2012-2013
Scenario C
(In thousands of US dollars)

	2010-2011	Change	2012-2013	Percentage
	$	$	$	%
To be financed from:				
Assessed Contributions	**186,400**	**-**	**186,400**	**0.0%**
Miscellaneous Income	20,000	(8,000)	12,000	-40.0%
WHO/AMRO (Approved by WHA)	80,700	-	80,700	0.0%
Regular Budget Total	**287,100**	**(8,000)**	**279,100**	**-2.8%**
By Major Cost type:				
FTP				
Mandatory Costs (Statutory/Inflationary)	194,300	15,100	209,400	7.8%
Post Occupancy Charges*	-	12,200	12,200	6.3%
Total FTP	194,300	27,300	221,600	14.1%
Non-FTP (incl. country variable)	87,800	(35,300)	52,500	-40.2%
Retirees' Health Insurance	5,000	-	5,000	0.0%
Other Sources Total	**355,851**	**(26,166)**	**329,685**	**-7.4%**
By Major Cost type:				
FTP	36,700	2,863	39,563	7.8%
Non-FTP	319,151	(29,029)	290,122	-9.1%
Total Budget	**642,951**	**(34,166)**	**608,785**	**-5.3%**

* Includes a mechanism to charge all PAHO-funded posts to partially fund PMIS, as presented to the 50th Directing Council in Document CD50/7 and endorsed through Resolution CD50.R10.

31. **Scenario D** involves zero nominal growth compared to the overall 2010-2011 regular budget of $287 million, including a 4.3% increase in assessed contributions. It includes an adjusted Miscellaneous Income estimated at $12 million, reflecting the most recent financial forecast. It also eliminates 3 more FTPs, for a total reduction of 21 FTPs, representing an additional savings of approximately $1 million in the FTP budget. Considering the increasing statutory and inflationary costs, a 0% increase in the overall Regular Budget poses a tremendous challenge to the Organization in its efforts to mobilize the adequate level of additional resources required to implement its Program as originally proposed in Scenario B. For this reason, a $16.2 million reduction in the Other Sources budget of compared to the 2010-2011 biennium is proposed: from $355.9 to $339.6 million. Therefore, the overall budget proposal is also decreasing from $643 million in 2010-2011 to $626.7. In line with the RBM approach, this reduction requires a corresponding reduction in the Program, which means that approximately 9% of the Strategic Plan targets will not be met by 2013. A further analysis will be conducted to determine which RER indicator targets included in section III will not be met under this scenario.

32. With this level of increase in the assessed contributions, the non-FTP budget (cost of operational activities, including personnel hired through any mechanism other than FTP) would decrease by 31.1% overall, compared to the 2010–2011 biennium.

Table 9. Regular Budget Proposal for 2012-2013
Scenario D: Zero nominal growth in the regular budget
(In thousands of US dollars)

	2010-2011	Change	2012-2013	Percentage
	$	$	$	%
To be financed from:				
Assessed Contributions	**186,400**	8,000	**194,400**	**4.3%**
Miscellaneous Income	20,000	(8,000)	12,000	-40.0%
WHO/AMRO (Approved by WHA)	80,700	-	80,700	0.0%
Regular Budget Total	**287,100**	**-**	**287,100**	**0.0%**
By Major Cost type:				
FTP				
Mandatory Costs (Statutory/Inflationary)	194,300	15,100	209,400	7.8%
Post Occupancy Charges*	-	12,200	12,200	6.3%
Total FTP	194,300	27,300	221,600	14.1%
Non-FTP (incl. country variable)	87,800	(27,300)	60,500	-31.1%
Retirees' Health Insurance	5,000	-	5,000	0.0%
Other Sources Total	**355,851**	**(16,226)**	**339,625**	**-4.5%**
By Major Cost type:				
FTP	36,700	2,863	39,563	7.8%
Non-FTP	319,151	(19,089)	300,062	-6.0%
Total Budget	**642,951**	**(16,226)**	**626,725**	**-2.5%**

- Includes a mechanism to charge all PAHO-funded posts to partially fund PMIS, as presented to the 50th Directing Council in Document CD50/7 and endorsed through Resolution CD50.R10.

Illustration of the Net Effect of the Proposed Assessed Contributions and the Regular Budget Allocations by Country

33. This section illustrates the country-specific impact of the proposed assessed contributions, as compared with the regular budget allocation to countries due to the overall regular budget increase. The percentage allocation distribution of the Regular budget ceilings for 2012-2013 would essentially remain unchanged from those of 2010-2011.

34. Annexes 1 through 4 present three tables showing this comparison in terms of the three different scenarios: Annex 1 shows Scenario A, with a 10.5% increase in the assessed contributions; Annex 2 shows Scenario B, with a 6.7% increase in the assessed contributions; Annex 3 shows Scenario C, with no increase in the assessed contributions, and Annex 4 shows Scenario D, with a 4.3% increase in the assessed contributions.

III. EXPECTED NEGATIVE IMPACT ON PAHO'S TECHNICAL COOPERATION PROGRAM IN SCENARIO C

35. The section below presents an analysis of the expected negative programmatic impact by Strategic Objective (SO) under worst-case scenario C (0% increase in assessed contributions). The analysis includes a list of indicator targets for Region-wide Expected Results (RERs) that would be most affected (see Table 9). According to the analysis, about 19% (48 of 256) of the RER indicator targets would be affected. SOs 15 and 16 will be the most affected, because the enabling functions covered under these SOs are primarily funded by the Regular Budget. Of the core technical cooperation program, SOs 1, 2, 4, and 11 will have the most RER indicator targets affected.

36. The following considerations and assumptions were taken into account in the preparation of this analysis:

(a) There will be no further reduction in fixed-term posts, other than the 18 posts already reflected in the PB 2012–2013 proposal. This is critical for responding to commitments and priorities established in the PAHO Strategic Plan 2008–2012. Maintaining existing fixed-term posts may prove to be a challenge, given the increasing cost of technical cooperation and the need to have sufficient flexible regular budget funds to respond to the needs of Member States.

(b) The outcome from PAHO resource mobilization efforts will remain relatively similar to that of 2010–2011, except for those topics/RERs identified under each SO below.

(c) WHO funding from other sources is expected to remain at the same level as that in previous biennia. Given WHO's financial situation, however, resources allocated to AMRO could be reduced. Because these funds are allocated during the course of the biennium, the funding level will only be ascertained during the implementation of the PB 2012–2013.

(d) While the regional level will be the most affected under Scenario C, budget reductions at the country and subregional levels will further compromise the achievement of RER indicators, particularly the "number-of-countries" type indicators.

(e) Other external factors, such as the ongoing devaluation of the US dollar, will not worsen beyond current trends.

37. It is worth noting that while all the Organization's levels will be affected by a budget reduction, under Scenario C, the regional level would be left with insufficient resources to support basic operations. The impact on the SOs would vary, depending how much each one relies on regular-budget funds versus funds from other sources. For those SOs that depend heavily on regular-budget funding, the viability of several technical cooperation initiatives would be compromised. The situation may further be exacerbated if funds from other sources also decrease. For purposes of this analysis, funds from other sources have been assumed to remain relatively stable as indicated above.

38. In the event that there are insufficient funds to cover the commitments presented in the Program and Budget for 2012–2013, priorities will need to be reviewed to determine which activities will be discontinued and funds will be reassigned accordingly. This exercise will need to consider the progress made by countries, their internal capacity, and the support provided by other partners.

Strategic Objective 1: To reduce the health, social, and economic burden of communicable diseases.

39. This SO has been financed primarily with funds from other sources (over 60%). However, regular funds are key for performing basic functions. The level of earmarking and/or complementarity of the regular operating funds (non-FTP) varies significantly depending on the subject and program.

40. Regular funds are used for maintaining the indicators (through monitoring and participation in regional activities) and covering technical cooperation gaps not covered by voluntary contributions. Therefore, a reduction in such funds would imply a reduction in technical cooperation to non-priority countries. Since the majority of voluntary contributions are earmarked, and in some cases involves restrictions on using the funds in some countries, the flexibility of regular operating funds helps to mitigate this situation.

41. It also should be emphasized that thanks to regular operating resources, the Organization is able to provide immediate technical cooperation in emergencies, such as those that arise in epidemic outbreaks.

42. Under scenario C in particular, technical cooperation activities in the following areas will be compromised:

(a) surveillance systems and interventions to combat antimicrobial resistance, including infections in health care facilities, and the notification of data on immunization monitoring;

(b) operational research based on research priorities related to communicable diseases;

(c) PASB's verification of public health events of international concern within the recommended time frame of the International Health Regulations; and

(d) PASB's response to requests from the Member States during emergencies or epidemics, pursuant to the International Health Regulations.

Strategic Objective 2: To combat HIV/AIDS, tuberculosis, and malaria.

43. This SO has obtained substantial financing from other sources (nearly 75%). However, funds from other sources for this objective have been declining in recent years. This means that any cuts in the regular budget would further compromise efforts to combat HIV/AIDS, tuberculosis, and malaria.

44. This SO is a high priority, since it is related to the attainment of Millennium Development Goal (MDG) 6. Lowering the prevalence of tuberculosis, HIV, and malaria faces major challenges. Reducing financial and human resources will impair technical cooperation directed at achieving a sustainable response, strengthening the health sector, and guaranteeing the availability and appropriate use of high-quality medicines and diagnosis for these diseases. Under scenario C, in particular, the following will be affected:

(a) Technical cooperation to the countries for prevention and treatment activities would decrease. Efforts would concentrate on sustaining achievements. It should be noted that the HIV treatment recommendations changed in 2010, to include new criteria for initiating treatment with higher CD4 count (350, a significant increase from the previous level of 200). This change poses even greater challenges to attaining the target of 80% antiretroviral treatment coverage.

(b) Support to the countries for developing policies and plans for the prevention, support, and treatment of HIV/AIDS, tuberculosis, and malaria would be affected by the reduction of human and financial resources.

(c) Support to countries for accessing quality medicines would be seriously affected. Moreover, the impact on the quality control of donated blood would be substantial. Funds will be insufficient to maintain the regional external control program, and it will have to be discontinued. The countries would then lack an external performance evaluation component, thereby compromising compliance with the quality assurance required for blood screening.

(d) In reference to epidemiological surveillance, a reduction in the budget would in some cases imply a reversal of the progress made up to 2011.

(e) A reduction in resources would imply a reversal of the achievements made in previous biennia in terms of functional coordinating mechanisms for the three diseases at the country level.

(f) Resources for developing and promoting new knowledge, tools, and interventions would not be available to meet the challenges of the three diseases.

Strategic Objective 3: To prevent and reduce disease, disability, and premature mortality from chronic non-communicable conditions, mental disorders, violence, and injuries

45. Financing for this SO relies on a substantial share of regular funds (nearly 60%). Moreover, the bulk of voluntary contributions are directly tied to the donors' priorities and, in some cases, there are restrictions to use these funds in some countries. Regular operating funds are more flexible and make it possible to cover this gap.

46. Under scenario C, in particular, the technical cooperation in the following areas will be compromised:

(a) The implementation of institutional development mechanisms, including human and financial resources, adequate training, and intersectoral partnerships to address chronic noncommunicable diseases, mental and behavioral disorders, violence, traffic injuries, and disabilities.

(b) Development of policies, strategies, and regulations on chronic noncommunicable diseases, mental and behavioral disorders, violence, and disabilities.

(c) Information systems with indicators for chronic noncommunicable diseases, mental and behavioral disorders, violence, and disabilities. The development of cost-effectiveness studies on these subjects would also be affected.

(d) Development and implementation of multisectoral programs for mental health promotion, chronic noncommunicable diseases, and disabilities.

(e) Integration of chronic noncommunicable disease programs in the health services, within the framework of primary health care.

Strategic Objective 4: To reduce morbidity and mortality and improve health in key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

47. Approximately 50% of the financing for this SO comes from regular funds. The slow progress toward attaining MDG 4 (reducing child mortality) and MDG 5 (reducing maternal mortality), and the uneven progress between and within countries are matters for concern. The impact of a budget reduction on these MDGs and their indicators will be severe, especially in the poorest, most vulnerable, marginalized, and indigenous populations. A reduction in financial and human resources will jeopardize technical cooperation for strengthening the health systems' response to meet the challenges of these MDGs. Under scenario C, in particular, it will compromise technical cooperation in the following areas:

(a) Development of policies, plans, and advocacy throughout the life-course and activities to forge strategic partnerships. In some cases, the development of norms and standards also would be limited.

(b) Regional strategies and plans for neonatal health, integrated management of child health, adolescent and youth health, prevention of chronic malnutrition, and healthy aging would be implemented only in few countries.

(c) Resources would only be able to support half of the Region's countries in their efforts to attain MDG 4 (reducing child mortality) by 2015.

(d) Technical cooperation to the countries for child and neonatal health care would be affected precisely at a critical time for accelerating the decline in infant mortality, neonatal mortality, and mortality in children under 5, in line with the commitment to achieving MDG 4 by 2015. Perinatology programs would also be drastically damaged, to the extent that they could experience reversals in achievements made.

(e) Implementation of national neonatal plans, responsible for a 60% reduction in infant mortality, would be compromised; and Integrated Management of Childhood Illnesses (IMCI) clinical and community activities (in primary health care), including the activities with universities, would also be seriously affected. It is expected that technical cooperation for the implementation of the new WHO Child Growth Reference Standard also would be severely limited.

(f) Support for plans to promote universal access to reproductive health in the young population would be limited, along with pregnancy prevention plans, which are key to achieving MDG 5.

(g) Healthy aging programs, recently initiated in the majority of the countries, would be affected, and the targets for 2013 would not be met.

Strategic Objective 5: To reduce the health consequences of emergencies, disasters, crisis and conflicts, and minimize their social and economic impact.

48. This SO is heavily dependent on voluntary contributions and receives a very small percentage of regular budget funds (10%–20%). The allocation of core regular budget funds is essential to cover managerial expenses, mainly resource mobilization for preparedness and response and operating expenses, which are not allowable under voluntary contribution agreements. Any reduction of this small allocation will jeopardize the successful mobilization of other resources for this SO, in turn compromising the achievement of the RER indicators, since they operate mainly through voluntary contributions.

49. In summary, the small regular budget allocation is needed to allow the S05 to remain operational, both in disaster preparedness and in response operations.

Strategic Objective 6: To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions.

50. The composition of the 2010–2011 approved budget for SO 6 is 48% regular budget and 52% other sources. Because many of the technical cooperation activities are funded by non-FTP regular budget funds, the negative impact under this SO will be significant in the following areas:

(a) A decrease in funds will affect capacity building and will limit the design and support for the implementation of national and local health promotion policies, strategies, plans and programs. Fewer countries will be able to establish healthy schools networks.

(b) There will be a negative impact on the number of countries that strengthen their national surveillance systems of major risk factors, including the Global School Health Survey.

(c) In order to continue combating the tobacco epidemic, countries need to adopt and implement national legislation in accordance with the guidelines of the WHO Framework Convention on Tobacco Control (FCTC). While the 2013 target for implementing 100% smoke-free legislation has already been achieved, a reduction in the budget will make it difficult to provide additional support to countries as they move forward with the implementation of FCTC requirements. The budget reduction will also affect support for country efforts to ban tobacco advertising and to

promote, sponsor, and issue regulations regarding the packaging of tobacco products. This support is critical, because the tobacco industry has redoubled its efforts to interfere with this process. A decrease in technical cooperation in this area will further risk the possibility that countries can successfully confront this powerful industry. It will also make it difficult to adhere to the guidelines of the CD50.R6 resolution adopted in September 2010. Tobacco surveillance will continue, as its funding comes from other sources.

(d) The reduction in funds will translate into difficulties to develop regional documents and effective technical cooperation related to the use of alcohol, drugs, and other psychoactive substances.

(e) Member States will receive less direct technical cooperation, which will affect the number of national policies implemented to promote a healthy diet and physical activity and the number of countries with pedestrian and bike-friendly environments and physical activity promotion programs in their major cities.

(f) PASB will not be able to meet the demands of countries to support programs promoting sexual health care. This is of critical importance because it is one of the pillars to reduce morbidity and mortality associated with unprotected sexual activity.

Strategic Objective 7: To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

51. The composition of the 2010–2011 approved budget for SO 7 is 38.5% from the regular budget and 61.5% from other sources. The expected impact on the different topics under Scenario C for this SO is included below. It should be noted, however, that if there is any significant decrease in voluntary contributions, the achievement of RER indicators under this SO might be further compromised.

52. A reduction in funding will limit PAHO's ability to support the implementation of action plans defined by the countries; it also will curtail follow-up on the recommendations from the Commission on Social Determinants of Health and on those that may arise from the Rio Conference to be held in October 2011. Countries are also mobilizing around the social determinants of health and are keen to document their experiences as part of gathering best practices from the Region. A reduction in funding will limit the countries' ability to share this information with one another as a way to deal with "how" to address the determinants of health and inequities.

53. With regards to supporting intersectoral interventions in the most vulnerable communities to address the MDGs, reduced funding will limit the support provided to countries to implement such interventions and related initiatives, such as the "Faces, Voices, and Places" initiative.

54. The production of reports to enable decision makers to understand how social and economic factors interact to determine their country's health situation with an intra-and intersectoral focus is essential for devising efficient and cost-effective strategies. Advancement in these areas would be seriously affected by the decline of actions planned to strengthen country capacity for measuring, monitoring, and analyzing inequalities in health and their determinants.

55. Overall, a reduction in regular budget funds will hinder the Bureau's ability to maintain and expand activities related to gender mainstreaming and human rights at the country and regional level. While it is expected that the countries will continue to implement plans for advancing gender in the health sector, there will be a reduction in the number of tools and guidance documents developed or updated by PASB to include gender equality in health analysis, programming, monitoring, or research. In addition, the budget cuts will lead to a reduction in the number of PASB entities that include a gender perspective in their situation analysis, plans, or monitoring mechanisms.

Strategic Objective 8: To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

56. The composition of the 2010–2011 approved budget for SO 8 is 54% regular budget funds and 46% funds from other sources. The expected impact on the different topics covered under this SO is as follows:

(a) The number of environmental burden-of-disease assessments conducted will decrease, as will the number of countries implementing WHO guidelines on occupational health and drinking water. Support for country efforts to implement water safety plans will be limited, which will slow down progress in improving coverage and access to safe water and sanitation.

(b) A reduction in the regular budget will directly affect the technical cooperation to countries on workers' health policies and programs (surveillance, training, implementation of preventive measures). A reduction also would affect programs targeting workers employed in high-risk areas, such as in the health care sector, mining, and agriculture, and in the informal sector.

(c) PASB will have to decrease the number of high-level fora on health and environment it supports for regional policymakers and stakeholders.

(d) Although studies on the public health impact of climate change will continue to be published, PASB will not be able to support, in all target countries, the implementation of plans to enable the health sector to respond to the health effects of climate change.

Strategic Objective 9: To improve nutrition, food safety, and food security throughout the life cycle, and in support of public health and sustainable development.

57. This Strategic Objective is heavily financed with regular funds (nearly 60% of its budget), which means that it would be severely affected by a funding cutback. The areas that would be most affected appear below:

(a) The budget cuts would affect the implementation of the Regional Strategy and Plan of Action on Nutrition in Health and Development 2006–2015, the Strategy and Plan of Action for the Reduction of Chronic Malnutrition, and the activities promoted by the Pan American Alliance for Nutrition and Development. In addition, activities programmed for developing intersectoral policies and for strengthening the health sector's capacity to propose actions to address social determinants of health and to monitor and evaluate the impact of the interventions will be affected.

(b) Cutbacks in the regular budget would affect the implementation of the Regional Plan on Food Safety and Food Security. Generating information on the following topics would be substantially reduced: (i) characterization of chemical and biological food contaminants and food- and water-borne diseases and (ii) determination of their burden and direct impact on health and their indirect impact on trade, tourism, and the economy as a whole. Expansion of the Webinar/Videocast platform for distance education for member laboratories of the regional and global surveillance networks and programs for the prevention and control of food-borne diseases would also be limited. Use of this efficient and cost-effective platform would also be limited for other training activities in risk assessment, risk management, and risk communication conducted at health events on food contamination and emerging and reemerging zoonotic diseases and their relation to the application of the International Health Regulations (IHR), 2005.

(c) The development of evidence-based prevention and control programs would also be seriously limited. Also affected would be the transfer of successful primary care experiences in food safety,

such as the implementation of WHO's five keys to safer food in schools, community kitchens, and the healthy markets strategy.

(d) The pace of cooperation in activities to harmonize legislation within the framework of the Codex Alimentarius and the training in modern inspection systems would slow, adversely affecting regional food safety and the food trade in subregional and global markets. This implies that some of the achievements attained in 2010–2011 would be lost in the 2012–2013 biennium.

Strategic Objective 10: To improve the organization, management and delivery of health services.

58. The composition of the 2010–2011 budget for SO 10 is approximately 30% regular budget and 70% other sources. The following impact is anticipated under Scenario C:

(a) The capacity of the regional level to guide the Renewal of Primary Health Care (PHC) and the Integrated Health Service Delivery Networks will be impaired. However, the countries will likely continue to advance towards PHC-based systems and integrated networks because enough momentum has been built thus far and there is widespread political commitment to PHC and integration throughout the Region.

(b) In reference to the strengthening of Essential Public Health Functions (EPHF), the development and application of the performance assessment methodology and instrument have benefited tremendously from the multidisciplinary, multi-country, multilateral collaboration made possible by the regional coordination of EPHF activities. Until now, these activities have been funded almost entirely with voluntary contributions, but this financing to support EPHF assessments and strengthening will be significantly reduced starting in October 2011. In this context, under scenario C, regional support for EPHF activities will probably be discontinued. Countries will likely continue to carry out EPHF assessment and strengthening activities with their own resources because the capacity has been built at the country level and because the countries have taken ownership of EPHF concepts and methods. The regional coordination and the sharing of experiences and lessons learned, on the other hand, will be lost.

(c) PASB's technical cooperation to Member States for the implementation of the Productive Management Methodology for Health Services and its related tools will be compromised, and regional activities will need to be suspended. This is a regional initiative and countries would not be able advance on this topic without regional leadership and support.

(d) In regards to technical cooperation to strengthen programs for the improvement of quality of care and patient safety, the budget decreases will result in the regional level's diminished capacity to support processes related to this topic.

Strategic Objective 11: To strengthen leadership, governance and the evidence base of health systems.

59. The composition of the 2010–2011 budget for SO 11 is approximately 38% regular budget and 62% other sources. The following impact is anticipated under Scenario C:

(a) In regards to PAHO's support for policy analysis and regulation, the capacity of the regional level to provide technical cooperation will be greatly limited, unless additional funding from other sources is mobilized. Although the development of policies and legislation is ultimately the responsibility of countries, PAHO provides important support in this process. It is anticipated that a significant reduction of regular funds will affect the quality of plans, policies, and regulatory frameworks. Budget reductions are particularly worrisome at this juncture, since the topic of

National Health Plans and Strategies is gaining momentum at the global level, with strong support from WHO.

(b) In reference to the Regional Core Health Data and Country Profiles, limited support will be provided for the development of basic national and sub-national data in the countries, the elaboration and updating of country health situation analyses, and monitoring of the health-related MDGs. Technical cooperation to strengthen country health statistics will suffer a substantial impact, thus affecting the outcomes of the Regional Plan of Action for Strengthening Vital and Health Statistics. In addition, the role of PAHO as the secretariat for the Latin American and Caribbean Network for Health Information Systems could be compromised, placing the organization at a disadvantage in regards to interagency collaboration efforts.

(c) The capacity to implement PAHO's Policy on Research for Health and WHO's Strategy on Research for Health would be limited. A budget reduction would result in losing the regional support for coordination, networking, monitoring, and evaluation. It will also compromise the operation of ongoing, effective partnerships and agreements, and will limit initiatives that support the promotion of research agendas that respond to country needs, essential public health functions that rely on research, the identification and targeting of critical knowledge gaps, human resources for health research, standards and best practices for research, and knowledge transfer. Support to PAHO's Advisory Committee on Health Research would also be curtailed.

(d) It will not be possible to sustain the Regional Health Information Platform and the Regional Health Observatory. This situation would affect accessibility and availability of regional health data for analysis and decision-making.

(e) The role of PAHO as a broker of evidence-based public health information and knowledge will be affected. Editorial quality controls may be compromised, thus weakening the scientific output of the Organization, including the production of the *Pan American Journal of Public Health*. PAHO might be unable to maintain virtual collaboration services, which would affect the delivery of technical cooperation and increase organizational costs related to duty travel and face-to-face meetings. The registration, classification, and preservation of institutional memory, both documentation and audiovisual (PAHO has one of the most complete audiovisual collection on the history of public health), will also be compromised. Lastly, PAHO's corporate image might be weakened due to lack of resources for communication actions, which are widely recognized as a priority for emergency situations or disasters.

Strategic Objective 12: To ensure improved access, quality and use of medical products and technologies.

60. The composition of the 2010–2011 budget for SO 12 is approximately 20% regular budget and 80% other sources. The following impact is anticipated under Scenario C:

(a) The work in medicines and health technologies will be severely affected in regards to the achievement of Strategic Plan targets for 2013. In particular, technical cooperation to ensure equitable access to medical products and health technologies, as this is a core area of work financed by regular budget.

(b) Even though the development of policies is ultimately the responsibility of countries and countries may still be able to achieve targets on their own (either with their own financing or from other sources), PAHO plays an important supportive role in this process. It is anticipated that a significant reduction of regular funds will affect the quality of policies related to pharmaceuticals, blood, and health technologies. Particularly in the area of blood, which receives considerable funding from the regular budget, the regional level support would be severely reduced, to the point where it may be discontinued. The tools to evaluate access to health technologies also are

developed at the regional level and a reduction on regular budget will mean that this coordination and leadership will be lost.

(c) The work related to the PAHO Strategic Fund of Essential Public Health Supplies receives significant funding from the regular budget. A decrease in those funds would compromise the achievement of the targets, which is critical at a moment when country interest in participating in the Strategic Fund is increasing.

(d) The work related to promoting the rational use of medicines, blood, radiological services, and health technologies will also be affected, unless additional resources are mobilized. The impact will be particularly severe on the work on radiology and medicines selection.

SO 13: To ensure an available, competent, responsive and productive health workforce to improve health outcomes.

61. The composition of the 2010–2011 budget for SO13 is approximately 45% from the regular budget. The expected impact on the different topics covered under the SO is as follows:

(a) Reductions in funding will adversely affect the quality of policy frameworks for human resources for health (HRH) and the time required for their development, particularly in priority countries, the Caribbean, and countries with limited institutional capacity in HRH. Even though the development of HRH plans and policies is ultimately the responsibility of countries, PAHO plays an important supportive role in this area. PAHO has also been heavily involved in supporting Member States in the development of a career path policy for health workers and in introducing the adjustments required by special commissions and parliaments.

(b) PAHO also plays a strong leadership role in the development of technical cooperation among countries (TCC) and broad regional alliances to fulfill the regional goals for HRH. Budget reductions will lead to a suspension of this role, leaving the countries in a weakened capacity to implement horizontal cooperation processes.

(c) Efforts to establish a set of basic indicators and information systems on HRH will also suffer. Specifically, PAHO is redesigning the regional initiative of the HRH Observatory. The development of this regional network will be affected with a reduction in the regular budget.

(d) PAHO's capacity to play a catalytic role in the reorientation of health sciences education towards primary health care (PHC) will be compromised at a moment in which PHC renewal is gaining momentum in the Region. Similarly, with a significant reduction in funding, the Virtual Campus of Public Health (VCPH) —a key strategy for technical cooperation— will stop expansion efforts to the Caribbean and Central America. The infrastructure of the Leaders in International Health Program also will be compromised, and the program will likely be discontinued.

(e) Regional-level support for the analysis and monitoring of health worker migration dynamics will need to be scaled down. This will particularly affect those countries where PAHO's cooperation plays a significant role, such as priority countries and small Caribbean islands (those most impacted by the migration of health workers). PAHO also plays an important supportive role in regards to bilateral and multilateral agreements that address health worker migration, particularly the active implementation by Member States of the WHO Global Code of Practice for the international recruitment of health workers.

Strategic Objective 14: To extend social protection through fair, adequate and sustainable financing.

62. Sixty percent of the funding for this Strategic Objective comes from regular budget (of which 80% is at the country level). This makes this SO particularly vulnerable to the budget reduction

envisioned under Scenario C. Regional support for the following topics would need to be significantly scaled down or discontinued:

(a) Policy work on financing schemes for the reduction or elimination of the financial risk associated with diseases and accidents, studies to assess household capacity to meet health expenditures, harmonization of Health Accounts/National Health Accounts, and studies on expenditure and financing of public health systems or social health insurance.

(b) PAHO plays a central role in the production of studies on health financing, which are mostly financed through the regular budget and rely heavily on the regional level. As such, under Scenario C, regional support will likely need to be discontinued. These studies generate crucial evidence to support the development of public policies on financing and universal coverage. Without relevant and updated information and evidence, the quality of these policies and processes will be affected. This is particularly worrisome given the priority that the topic of financing is receiving at the global level with The World Health Report 2010—Health Systems Financing: The Path to Universal Coverage.

(c) The Organization's capacity to provide support to countries in the extension of social protection in health would also be affected. The regional level has played an important role in the documentation of lessons learned and good practices in social protection in health (SPH), providing countries with tools to analyze and identify different mechanisms and strategies to advance toward SPH. Without regional support, the quality of these processes will suffer and targets will be compromised.

Strategic Objective 15: To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system, and other stakeholders to fulfill the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work and the Health Agenda for the Americas.

63. SO15 covers enabling functions to support the achievement of other strategic objectives. Progress towards the achievement this SO's expected results has been made under certain budgetary constraints. The SO will be even more affected under any of the three scenarios, since it relies exclusively on regular funds. This adverse impact includes constraints on the performance of certain basic functions of the Bureau, in particular:

(a) Improvement of the operational administrative support of country entities;

(b) The capacity to mobilize resources at the regional and country level;

(c) The commitment to maintain PASB's presence and leadership in the countries and sub-regions.

Strategic Objective 16: To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

64. This SO covers the enabling functions to support the work undertaken under SOs 1–15. As such, the funding for this SO depends heavily (over 70%) on the regular budget. Therefore, a reduction of 96% in regular budget funding would have a major impact on the Organization's capacity to deliver the technical cooperation programs in an effective and efficient manner.

65. While PASB will make every effort to continue implementing important initiatives, such as Results-based Management (RBM) and IPSAS, most of the RER indicators of SO 16 would be severely affected. This would precipitate the necessity of undertaking severe austerity measures that would affect the ability to provide basic essential enabling services and the introduction of a number of safety and security concerns; it would also threaten the functionality of PAHO's infrastructure.

66. The decrease in resources available to fund investment fees, audit fees, travel and financial systems support, as well as the potential limitations to the capability of the information technology systems (ITS) to support legacy systems, would pose a risk to obtaining an unqualified audit opinion and closing of the accounts. It would also affect resource mobilization efforts. Furthermore, the PASB would not be able to engage in new information technology development efforts and would be able to focus only on minimal changes to systems due to business rule requirements. The capability to sustain current telecommunications and business continuity services would decrease and problems would take longer to resolve. This, in turn, would result in information technology services and systems that are less stable at Headquarters and at Country Offices and centers. PAHO's business systems would likely also become unstable, and the Organization would be unable to sustain its current support model to Country Offices and centers with reliable and real-time data.

Table 10. RER Indicators that would be most affected under Scenario C

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
SO1 - Communicable diseases					
1.3.2 – Number of countries that have eliminated human rabies transmitted by dogs.	11	14	16	18	It is estimated that only 16 countries will achieve this indicator. Resources would only be sufficient to maintain the achievements up to 2011. It should be noted that two countries dropped from the baseline in 2009.
1.4.3 – Number of countries routinely implementing antimicrobial resistance (AMR) surveillance and interventions for AMR containment, including health care associated infections.	17/35	22/35	24/35	27/35	It is estimated that only 22 countries will achieve this indicator; which would represent a regression in achievements.
1.8.1 – Percentage of public health events of international importance verified in the time recommended by the International Health Regulations.	85%	90%	95%	98%	It is estimated that only 85% would be achieved during the 2012–2013 biennium.
1.9.1 – Percentage of PASB International Health Regulations compliant responses based on requests for support from Member States during emergencies or epidemics.	90%	100%	100%	100%	It is estimated that 90% would be achieved. Regular budget funds are required for immediate response, while funds are mobilized from partners. Hence, any reduction would affect the Bureau's capacity to respond effectively to support Member States and mobilize resources from other partners.
SO2 - HIV/AIDS, TB and Malaria					
2.1.2 – Number of countries that provide antiretroviral treatment to at least 80% of the population estimated to be in need as per PAHO/WHO guidelines.	6	7	12	15	Only 7 countries would reach this indicator. In addition to the funding limitations, changes in HIV treatment recommendations in 2010, including new criteria for initiating treatment at 350 CD4

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
					count (increased from 200), makes attaining 80% of treatment coverage even more challenging.
2.4.1 – Number of countries reporting HIV surveillance data disaggregated by sex and age to PAHO/WHO.	25	27	32	33	Only 26 countries would achieve this indicator, representing a reversal in progress made in previous biennia.
2.4.6 – Number of countries reporting malaria drug resistance surveillance data to PAHO/WHO, as per PAHO/WHO guidelines.	9/21	11/21	17/21	20/21	It is estimated that only 13 countries would achieve the indicator, representing a reversal in achievements.
SO3 -Chronic noncommunicable diseases					
3.3.3 – Number of countries that have a national health information system that includes indicators of disabilities.	18	22	23	26	Only 18 countries would achieve this indicator, representing a reversal to 2007.
SO4 Maternal, child, adolescent and elderly health					
4.1.2 – Number of countries that have a policy of universal access to sexual and reproductive health.	7	11	13	16	Only 9 countries would achieve this indicator, representing a reversal in achievements before 2009.
4.1.3 – Number of countries that have a policy on the promotion of active and healthy aging.	11	15	17	18	Only 15 countries would achieve this indicator, representing a reversal to 2009 achievements.
4.2.1 – Number of countries that implement information systems and surveillance systems to track sexual and reproductive health, maternal, neonatal and adolescent health, with information disaggregated by age, sex and ethnicity.	10	15	17	20	Only 12 countries would achieve this indicator, representing a reversal in achievements before 2009.
4.3.1 – Number of countries adapting and utilizing PAHO/WHO-endorsed technical and managerial norms and guidelines for increasing coverage with skilled care at birth, including prenatal, post-natal, and newborn care.	10	12	19	23	It is estimated that only 12 countries would achieve this indicator, representing a reversal to 2009 achievements.
4.6.1 – Number of countries with a functioning adolescent and youth health and development program.	10	12	16	17	It is estimated that only 12 countries would achieve this indicator, representing a reversal to 2009 achievements.
4.6.2 – Number of countries implementing a comprehensive package of norms and standards to provide adequate health services for young people's	3	10	14	15	It is estimated that only 12 countries would achieve this indicator.

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
health and development (e.g. Integrated Management of Adolescent Needs [IMAN]).					
SO5 - Emergencies and disasters					
5.2.1 – Number of Regional training programs on emergency response operations.	4	6	7	7	Achievement of this indicator depends on regular budget from the regional level. Hence, a reduction in funding would represent cutting the number of trainings to 6.
SO6 - Health promotion and risk factors					
6.3.3 -Number of countries with regulations on packaging and labeling of tobacco products consistent with the WHO Framework Convention on Tobacco Control.	8	10	17	23	It is estimated that only 16 countries would achieve this indicator.
SO7 - Social and economic determinants of health					
7.1.1 - Number of countries that have implemented a national strategy for addressing key policy recommendations of the Commission on the Social Determinants of Health.	0	4	10	12	It is estimated that only 10 countries would achieve this indicator.
S08 - Healthier environment					
8.1.1 - Number of new or updated risk assessments or environmental burden of disease (EBD) assessments conducted per year.	2	3	4	7	It is estimated only 5 assessments would be conducted.
8.5.1 – Number of regular high-level fora on health and environment for regional policymakers and stakeholders supported by PASB.	1	2	3	4	Only 3 fora would be held.
SO9 – Nutrition, food safety and food security					
9.3.3 – Number of countries that produce evidence based information in nutrition and food security.	11	15	20	22	It is estimated only 20 countries would achieve the indicator. Efforts will focus on sustaining achievements up to 2011.

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
9.4.5 – Number of countries that have national preparedness and response plans for food and nutrition emergencies.	11	16	20	25	It is estimated only 20 countries would achieve the indicator. Efforts will focus on sustaining achievements up to 2011.
SO10 - Health services					
10.1.2 - Number of countries that show improvement in the performance of the steering role as measured by the assessment of Essential Public Health Functions.	3	8	11	14	It is anticipated that only 11 countries would achieve this indicator. Efforts will focus on sustaining achievements.
10.2.1 – Number of countries that have implemented strategies to strengthen health services management.	3	14	17	20	It is anticipated that only 17 countries would achieve this indicator. Note that this indicator includes the development and implementation of Productive Management Methodology for Health Services, which depends on regular budget funding from the regional level.
SO11 - Health systems leadership and governance					
11.1.2 - Number of countries that have formulated policies, mid-term and long-term plans or defined national health objectives.	9	17	29	35	It is anticipated that only 29 countries would achieve this indicator. Efforts will focus on sustaining achievements.
11.2.1 – Number of countries that have implemented processes to strengthen the quality and coverage of their health information systems.	3	7	10	15	It is anticipated that only 7 countries would achieve this indicator, representing a reversal to 2009 levels.
11.3.1 - Number of countries that update their health situation analysis at least every two years.	5	7	9	10	It is anticipated that only 5 countries would comply with the timely updating of health situation analysis with reliable and up-to-date information. This is due to the technical cooperation required from PASB, which is funded from regular budget, to support countries in updating their health situation analysis on a periodic basis.
SO12 – Medical products and technologies					
12.1.1 - Number of countries that have implemented policies promoting the access to, or technological innovation for medical products.	17	23	25	27	It is anticipated that only 25 will achieve the indicator. Efforts will focus on maintaining the achievement of 2011.

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
12.3.1 - Number of countries that have norms to define the incorporation of health technologies.	11	14	17	20	It is anticipated that only 17 countries will achieve this indicator. The areas that would be most affected include radiological services and technical cooperation for the incorporation of new health technologies.
SO13 - Human resources for health					
13.2.2 – Number of countries participating in the Human Resources for health Observatories network for the production of information and evidence for decision making.	18	29	31	36	It is anticipated that only 31 countries will achieve this indicator.
13.4.4 – Number of countries participating in the PAHO leaders in international health program.	0	18	25	25	It is anticipated that only 10 countries will achieve this indicator, representing a reversal in achievements prior to 2009.
SO14 - Social protection and financing					
14.2.1 - Number of completed country studies applying the PAHO evaluation framework to assess household capacity to meet health expenditures.	0	3	5	7	Resources would only be sufficient to support 5 studies. Resources will be prioritized for the achievement of other indicators under this SO.
14.3.3 - Number of countries with studies on expenditure and financing of public health systems or social health insurance.	0	0	10	15	It is anticipated that only 10 countries will achieve this indicator. Resources will be prioritized for the achievement of other indicators under this SO.
SO15 - PAHO/WHO leadership and governance					
15.1.3 - Number of PASB entities implementing leadership and management initiatives (coordination and negotiation of technical cooperation with partners, technical cooperation among countries [TCC], advocacy for the PAHO/WHO mission, and Biennial Workplans, and reports) on time and within budget.	43/69	57/69	61/69	69/69	It is estimated only 57 entities would be able to implement such initiatives.
15.2.4 - Number of PASB subregions that have a Subregional Cooperation Strategy (SCS).	0/5	1/5	2/5	4/5	Only two subregions would have a SCS.
15.2.5 - Number of PASB country and subregional entities with improved administrative support, physical infrastructure, transport, office equipment, furnishings and	20/29	25/29	27/29	29/29	It is estimated that only 24 entities would be able to achieve this indicator, representing a reversal in achievements.

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
information technology equipment as programmed in their Biennial Workplans.					
15.2.6 - Number of PASB country and subregional entities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) Compliance.	20/29	25/29	27/29	29/29	It is estimated that only 24 entities would be able to achieve this indicator, representing a reversal in achievements.
SO16 - Flexible and learning Organization					
16.2.1 – International Public Sector Accounting Standards (IPSAS) implemented in PAHO.	IPSAS not implemented	IPSAS approved by Member States	IPSAS implemented	IPSAS implemented	There will be insufficient resources to maintain current IPSAS requirements—property valuation, actuaries, and financial instruments experts.
16.2.5 – Sound financial practices as evidenced by an unqualified audit opinion.	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion	Unqualified audit opinion	A decrease in resources will pose a risk to obtaining an unqualified audit opinion, leading to the liquidation of investments in the portfolio managed by experts, and a requirement to eliminate posts to cover the audit fees and financial systems support.
16.3.3 – Percentage of Selection Committees working with new framework approved by the Executive Management, which includes psychometrical evaluation for key positions.	N/A	100%	100%	100%	The use of the new framework would be continued, but only 50% the psychometric evaluations would be met.
16.4.1 - Percentage of significant IT-related proposals, projects, and applications managed on a regular basis through portfolio management processes.	0%	40%	60%	80%	No portfolio management process would be implemented due to the fact that functioning of IT systems will be compromised with the budget reduction.
16.4.2 - Level of compliance with service level targets agreed for managed IT-related services.	0%	50%	60%	75%	Only 25% would be achieved. This is due to the fact that service contractors will be cut, which will diminish the level of user support and services. Infrastructure problems will be more common and will last longer.
16.4.3 - Number of PAHO/WHO country and subregional entities, and Pan American centers using consistent, near real-time management information.	35/35	35/35	35/35	35/35	While the system will continue to operate, there will be significant interruption when real time management information is unavailable.

RE Indicator	Baseline 2007	Target 2009	Target 2011	Target 2013	Comments
16.5.1 – Level of user satisfaction with selected managerial and administrative services (including security, travel, transport, mail services, health services, cleaning and food services) as measured through biennial surveys.	Low (satisfa-ction rate less than 50%)	Medium (satisfa-ction rated over 75%)	High (satisfa-ction rated over 75%)	High (satisfa-ction rated over 75%)	The satisfaction level is expected to decrease to medium or even low, due to the inability to maintain the quality of services; severe cuts in everyday services will diminish personnel performance.
16.5.3 – Percentage of internal benchmarks met or exceeded for translation services.	60%	70%	75%	80%	Only 70% would be met. Limitations with basic software and challenges to implementing established quality control standards will compromise even those targets already achieved.
16.5.4 A new procurement management system, to measure and monitor compliance with procurement best practices, including targeted training, improved statistical reporting, expanded bidder lists, service level agreements and procedural improvements, implemented.	N/A	Guiding principle s elaborat ed	Busines s rules elaborat ed	Procurem ent manage ment System Impleme nted	No resources will be available to: 1) perform adequate monitoring, control, and technical support; 2) integrate new requirements in the e-tendering system and 3) implement procurement systems at the country level.
16.5.5 – Percentage of PASB internal requests for legal advice and services acted upon within 10 working days of receipt.	70%	90%	95%	100%	Only 40% would be accomplished within the established period of 10 days. The budget reduction would cut legal support and slow down the ability to provide the necessary reviews.
16.6.3 – Percentage of HQ and Pan American Centers physical facilities that have implemented policies and plans to improve personnel health and safety in the workplace, including Minimum Operating Safety Standards (MOSS) compliance.	65%	75%	80%	100%	Only 90% would be met. A reduction in resources will compromise services required to ensure the safety and security of facilities and staff. The impact will be severe in HQ.
16.6.4 – Percentage of PASB regional entities and PAHO Pan American Centers that improve and maintain their physical infrastructure, office equipment, furnishings, information technology equipment and transport, as programmed in their Biennial Workplans.	75%	90%	95%	100%	Only 90% would be met. A reduction in resources will compromise meeting basic services, maintenance, and general operating expenses. The impact will be more severe in HQ, including ITS.

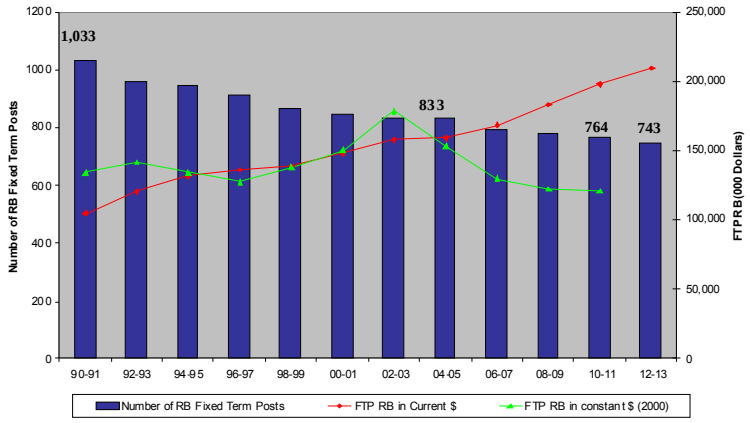
IV. PASB'S EFFORTS TO IMPROVE EFFICIENCY AND PRODUCTIVITY

The PASB Workforce and Regular Budget Trends

67. PASB's workforce is the critical element in achieving the Strategic Objectives (SOs) and Region-wide Expected Results (RERs) as set out in the Strategic Plan.

68. As shown in Figure 3, fixed-term posts (FTPs) funded through PAHO/WHO's regular budget have been steadily decreasing for the past two decades (blue bars), dropping from 1,033 posts in 1990–1991 to 764 in 2010–2011. As part of the Organization's austerity budgetary discipline, 18 post were eliminated during 2010-2011 alone. At the request of Member States to study a further reduction in the FTP budget, an additional 3 posts have been reduced in the Program and Budget proposal, resulting in a reduction of a total of 21 posts. Hence, the Organization will operate in 2012-2013 with only 743 posts. Further reductions in FTPs should be carefully analyzed, as this could compromise the Organization's ability to implement its core and enabling functions, including its capacity to mobilize resources.

Figure 3
Number of RB FTPs compared with FTP regular budget in current and constant dollars*, from 1990-1991 to 2012-2013



* LAC Implicit Deflactor GDP; Constant Market Prices of 2000. - Source: Elaborated with data from ECLAC, UN National Accounts and WEO from the IMF

69. Although the fixed-term post budget curve in current dollars[2] (red curve) has steadily risen, the FTP budget in constant dollars[3] (green curve) peaked in the 2002–2003 biennium and has declined to a level below that of the 1990–1991 biennium.

70. Despite PASB's efforts to contain staff expenditures, as shown by the constant decline in the number of FTPs funded through PAHO/WHO's regular budget, in the past two decades the budget, in current dollars, has continued to increase for the past two decades (red curve). Figure 3 shows that the budget for FTPs in the current biennium (2010–2011,) in constant dollars, is at the same level as that in 1996-1997, but it funds fewer fixed-term posts.

71. The Economic Commission for Latin America and the Caribbean's (ECLAC) deflator for the Region as a whole was used in this calculation. This statistic is based on a macro "basket" view of the behavior

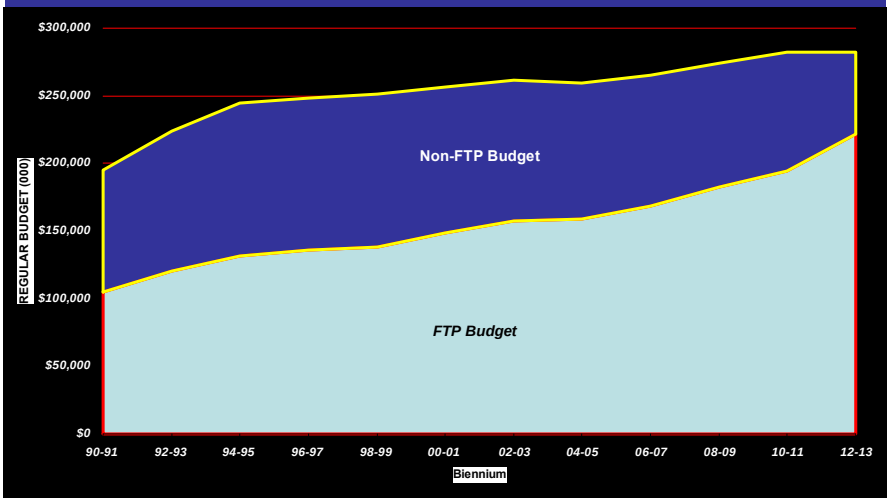
[2] Refers to the use of actual prices and costs.

[3] The term constant dollars refer to a metric for valuing the price in dollars of something over time, with adjustment for inflation or deflation.

of Latin American economies versus the US dollar. However, the mix of locations and currencies involved in PAHO's operations, suggests that the effect of the loss of purchasing power of the Organization's budget is even more dramatic, given that individual country inflation rates range from 1.5% to 30%. In order to use referenced evidence, however, it was decided to keep the ECLAC deflator.

72. As shown in Figure 4, the FTP portion of the regular budget has steadily increased been constantly increasing for the past 24 years. However, the Bureau has been successful in mobilizing resources, providing sufficient non-FTP funds from Other Sources to implement its Program. This is indicative in the FTP to non-FTP ratio depicted in Figure 1.

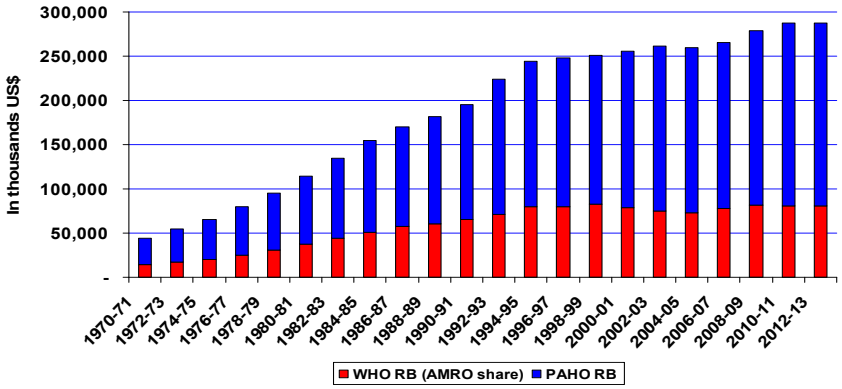
Figure 4
TRENDS OF THE FTP and Non-FTP PAHO/WHO REGULAR BUDGET, from 199O-1991 to 2012-2013



Trends in PAHO/WHO Regular Budget Funding

73. Since 1994–1995, increases due to inflation have outpaced nominal budget increases. While FTP costs have continued to increase, the non-FTP budget has been reduced in both constant and current terms. This resulted in a significant loss in purchasing power for technical cooperation during that period. Furthermore, in the past 15 years, the AMRO share has proportionally decreased as a percentage of the total PAHO/WHO regular budget. Figure 5 presents four decades of history in the composition of the regular budget in the approved PAHO/WHO Program and Budget. In the past decade, the AMRO share of total regular budget has decreased from 33% in 1994–1995 to 28% in 2012–2013; maintaining the same level as in 2010-2011.

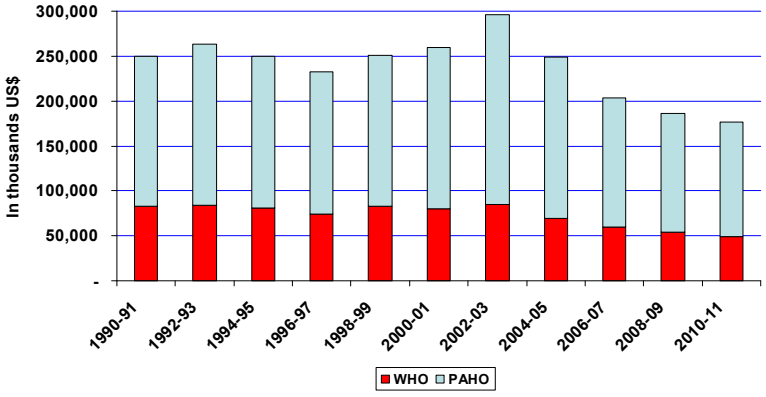
Figure 5
HISTORY OF THE PAHO VS WHO (AMRO share) REGULAR BUDGETS IN CURRENT DOLLARS
1970-71 / 2012-13 BIENNIA



* LAC Implicit Deflator GDP; Constant Market Prices of 2000. – Source: Elaborated with data from ECLAC, UN National Accounts and WEO from the IMF.

74. Although there has been an increase in the PAHO/WHO regular budget in current dollars, in the 1990–2011 period, the regular budget reduced its purchasing power capacity by 29% in constant 2000 US dollars (see Figure 6). WHO (AMRO) funding remained relatively stable from 1990 to 2003, but from 2004 to 2011 there was an ongoing reduction in this component.

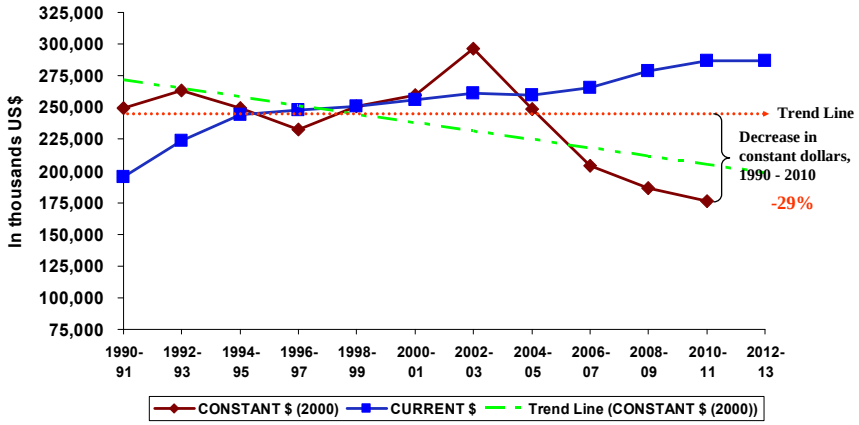
Figure 6
HISTORY OF THE PAHO vs. WHO REGULAR BUDGETS IN CONSTANT DOLLARS *
1990-91 / 2010-11 BIENNIA



* Using 2000 constant dollars. LAC Implicit Deflator. Implicit Deflactor GDP; Constant Market Prices of 2000. - Source: Elaborated with data from ECLAC

75. In current dollars, PAHO/WHO's regular budget has increased, but the trend in constant dollars has decreased. The observed reduction in constant dollars is estimated at about 29% ($73.4 million) in the 1990–2010 period, as shown in Figure 7.

Figure 7
PAHO/WHO REGULAR BUDGET IN CURRENT DOLLARS COMPARED TO 2000 CONSTANT DOLLARS
1990-91 / 2010-11



* Source: Elaborated with data from ECLAC, Statistical Yearbook 2008; pp 88&90.

PAHO/WHO Total Program and Budget Trend

76. The Organization's three main sources of funding are as follows:

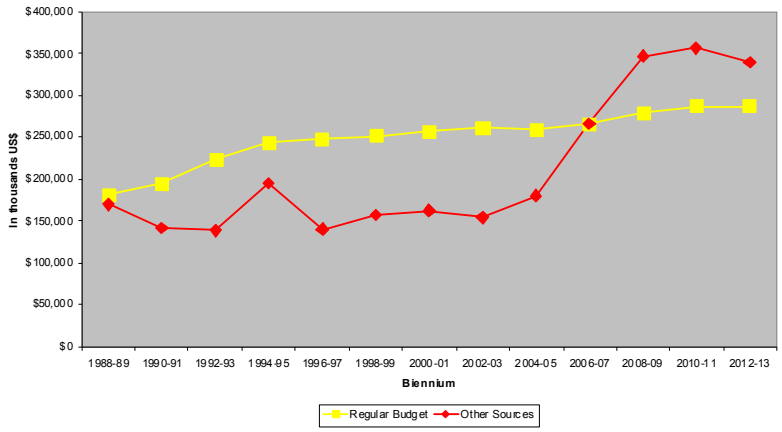
(a) **PAHO Regular Budget (RB)**, which comprises assessed contributions (quotas) from PAHO Member States, plus estimated miscellaneous income;

(b) **AMRO Share**, which is the portion of the WHO regular budget approved for the Region of the Americas by the World Health Assembly;

(c) **Other Sources (OS)**, which mainly comprises voluntary contributions mobilized by PAHO or through WHO, program support-generated funds, and funding from the Master Capital Investment Fund; among other categories.

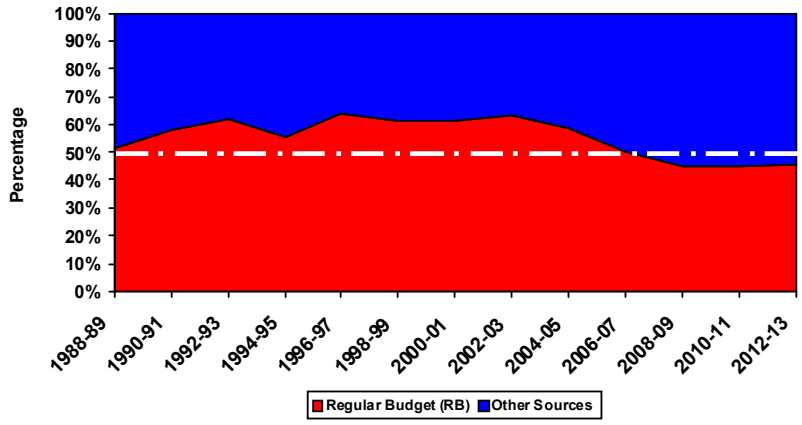
77. Figure 8 shows that for many years resources from OS were lower than those in the Regular Budget. However, since 2002–2003, OS resources (mainly voluntary contributions) have increased steadily. In 2006–2007, OS funds were almost equal to those in the RB, and in 2008–2009, they surpassed them by $67.9 million. Given the global financial climate, the proposed Program and Budget for 2012–2013 considers a reduction in Other Sources, compared to the 2010–2011 level. The reduction in OS varies with each scenario, as described in section II. Efforts to mobilize additional resources will be challenging. However, in the ever-growing role and importance that public health plays in the global development arena, PASB will continue to make every effort to mobilize the needed voluntary contributions required to achieve the Organization's Region-wide Expected Results. Section IV of this addendum, "PASB's efforts to improve corporate programmatic performance," addresses the Bureau's efforts in this regard.

Figure 8
PAHO/WHO PROGRAM AND BUDGET HISTORY BY REGULAR BUDGET (RB) AND OTHER SOURCES (OS), 1988-89 / 2012-13 BIENNIA



78. As depicted in figure 9, the OS/RB ratio has evolved from 50/50 in 1988–1989 to 54/46 in the 2012–2013 biennium. According to an analysis of the Organization's performance in the past two bienniums, the 54/46 ratio is at a critical point for maintaining an adequate balance that guarantees the Organization's capacity to implement its Program. It is considered that a reduction below 46% of regular budget will compromise the Organization's ability to respond to its collective mandates, and Member States' priorities will be placed at risk.

Figure 9
REGULAR BUDGET (RB) AND OTHER SOURCES (OS) AS PERCENTAGE OF THE PROGRAM AND BUDGET FROM 1988-89 TO 2012-13



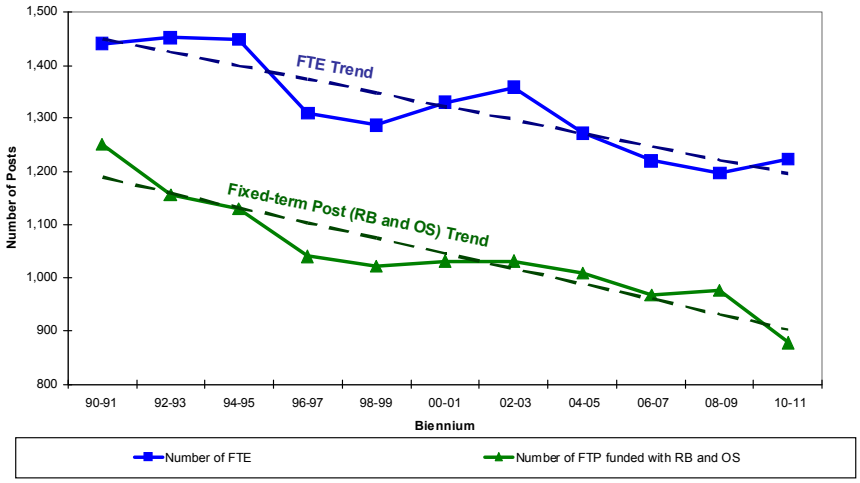
79. As of the second semester of the current biennium (31 December 2010), the overall funding gap is similar to that of the second semester of 2008–2009. During 2008–2009, PAHO received $281 million in voluntary contributions, of which 90% were earmarked. The last Performance Monitoring and Assessment exercise of December 2010 reported $194.8 million of voluntary contributions, of which $41.5 (21%) were unearmarked and $153.3 million, earmarked (79%).

Workforce: Efficiency and Productivity

80. PASB's total workforce, measured as full-time equivalent (FTE) is composed of fixed-term posts funded with RB and OS resources, and all other personnel hired through other types of mechanisms (e.g., short-term professionals, short-term consultants, personnel assigned by ministries of health, personnel hired through temporary staffing agencies, etc.). The full time equivalent (FTE) concept is useful for establishing comparisons.

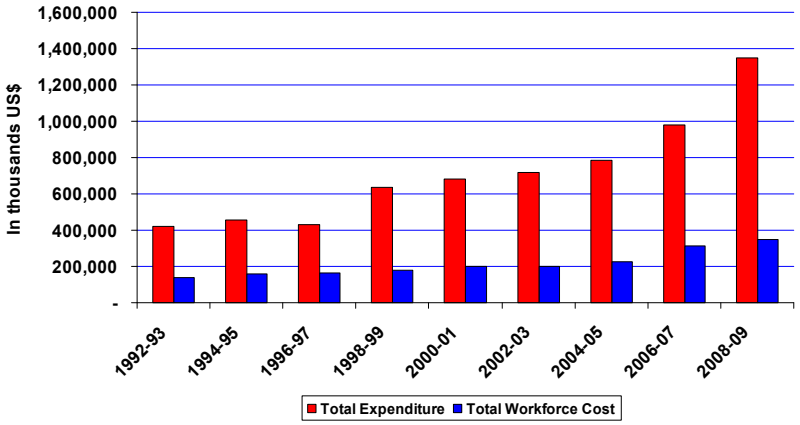
81. Figure 10 shows that the total workforce has been decreasing between 1990 and 2011. It is noteworthy that the FTE trend parallels the decrease in FTPs funded with PAHO/WHO RB and OS, showing the effort that PASB is making in decreasing its workforce. A reduction of 371 FTPs has occurred in FTPs funded by the RB and OS. A total FTE reduction of 216 FTPs occurred in the same period. Thus, the brunt of the reduction is in the FTPs.

Figure 10
Number of full time equivalent (FTE) compared with fixed-term posts funded with PAHO/WHO RB and OS, 1990-91 / 2010-2011



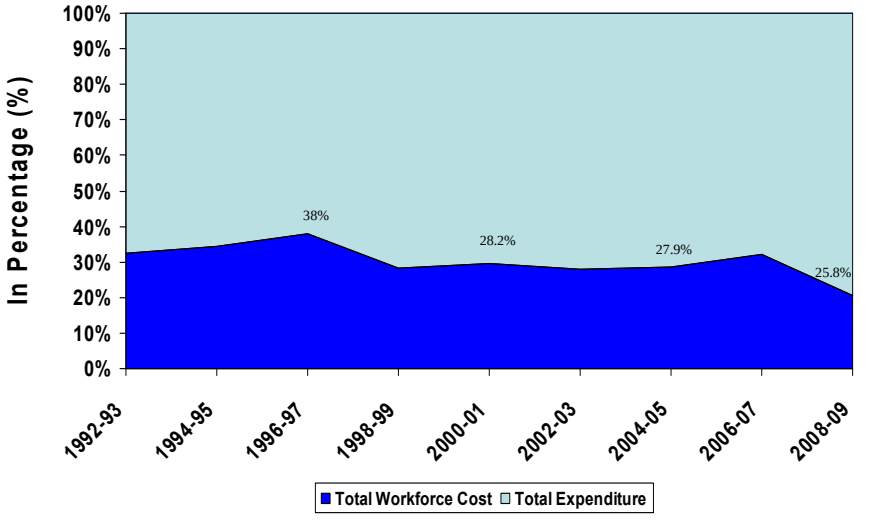
82. Figure 11 compares workforce expenditures with total PAHO/WHO expenditures during 1992–2009.

Figure 11
TOTAL PAHO/WHO EXPENDITURE HISTORY (1992 – 2009)
COMPARED WITH TOTAL WORKFORCE COST



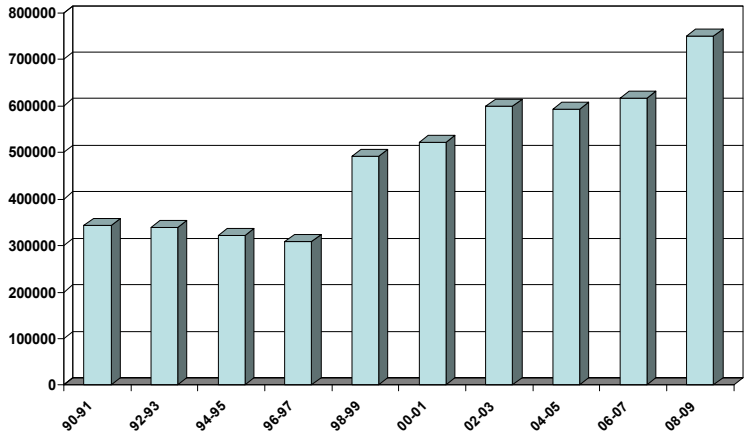
83. Despite the reduction of the total workforce, PASB has been able to maintain a fairly stable *efficiency rate* (workforce expenditure expressed as a percentage of total expenditures), as shown in Figure 12. In the 2004–2005 biennium, the efficiency rate was 27.9. During 2006–2007, the curve increases slightly, indicating a moderate reduction in the efficiency gains. Data from 2008–2009, however, shows an improvement in the efficiency rate (25.8), outperforming the 2004–2005 biennium. This indicator continues to improve, despite the reduction in the number of posts.

Figure 12
PAHO/WHO WORKFORCE EFFICIENCY RATE
1992-93 / 2008-09



84. *Workforce productivity* (measured here as PAHO/WHO's total expenditure per year [gross output] in constant dollars per full-time equivalent person)[4] has increased, despite a decreasing FTE overtime. Figure 13 shows that staff productivity increased from $342,575 per FTE in 1990–1991 to $750,237 per FTE in 2008–2009, in 2000 constant dollars. This represents a 118% increase in productivity in nearly two decades. A significant increase in productivity can be seen since 1998–1999, reflecting the significant level of non-project expenditure (all other expenditures not included in the Program and Budget) managed by PASB.

Figure 13
Productivity: PAHO/WHO total expenditure in constant dollars per full time equivalent *
1990-91 / 2008-09



* Value added per FTE in dollars at constant 2000 prices.

Efficiency Gains and Cost Containment

85. Considering the global financial environment and in keeping with its budgetary discipline, the Bureau, in addition to reducing fixed-term posts (FTPs) (as mentioned above), has taken other steps to improve efficiency and cut costs. These measures can be divided into three broad categories: organizational restructuring, implementation of new technical cooperation processes and modalities, and optimization of technology use.

86. In line with the Regional Program Budget Policy and the Country Focus Policy, the Bureau has increasingly shifted resources from the regional level to the country and subregional levels in an effort to further enhance the country presence and facilitate technical cooperation among the different levels of the Organization. Since 2006, a total of 50 posts have been decentralized to the country and subregional levels. This has resulted in fixed-term post (FTP) cost savings while better responding to country needs. At the request of the Governing Bodies, PAHO has also been reviewing its role in the administration of the Pan American Centers since 1978 to ensure that they remain responsive to the mandates of their Member States. As a result, the administration of 7 of 13 Centers has been transferred to their respective

[4] This is based on the OECD definition of labor productivity measured as the deflated (volume) of gross output divided by labor inputs (Source: The OECD Productivity Manual. A Guide to the Measurement of Industry-Level and Aggregate Productivity).

Member States, and it is anticipated that with the creation of the Caribbean Public Health Agency, 2 additional Centers will be transferred in the coming years.

87. In the context of increasing the efficiency of the Organization, the Bureau has been consistently reviewing its processes and exploring new modalities for technical cooperation. Since 2008, with the launch of the Strategic Plan 2008-2012 and in line with the RBM framework, the Bureau has been implementing the horizontal, team-oriented approach, establishing collaborative groups to optimize the use of both human and financial resources. The Bureau has also been expanding and building on alliances and strategic partnerships to enhance its technical cooperation capacity. For instance, the new modality for technical cooperation with collaborating centers and national reference institutions has improved the Organization's capacity to respond to its Member States, while at the same time building national capacity in international cooperation in health. With respect to resource mobilization, the Bureau has been successful in negotiating with major donors to shift towards a programmatic approach with an increased level of unearmarked funds (resulting in an increase from 10% in 2008-2009 to about 21% at the end of 2010). Resource coordination processes have also been shifting, with greater focus on the programmatic priorities of the Organization as established in the Strategic Plan 2008-2012.

88. Optimizing the use of technology, such as online conferencing using Elluminate, a modern telephone system, and the centralization of information technology infrastructure, has also helped increase the efficiency of PAHO's technical cooperation and reduce operating costs. The use of Elluminate has been steadily growing, especially at the regional level. The platform has become an essential tool for technical cooperation, increasing communication and interaction within offices and with other offices, as well as with counterparts and partners. In addition to extending the reach of technical cooperation, the use of Elluminate has also helped reduce travel and meeting expenses by increasing the number of virtual sessions. From January to June 2011, alone, 10,353 virtual meetings were held, representing a 64% increase over the previous biennium. The number of virtual spaces has also increased significantly, from 145 in 2008 to almost 900 in June 2011. Regarding the telephone system, the Bureau has installed the Voice over Internet Protocol (VoIP) in 16 offices to date and connected legacy telephone network systems to VoIP in another 10 offices; this will eventually be deployed to the remainder of the Representative Offices and centers. This represents a savings of approximately $500,000 in long distance calls between Representative Offices and centers, HQ, and WHO locations. In addition to these savings, the new telephone system allows for unlimited communication among offices inside and outside the Region at no additional cost. Also, one third of the servers in the Representative Offices have been migrated to a centralized system in Washington, D.C., resulting in further savings in infrastructure and maintenance cost, along with better security. Eventually, all corporate information systems will be centralized, resulting in further savings. In addition to the savings realized through the use of technology, the Bureau has also been using economy-class fares for official travel.

V. PASB'S EFFORTS TO IMPROVE CORPORATE PROGRAMMATIC PERFORMANCE

89. Performance monitoring and assessment (PMA) are essential for the proper management of the Program and Budget; they also constitute an important component of the Results-based Management (RBM) framework. With this in mind, the Bureau has institutionalized a systematic PMA process since 2008. As part of this process, PMA exercises are conducted every six months to assess progress of the implementation of the Biennial Workplans and, consequently, progress towards achieving the targets established in the Strategic Plan, which is implemented through the biennial Program and Budgets.

90. The PMA exercises provide information about the results chain and the targets at PASB's corporate and entity level, as established in the Strategic Plan 2008–2012, Program and Budgets, and the respective biennial workplans (BWPs). The system allows for corporate and entity analysis to be made, combines programmatic and budgetary implementation assessments, and examines resource mobilization efforts. Progress is measured by a combination of system-generated data (such as number of milestones achieved) and technical and managerial analyses of the rate of programmatic and budgetary implementation. As such, the PMA documents progress and challenges and points to necessary corrective actions to ensure that the Strategic Plan targets are met.

91. PASB presented the first interim PAHO Strategic Plan 2008–2012 progress report, covering the 2008–2009 biennium, to the 50th Directing Council (September 2010). According to this assessment, the Organization was well positioned to achieve the Strategic Plan targets in 2013—of the 16 SOs, 12 were on track and 4 were at risk; 67 (76%) of the 88 RERs were on track and 21 (24%) were at risk; and 275 (85%) of the 324 RER indicator targets had been met. The report noted the need to improve alignment between the mobilization and allocation of resources and the programmatic priorities (of the SOs) as established in the Strategic Plan. It also recommended directing interventions to those RER indicators that lagged behind, particularly the "number of countries" indicators that had not met their targets. The assessment also revealed an overall budgetary implementation for 2008–2009 of 94% ($525 million of $559 million) and stated that the Organization was able to mobilize financial resources to cover 81% of the initial funding gap in voluntary contributions ($281 million of $347 million).

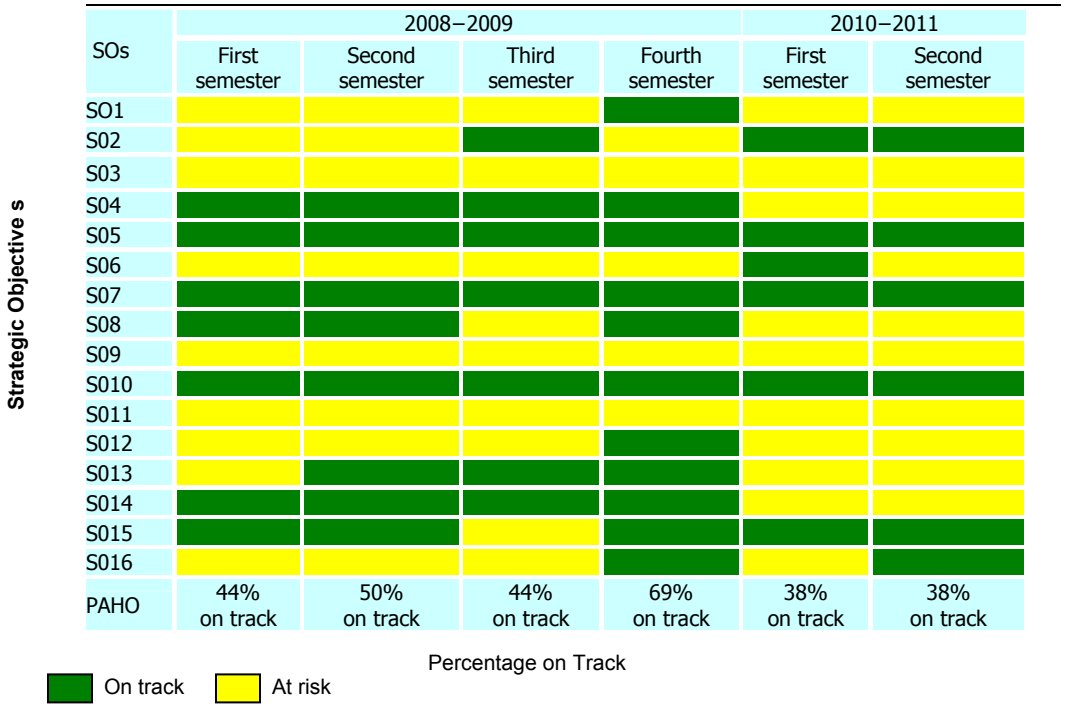
92. The following section and its accompanying figure illustrate the main results of PMA exercises for the past biennium and the 2010–2011 mid-term assessment. During the PMA exercises, the 69[5] PASB entities and the 16 SOs, 90 RERs, and 256 RER indicators of the Strategic Plan were assessed.

Progress towards achieving Strategic Objectives (SOs)

93. Figure 14 shows the SOs' performance since the beginning of the Strategic Plan (2008–2009), up until the second semester of the current 2010-2011 biennium. The figure shows that at the end of the second semester of the current biennium, 6 SOs (38%) were rated as being on track (green) and 10 (62%) as being at risk (yellow). No SOs were rated as being in trouble (red). While there is a trend towards increasing the number of SOs rated as at risk, a detailed analysis of the RER and RER indicators reveals an improvement of the implementation rate during 2010 (Figures 17 and 18).

[5] Since December 2008 the number of Entities has been reduced from 79 to 69 by merging some of them.

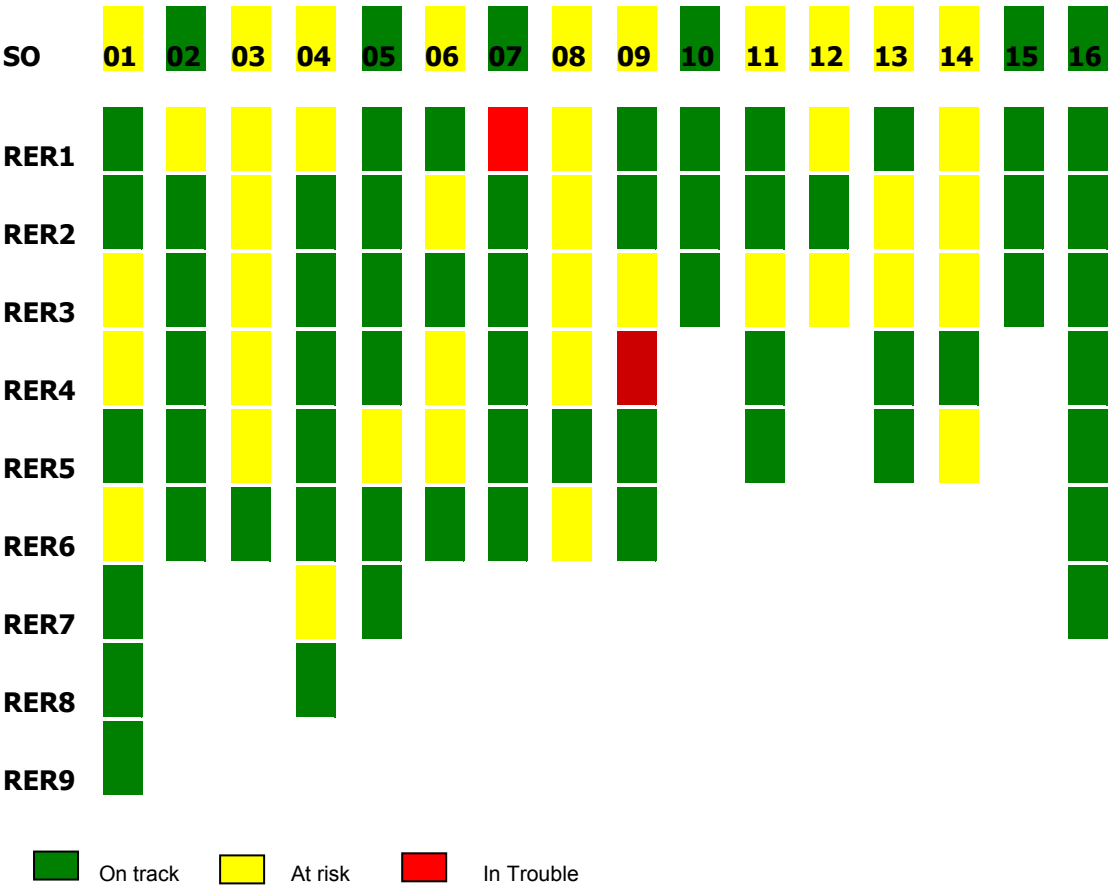
Figure 14. Progress towards achieving Strategic Objectives, 2008–2009 to December 2010



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

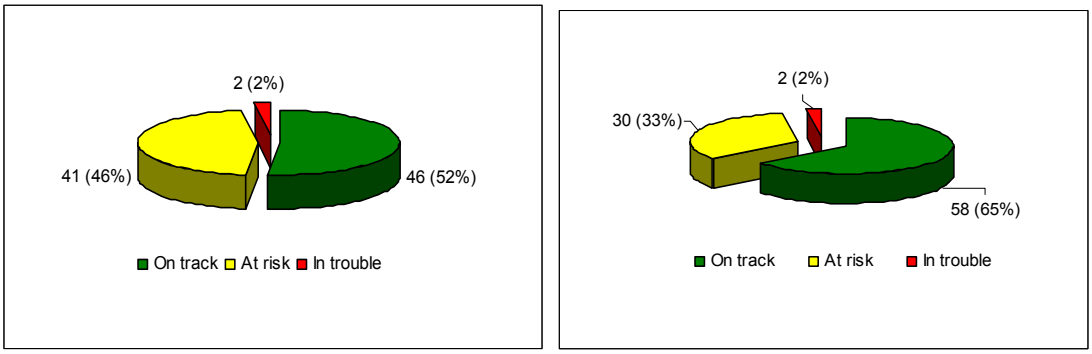
94. Figure 15 shows the status the Region-wide Expected Results at the end of the second semester (December 2010) of the 2010–2011 biennium. One can see that only two RERs were in trouble (red): incorporation of the determinants of health into national policies and norms (RER 7.1) and development and implementation of nutrition plans (RER 9.4). We are currently working on these RERs to improve their performance and ensure their achievement by the end of the current planning cycle.

Figure 15. Rating of Strategic Objectives and Region-wide Expected Results, 2010-2011 Second Semester Performance Monitoring and Assessment



95. Figures 16 and 17 show how the implementation rate of the RERs and RER indicators, respectively, has improved from the first semester to the second semester of the biennium.

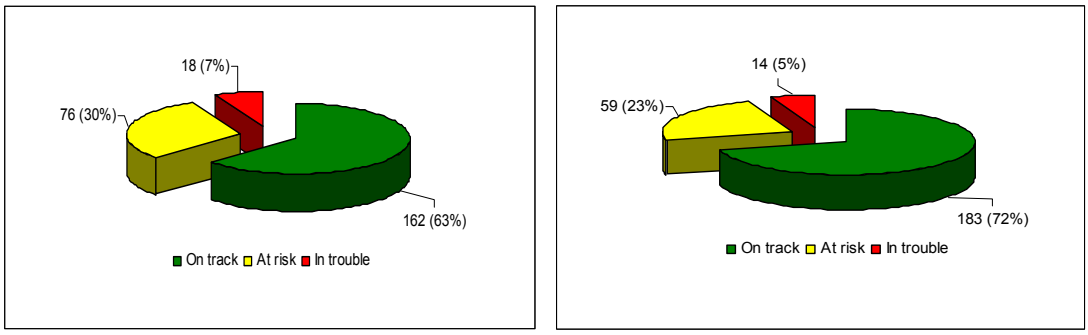
Figure 16. Progress toward achieving RERs, 2010–2011 PMAs, first and second semesters



First semester

Second semester

Figure 17. Progress toward achieving the RER indicator targets, 2010−2011 PMAs, first and second semesters



First semester Second semester

96. The main achievements under each SO, up to December 2010, are described below, and a complete analysis of the different SOs, RERs and RER indicators is presented in Annex 4.

SO1 - Communicable diseases

(a) All countries have prepared a plan of action to strengthen immunization and epidemiological surveillance in municipalities and among population groups with lower coverage and difficult access to health services.

(b) The countries of the Americas have successfully interrupted endemic measles and rubella virus transmission and are in the process of documenting the required evidence to demonstrate elimination of these diseases. An International Expert Committee has been established to verify their elimination at the regional level by 2012.

(c) Fifteen countries of the Region have introduced rotavirus vaccine into their routine program, eighteen have successfully introduced pneumococcal vaccine, and five have included HPV vaccine in their national vaccination schedules.

(d) There has been an effective response to outbreaks caused by diseases of international concern under IHR, such as dengue in several Central American and Caribbean countries, pneumonic plague in Peru, and cholera in Haiti.

(e) All Member States have put in place standard operating procedures (SOPs) within their national influenza pandemic preparedness plans (NIPPPs) for rapid response teams.

(f) Thirty-four countries have completed the assessment of epidemiological surveillance and are in the process of implementing their core capacities for surveillance and response requirements for the International Health Regulations (IHR 2005). In addition, the subregional integration mechanisms (such as CARICOM, SICA/COMISCA, CAN, MERCOSUR, and UNASUR) have adopted the implementation of IHR in their respective countries as a common development goal.

(g) There is a Region-wide commitment to implement in this biennium national plans for the control or elimination of Neglected Tropical Diseases (NTDs) beyond the four targeted countries (Brazil, the Dominican Republic, Haiti, and Honduras. Brazil and Mexico have formulated integrated plans for the control and elimination of multiple NTDs; the Inter-American Development Bank (IDB), the Global Network for Neglected Tropical Diseases/Sabin Vaccine Institute, and PAHO have supported their implementation in demonstration areas. The Dominican Republic, Guyana,

Honduras, and Suriname have initiatives which are moving from policies to the formulation of integrated plans of action for NTDs.

(h) The Region has seen significant progress in the elimination and control of Chagas' disease and its principal vectors:

i. In 2010, Honduras and Nicaragua interrupted the transmission of *Trypanosoma cruzi* by *Rhodnius prolixus* and Costa Rica certified the elimination of *Rhodnius prolixus*. The lack of transmission of *Trypanosoma cruzi* was revalidated in Belize. It is worth noting that in 2009, the elimination *Rhodnius prolixus* was achieved in El Salvador and in Chiapas and Oaxaca states, Mexico, which represents the elimination of the main vector in Central America and Southern Mexico. In addition, the transmission of *Trypanosoma cruzi* by *Triatoma infestans* was interrupted in Moquegua, Peru.

ii. Twenty of the twenty-one Chagas endemic countries have implemented universal screening for *Trypanosoma cruzi in* their blood banks.

(i) The Region continues its steady march to eliminate onchocerciasis, with the elimination of onchocerciasis transmission in two foci in Guatemala (Escuintla and Santa Rosa) and the interruption of transmission in the Northern Chiapas focus in Mexico and the North-Central focus in Venezuela. Continued post-treatment surveillance was ongoing in five foci: Oaxaca and Southern Chiapas in Mexico, Huehuetenango in Guatemala, and in each of the single foci in Colombia and Ecuador.

(j) Haiti's Ministry of Health, in cooperation with partners treated three million people with the two medicines used to eliminate transmission of lymphatic filariasis, even in the face of the country's devastating earthquake of January 2010 and the cholera epidemic.

SO2 - HIV/AIDS, TB and malaria

(a) The 50th Directing Council approved (September 2010) the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis.

(b) Price reductions of up to 20% were achieved for HIV/AIDS anti-retrovirals (ARVs) (the lowest regional reference prices currently available) that were purchased via the consolidated procurement mechanism under the PAHO Strategic Fund. This mechanism is contributing to ensure equitable access and affordability of ARVs in the Region.

(c) The Region continued to advance in the reduction of morbidity and mortality due to malaria. In 2009, the number of reported cases dropped by 52% (565,025 compared to 1,182,866 in 2000) and the number of deaths was reduced by 61% (144 compared to 371 in 2000). Of the 21 malaria-endemic countries in the Region, 18 saw a decrease in cases in 2009 relative to 2000; eight of these reported reductions of more than 75%, meeting both the Roll Back Malaria (RBM) and UN Millennium Development Goals (MDGs); four countries with decreases between 50% and 75%, have also met the RBM target.

(d) Anti-malarial drug resistance surveillance has been strengthened in the Region through efforts in the Amazon Network for the Surveillance of Anti-malarial Drug Resistance/Amazon Malaria Initiative (RAVREDA/AMI), which operates in Bolivia, Brazil, Colombia, Ecuador, Guyana, Suriname, and Peru.

(e) Global Fund resources amounting to $317 million have been committed to malaria efforts in Region since 2003. Of the 21 endemic countries, 13 have benefited from these funds through individual country grants or through a joint country project. As of May 2011, the Americas had 12 active malaria grants in 11 countries, with a signed or committed amount of US$ 140 million and a total lifetime budget of $250 million.

(f) The Region of the Americas has reached the MDG targets related to TB, reducing mortality and prevalence and declining incidence; 23 countries have achieved their national targets and 7 more are on track to achieve them by 2015.

(g) The regional plan for management of multidrug-resistant TB (MDR TB) is being used as a model to develop national plans across the Region, with 14 countries already implementing their national plans to expand the programmatic management of MDR TB. Importantly, about 50% MDR TB cases are being diagnosed and treated.

(h) Coverage of HIV testing in TB patients has improved, with 73% of cases of TB-HIV receiving ARV treatment.

(i) Actions for TB control among vulnerable populations have expanded, with all countries implementing actions to control TB in prisons. There are also successful experiences of TB control among indigenous people in five countries.

(j) Since the beginning of the Global Fund, PAHO has supported the countries' access to resources and their management of grants. The Global Fund has approved $307 millions in 28 TB grants in 14 countries. Currently in the Americas there are 20 active grants in 15 countries with a committed amount of $174,063,310 and a total lifetime budget of $255,899,852.

SO3 -Chronic noncommunicable diseases

(a) The Region's ministers of health, working with their leading partners, arrived at a consensus and adopted a regional declaration on noncommunicable disease prevention and control. The declaration sets forth the Region's position in preparation for the 2011 UN Summit on NCDs. The Summit will reiterate the importance of addressing these diseases and issues related to them in the national, regional, and global agendas.

(b) In September 2010, the 50th Directing Council adopted the resolution on Health, Human Security, and Well-being.

(c) Seven countries implemented guidelines for the evaluation of disability programs.

(d) A Region-wide analysis on oral health was completed.

(e) Six countries in the Region implemented the Communities Free of Dental Caries initiative implemented in 6 countries of the Region (funded by Colgate).

SO4 - Maternal, child, adolescent and elderly health

(a) In 2010, the Region continued to progress in reducing child and infant mortality, reducing it from 20.6 per 1,000 live births in 2009 to 19.7 in 2010.

(b) The Integrated Management of Childhood Illnesses (IMCI) strategy was expanded to the six countries with the most vulnerable and indigenous population areas.

(c) Eighteen countries launched a regional inter-agency initiative for safe motherhood.

(d) Seventeen countries developed national action plans for neonatal health, within the framework of the continuum of health care.

(e) Working with strategic partners (UN agencies, civil society, and academia), PAHO developed a new framework for the integrated management of child health.

(f) A conceptual framework on healthy life-course and its implication for public health was developed.

(g) Eleven countries implemented the Regional Plan on Healthy Aging.

(h) Five countries developed programs focused on indigenous youth groups.

SO5 - Emergencies and disasters

(a) Thirty-one countries have updated national disaster preparedness and response plans.

(b) The 50th Directing Council approved the Plan of Action on Safe Hospitals in September 2010.

(c) More than half of the Region's countries have implemented the safe hospitals. A separate safe index has been developed for small health facilities.

(d) PAHO responded effectively to the Haiti and Chile earthquakes.

SO6 - Health promotion and risk factors

(a) The 50th Directing Council approved the Regional strategy on substance use (September 2010).

(b) Twenty-eight countries have ratified the WHO Framework Convention on Tobacco Control (FCTC) and nine have approved national legislation banning smoking in public places and workplaces in accordance with WHO FCTC.

(c) Fourteen Caribbean countries and sic Latin American countries have implemented the standardized indicators for chronic noncommunicable diseases in their national health information systems; two subregions (CARICOM and MERCOSUR) have incorporated them in their health situation analysis.

(d) A Regional Consumers' Health Network was established by PAHO in collaboration with the OAS.

(e) PAHO developed a Regional Strategy and Plan of Action on Urban Health; it will be presented to the Executive Committee and Directing Council in 2011 for their approval.

(f) The 50th Directing Council (September 2010) approved the Regional Strategy on Substance Use and Public Health. The World Health Assembly approved the global alcohol strategy in 2010; it had input from countries in the Region.

(g) Three countries in the Americas (Brazil Chile, and Mexico) have initiated programs to curb the negative impact of marketing of food to children and the sale of junk food in schools, following the landmark resolution by World Health Assembly in 2010 inviting Member States to establish policies to curb marketing of food to children.

(h) The initiative, "Recreational Ciclovías", first started in the Latin America, achieved international notoriety after being featured as symbol of World Health Day celebration on 6 April 2010.

SO7 - Social and economic determinants of health

(a) Nineteen countries are producing and gathering disaggregated data on health and its determinants, particularly geo-administrative and geo-political disaggregation, and proxy indicators for socioeconomic position and social gradients.

(b) Resolution and the 50th Directing Council approved a concept paper on Health and Human Rights and adopted a resolution to that effect (CD50 R8). This is the first intergovernmental mandate within PAHO/WHO that establishes measures regarding the use of human rights instruments to reform health systems.

(c) Argentina enacted national mental health legislation (December 2010). The legislation incorporated all the universal and regional human rights treaties and standards on mental health and disability to which the country is Party, in a manner consistent with UN and OAS treaties.

(d) Seven countries developed plans to advance gender mainstreaming within their ministries of health, including the provision of training, improving information systems, and establishment of intersectoral groups to support the ministries.

(e) Four Eastern Caribbean countries implemented the Faces, Voices, and Places initiative. The initiative is also being implemented in communities in El Chaco (a transnational territory in South America) through technical cooperation among Argentina, Bolivia, and Paraguay.

S08 - Healthier environment

(a) Regional policy brief document for the development of scientifically sound policies for addressing water as a human right was prepared.

(b) Ecuador signed the United Nations Framework Convention on Climate Change 16th Conference of Parties (UNFCCC/COP16), whereby the country sets forth its commitment to address climate change. Bolivia has included health in its national climate change adaptation plan.

(c) Belize, Costa Rica, El Salvador, Honduras, Nicaragua, and Panama have safely repackaged and stored all their DDT stockpiles.

SO9 – Nutrition, food safety, and food security

(a) The 50th Directing Council approved the Strategy and Plan of Action for the Reduction of Chronic Malnutrition (September 2010).

(b) The Pan American Alliance for Nutrition and Development was consolidated and is working in three countries.

(c) The World Health Assembly approved the progress report and resolution on Infant and Young Child Nutrition and adopted a resolution in that regard in 2010; the Region of the Americas provided major input for the report.

(d) The World Health Assembly adopted a resolution on food safety in 2010; the Region of the Americas provided significant input into this resolution, and the countries are implementing updated food safety guidelines and norms.

SO10 - Health services

(a) Thirteen of the Region’s countries are implementing reforms to strengthen their health systems based on the 2005 Montevideo declaration and pledge, which was signed by all countries to develop primary health care (PHC) based systems.

(b) Seven countries developed national policies and programs to implement integrated health service delivery networks (following Resolution CD49.R22).

(c) The Regional Strategic Plan on Quality of Care and Patient Safety is being implemented; three countries have established quality of care and patient safety as the highest priority, three countries are implementing surgery check lists, and one country has standardized the program Clean Care is a Safe Care nationwide.

(d) The Productive Management Methodology for Health Services is being implemented across the Region.

SO11 - Health systems leadership and governance

(a) The PAHO Health Information Platform (PHIP) and the Regional Observatory for Health were established and are functioning.

(b) Fifteen countries have implemented processes to strengthen the coverage and quality of their health information systems; twenty-seven continue to progress in applying the Regional Core Health Data and Country Profiles Initiative, ten countries have updated their health situation analysis every two years, and thirty-six countries and territories are monitoring the health related MDGs.

(c) The PAHO health research policy is being implemented, including the mapping of national research systems, development of initiatives and tools for knowledge transfer, development of national policies and agendas for research and increased participation of countries of the region in the international clinical assays register.

SO12 – Medical products and technologies

(a) The 50th Directing Council adopted the resolution on Strengthening of the National Regulatory Authorities (September 2010).

(b) Three quality control laboratories for medicines in the Region have been prequalified as reference laboratories for the United Nations.

(c) In Haiti, medicines were distributed via PROMESS, which treated 700,000 severe cholera cases and 130,000 moderate cases; in addition, 6,000 units of red blood cells were delivered to the National Blood Program and 8 radiography units were installed and personnel trained to operate them.

(d) Twenty-three countries are participating in the PAHO Strategic Fund, and a record $31 million in essential medicines were purchased for 15 Member States through the Fund.

(e) The regional platform on innovation, research, development, production, and use of medicines and medical technologies was launched.

(f) Two subregions updated pharmaceutical policies, two countries adopted the regional strategy for the rational use of medicines, and two additional countries are in the process of adopting the strategy.

(g) Radiological services were evaluated in four countries.

(h) In Latin America and the Caribbean, 99.97% of blood was screened for HIV and Hepatitis B and C.

SO13 - Human resources for health

(a) A baseline assessment of the 20 Regional Goals for Human Resources for Health 2007–2015 (in line with CSP27.R7) was conducted at the country level in South America and the Caribbean; results are being used to inform policy decisions.

(b) The Strategy for Health Personnel Competency Development in Primary Health Care-based Health Systems (Resolution CD50.R7) was approved by the 50th Directing Council.

(c) The development of learning resources for human resources in health expanded through the Virtual Campus of Public Health (VCPH), online courses (for example, through 15 regional online tutored courses implemented and 896 professionals trained), and increased participation in the Leaders in International Health Program.

SO14 - Social protection and financing

(a) The review, expansion, or creation of publicly funded social protection in health schemes (Social Health Insurance/Public Insurance) has become the centerpiece of health policies, strategies, and health sector reforms currently taking place in Chile, Colombia, Costa Rica, The Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Peru, and Uruguay.

(b) Eleven of the Region countries have established specialized health economics units or departments within the ministries of health, which is contributing to improve the work of the ministries in assessing the sustainability and performance of health financing mechanisms.

(c) Two of the Region's countries completed their assessments of the impact of household out-of-pocket catastrophic expenditures on poverty, using PAHO's evaluation framework (Health Adjusted Poverty Lines).

(d) Ten of the Region's countries have exceeded the target of 6% of the GDP devoted to health; nine have national health care systems that provide universal coverage. Targets for increasing public expenditures as percentage of GDP to at least 6% of the GDP are included in policy dialogues/debates on financing universal coverage across countries. Four countries have specific medium-term targets of public expenditures as % of GDP included in their national health systems reforms or plans that aim to achieve universal coverage.

(e) Fifteen countries have put in place periodic production of National Health Expenditure Accounts (NHEA) and/or Health Satellite Accounts (HSA) harmonized with the United Nations System of National Accounts (UN-SNA).

SO15 - PAHO/WHO leadership and governance

(a) PAHO's presence in international high level meetings, such as the UN Regional Directors Group (UNDG-LAC), and the IDB (the Annual Board meeting and the Interamerican Corporation Investment meeting), has been enhanced.

(b) Policy dialogue instruments agreed with major partners (Canada, USA and Spain), which have increased the programmatic focus and building synergies for greater efficiency and effectiveness to fulfill gaps of the PAHO Strategic Plan.

(c) The Partners' Forum mechanism was revitalized, providing an opportunity to continue building partnerships within the multi-partners mechanism.

(d) Mobilized resources covered 55% of the funding gap of the 2010–2011 Program and Budget by the biennium's mid-point, December 31, 2010.

(e) Country Cooperation Strategies were developed in 32 countries and territories.

(f) Two Subregional Cooperation Strategies (SCS) were developed (Andean and Caribbean subregions).

SO16 - Flexible and learning organization

(a) The 50th Directing Council approved PAHO's RBM Framework in September 2010.

(b) The financial statements for 2010 were the first to be completed with IPSAS.

(c) Over 80% of PASB entities achieved 75% and or more of programmatic and budgetary implementation at the end of the first year of the 2010–2011 BWPs.

(d) The Performance Monitoring and Assessment (PMA) dashboard was completed.

(e) Un-earmarked voluntary contributions increased to 21%, increased from 11% in 2009.

(f) Of the total human resources learning plans, 90% were developed and approved by PASB's Executive Management.

(g) Voluntary contribution funds returned to partners were reduced to 0.25% of overall resources (below the 0.7% target for end of 2011).

(h) The first interim progress report on the implementation of the Strategic Plan 2008–2012 was presented to the 50th Directing Council (September, 2010).

Budgetary Implementation

97. The total budgetary implementation during 2008–2009 was $525 million (94% of $559 million available for the biennium) (see Table 10). This was a significant increase compared to the average implementation rate of the last two biennia (79%). The implementation by organizational levels consistently surpassed 90%.

98. The high implementation rate of OS (89%), compared to the historical average of 69%, reflects the improved programming of resources needed for the biennium, regardless of the availability of funds for the life of projects. This allows funds from "other sources," mainly voluntary contributions, to be aligned with the biennial planning cycle.

Table 11. Budgetary implementation by organizational levels and source of funds, end-of-biennium, 2008–2009

Organizational level	Funds available for the biennium (US$ thousand)			Expenditure (US$ thousand)			Implementation rate (%)		
	RB	OS	Total	RB	OS	Total	RB	OS	Total
Country	103,965	119,968	223,933	103,241	103,935	207,176	99	87	93
Subregional	15,276	14,576	29,852	15,116	13,428	28,544	99	92	96
Regional	158,823	146,132	304,955	157,672	131,606	289,278	99	90	95
Total	278,064	280,676	558,740	276,029	248,969	524,998	99	89	94

Note: The figures do not include funds from government financed internal projects, the Revolving Fund, the Strategic Fund, or any other funds that are not directly funding the Strategic Plan.

99. By the end of the second semester of the 2010–2011 biennium (December 2010), the Organization's overall budgetary implementation rate (disbursed funds divided by available funds) was 46% ($219 million of $482 million), which indicates that PASB is implementing its funds at an appropriate pace (Table 11). If this implementation rate continues, the average biennial implementation rate is expected to be achieved at the end of the biennium.

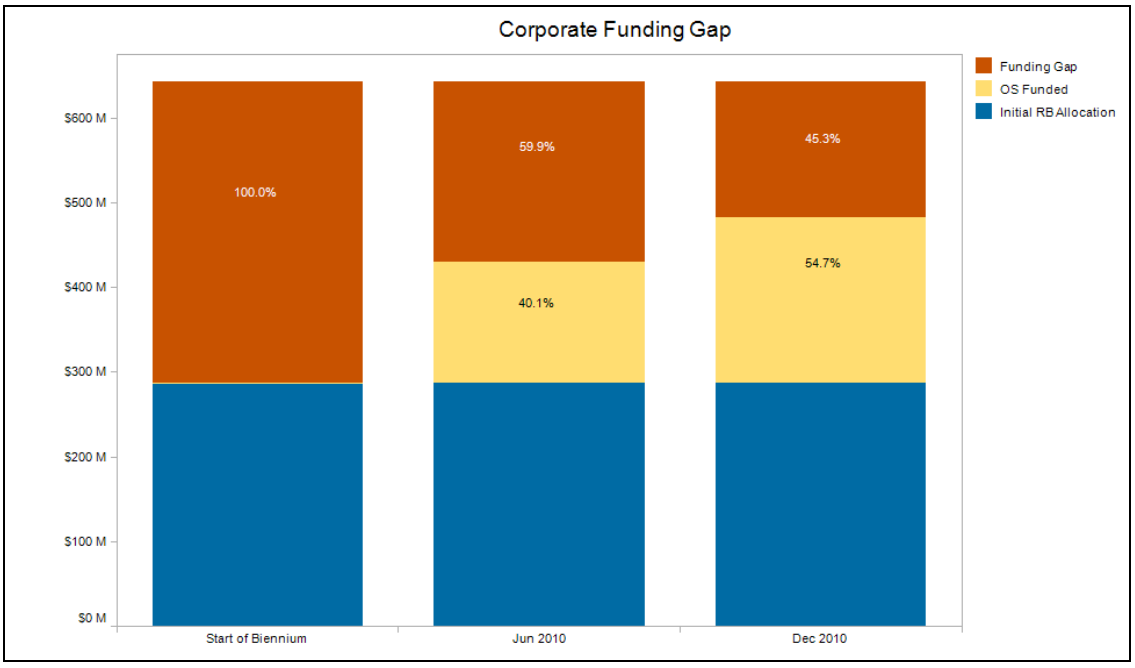
Table 12. Budgetary Implementation, by source of funds, as of 31 December 2010		
Type of Funding	Total funds available	% Implemented
Regular Budget	$287,100,000	40%
Other Sources	$194,761,974	54%
Total	$481,861,974	46%

Status of the Funding Gap

100. The funding gap is the difference between the planned cost and the total funds allocated (Regular Budget funds and funds from Other Sources) at any given point in time of the planning period. This analysis can be performed to determine the resource requirements of a given entity's BWP, PASB as a whole, or for a given Strategic Objective. This funding gap, then, becomes the focus of resource mobilization for the Organization.

101. Figure 18 shows how the PAHO corporate funding gap has been reduced during the first two semesters of the 2010-2011 biennium. As of December 2010, 55% ($194.8 million) of the funding gap ($355.85 million) had been covered.

Figure 18
Status of the PAHO corporate funding gap, expressed as a percentage of the initial funding gap, as of December 2010.
Biennium 2010-2011



	Beginning of the Biennium	First Semester	Second Semester
Regular Budget	287,100,000	287,100,000	287,100,000
Resources Mobilized[a]	0	142,817,000	194,761,974
Funding Gap	355,851,000	213,033,569	161,089,026
Total Planned Cost	**642,951,000**	**642,951,000**	**642,951,000**

[a]Excludes government-financed internal projects and outbreak, crisis and response funds.

ACRONYMS

AMRO	Regional Office for the Americas of the World Health Organization
BWP	Biennial Work Plan
CAN	Andean Community of Nations
CARICOM	Caribbean Community
COMISCA	Council of Ministers of Health of Central America
FTE	Full-time equivalent
FTP	Fixed-term post
MERCOSUR	Southern Common Market
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
RB	Regular Budget
RBM	Result-based Management
RER	Region-wide Expected Results
RPBP	Regional Program Budget Policy
SICA	Central American Integration System
SO	Strategic Objective
SPBA	Subcommittee on Program, Budget, and Administration
UNICSC	United Nations International Civil Service Commission
OS	Other Sources
OSER	Office-Specific Expected Result
UNASUR	Union of South American Nations
VC	Voluntary Contributions
WHA	World Health Assembly
WHO	World Health Organization

GLOSSARY

AMRO Share
Portion of the WHO Regular Budget approved by the World Health Assembly for the Region of the Americas.

Current dollars
Value of a dollar without adjustment for the effect of inflation or deflation.

Constant dollars
A metric for valuing the price in dollars of something over time, with adjustment for *inflation* or *deflation*.

Financial Implementation Rate
Total disbursements divided by total allocation of financial resources.

Full-time equivalent (FTE)
A measurement of workforce effort equivalent to one person working a full-time work schedule for one year. A way to measure the total PASB workforce, including fixed-term posts (FTP) funded with regular budget (RB) and other sources, as well as all other personnel contracted through different mechanisms other than FTP.

Fixed-term posts (FTP)
PASB positions for a determined length of time subject to United Nations human resources regulations. FTPs can be funded either by regular budget or other sources.

Fixed-term post budget
The cost associated with the funding of the fixed-term posts within the PAHO/AMRO regular budget.

Funding gap
The funding gap is the difference between the planned cost and the total funds allocated (both Regular Budget and funds from Other Sources) at any given point in time of the planning period. This analysis can be performed to determine the resource requirements of an entity's BWP, the PASB as a whole or for a Strategic Objective. This funding gap becomes the focus of resource mobilization for the Organization.

Initial unfunded gap
Difference between planned costs to implement a BWP and the initial allocation (both regular budget and other sources) for a given entity or Strategic Objective (SO) at the beginning of the planning period.

Resources mobilized
Funds from Other Sources destined to fill the unfunded gap for a given entity or SO at any point in time. This may include voluntary contributions that PAHO receives as a result of direct negotiations with donor partners or any other type of funds mobilized for the implementation of workplans, such as program support generated funds, or funds from the Master Capital Investment Fund.

Non-fixed-term posts

PASB personnel hired through any mechanism other than fixed-term posts.

Non-fixed-term post budget

The non-FTP budget includes all other costs not related to fixed-term posts. These can be:

(a) Non-FTP budget *activities*: Cost of program and operational activities, such as expenses for travel, meetings, publications, courses and seminars, and general operations.

(b) Non-FTP budget *personnel*: Cost of PASB personnel hired through any of mechanism other than fixed-term posts.

Workforce Efficiency

Workforce cost expressed as percentage of total expenditures.

Workforce Productivity

The total PAHO/WHO expenditure per year (gross output) in constant dollars per full-time equivalent.

ANNEXES

ANNEXES: 1–4

Net Effect of Proposed Assessed Contribution and the Regular Budget Allocations by Country

ANNEX 5

Programmatic and Budgetary Analysis by Strategic Objective End of 2010 Assessment

Annex 1
Scenario A (10.5% assessed contribution increase)
Net effect of the proposed assessed contributions
and the Regular Budget Allocation by Country

Member States	Assessed Contributions			Country Allocations			Net Effect
	2010-2011	2012-2013	Difference	2010-2011	2012-2013	Difference	
Antigua and Barbuda	41,008	45,320	4,312	519,000	546,000	27,000	22,688
Argentina	5,985,304	4,960,480	(1,024,824)	3,645,000	3,833,000	188,000	1,212,824
Bahamas	143,528	127,720	(15,808)	937,000	985,000	48,000	63,808
Barbados	111,840	92,700	(19,140)	632,000	665,000	33,000	52,140
Belize	41,008	45,320	4,312	790,000	831,000	41,000	36,688
Bolivia	85,744	100,940	15,196	5,529,000	5,815,000	286,000	270,804
Brazil	14,824,392	20,478,460	5,654,068	11,397,000	11,987,000	590,000	(5,064,068)
Canada	25,650,504	24,662,320	(988,184)	553,000	582,000	29,000	1,017,184
Chile	2,000,072	2,449,340	449,268	2,471,000	2,599,000	128,000	(321,268)
Colombia	1,563,896	2,160,940	597,044	4,593,000	4,830,000	237,000	(360,044)
Costa Rica	348,568	455,260	106,692	2,065,000	2,172,000	107,000	308
Cuba	449,224	376,980	(72,244)	4,232,000	4,451,000	219,000	291,244
Dominica	41,008	45,320	4,312	575,000	605,000	30,000	25,688
Dominican Republic	383,984	529,420	145,436	3,780,000	3,976,000	196,000	50,564
Ecuador	383,984	531,480	147,496	6,624,000	6,967,000	343,000	195,504
El Salvador	195,720	234,840	39,120	3,317,000	3,489,000	172,000	132,880
France	538,696	451,140	(87,556)	361,000	380,000	19,000	106,556
Grenada	41,008	45,320	4,312	700,000	736,000	36,000	31,688
Guatemala	348,568	346,080	(2,488)	6,500,000	6,836,000	336,000	338,488
Guyana	41,008	45,320	4,312	2,155,000	2,267,000	112,000	107,688
Haiti	83,880	70,040	(13,840)	5,619,000	5,910,000	291,000	304,840
Honduras	83,880	105,060	21,180	4,954,000	5,210,000	256,000	234,820
Jamaica	229,272	191,580	(37,692)	2,099,000	2,207,000	108,000	145,692
Mexico	15,174,824	17,058,860	1,884,036	6,827,000	7,180,000	353,000	(1,531,036)
Netherlands	167,760	140,080	(27,680)	361,000	380,000	19,000	46,680
Nicaragua	83,880	70,040	(13,840)	4,435,000	4,664,000	229,000	242,840
Panama	303,832	325,480	21,648	1,602,000	1,685,000	83,000	61,352
Paraguay	231,136	191,580	(39,556)	3,182,000	3,347,000	165,000	204,556
Peru	1,030,792	1,417,280	386,488	6,398,000	6,729,000	331,000	(55,488)
Puerto Rico	206,904	173,040	(33,864)	181,000	190,000	9,000	42,864
Saint Kitts and Nevis	41,008	45,320	4,312	463,000	487,000	24,000	19,688
Saint Lucia	41,008	45,320	4,312	677,000	712,000	35,000	30,688
Saint Vincent and the Grenadines	41,008	45,320	4,312	643,000	676,000	33,000	28,688
Suriname	83,880	70,040	(13,840)	1,117,000	1,175,000	58,000	71,840
Trinidad and Tobago	283,328	370,800	87,472	1,614,000	1,697,000	83,000	(4,472)
United Kingdom	111,840	94,760	(17,080)	372,000	391,000	19,000	36,080
United States	110,805,480	122,456,700	11,651,220	361,000	380,000	19,000	(11,632,220)
Uruguay	337,384	440,840	103,456	1,332,000	1,400,000	68,000	(35,456)
Venezuela	3,839,840	4,503,160	663,320	3,588,000	3,774,000	186,000	(477,320)
Country Variable	0	0	0	5,640,000	5,934,000	294,000	294,000
	186,400,000	206,000,000	19,600,000	112,840,000	118,680,000	5,840,000	(13,760,000)

Annex 2
Scenario B (6.7% assessed contribution increase)
Net effect of the proposed assessed contributions
and the Regular Budget Allocation by Country

Member States	Assessed Contributions			Country Allocations			Net Effect
	2010-2011	2012-2013	Difference	2010-2011	2012-2013	Difference	
Antigua and Barbuda	41,008	43,736	2,728	519,000	533,000	14,000	11,272
Argentina	5,985,304	4,787,104	(1,198,200)	3,645,000	3,740,000	95,000	1,293,200
Bahamas	143,528	123,256	(20,272)	937,000	961,000	24,000	44,272
Barbados	111,840	89,460	(22,380)	632,000	648,000	16,000	38,380
Belize	41,008	43,736	2,728	790,000	811,000	21,000	18,272
Bolivia	85,744	97,412	11,668	5,529,000	5,674,000	145,000	133,332
Brazil	14,824,392	19,762,708	4,938,316	11,397,000	11,696,000	299,000	(4,639,316)
Canada	25,650,504	23,800,336	(1,850,168)	553,000	567,000	14,000	1,864,168
Chile	2,000,072	2,363,732	363,660	2,471,000	2,536,000	65,000	(298,660)
Colombia	1,563,896	2,085,412	521,516	4,593,000	4,713,000	120,000	(401,516)
Costa Rica	348,568	439,348	90,780	2,065,000	2,119,000	54,000	(36,780)
Cuba	449,224	363,804	(85,420)	4,232,000	4,343,000	111,000	196,420
Dominica	41,008	43,736	2,728	575,000	591,000	16,000	13,272
Dominican Republic	383,984	510,916	126,932	3,780,000	3,879,000	99,000	(27,932)
Ecuador	383,984	512,904	128,920	6,624,000	6,797,000	173,000	44,080
El Salvador	195,720	226,632	30,912	3,317,000	3,405,000	88,000	57,088
France	538,696	435,372	(103,324)	361,000	371,000	10,000	113,324
Grenada	41,008	43,736	2,728	700,000	718,000	18,000	15,272
Guatemala	348,568	333,984	(14,584)	6,500,000	6,670,000	170,000	184,584
Guyana	41,008	43,736	2,728	2,155,000	2,212,000	57,000	54,272
Haiti	83,880	67,592	(16,288)	5,619,000	5,767,000	148,000	164,288
Honduras	83,880	101,388	17,508	4,954,000	5,084,000	130,000	112,492
Jamaica	229,272	184,884	(44,388)	2,099,000	2,154,000	55,000	99,388
Mexico	15,174,824	16,462,628	1,287,804	6,827,000	7,006,000	179,000	(1,108,804)
Netherlands	167,760	135,184	(32,576)	361,000	371,000	10,000	42,576
Nicaragua	83,880	67,592	(16,288)	4,435,000	4,551,000	116,000	132,288
Panama	303,832	314,104	10,272	1,602,000	1,644,000	42,000	31,728
Paraguay	231,136	184,884	(46,252)	3,182,000	3,266,000	84,000	130,252
Peru	1,030,792	1,367,744	336,952	6,398,000	6,566,000	168,000	(168,952)
Puerto Rico	206,904	166,992	(39,912)	181,000	185,000	4,000	43,912
Saint Kitts and Nevis	41,008	43,736	2,728	463,000	475,000	12,000	9,272
Saint Lucia	41,008	43,736	2,728	677,000	695,000	18,000	15,272
Saint Vincent and the Grenadines	41,008	43,736	2,728	643,000	660,000	17,000	14,272
Suriname	83,880	67,592	(16,288)	1,117,000	1,146,000	29,000	45,288
Trinidad and Tobago	283,328	357,840	74,512	1,614,000	1,656,000	42,000	(32,512)
United Kingdom	111,840	91,448	(20,392)	372,000	382,000	10,000	30,392
United States	110,805,480	118,176,660	7,371,180	361,000	371,000	10,000	(7,361,180)
Uruguay	337,384	425,432	88,048	1,332,000	1,366,000	34,000	(54,048)
Venezuela	3,839,840	4,345,768	505,928	3,588,000	3,681,000	93,000	(412,928)
Country Variable	0	0	0	5,640,000	5,790,000	150,000	150,000
	186,400,000	198,800,000	12,400,000	112,840,000	115,800,000	2,960,000	(9,440,000)

Annex 3
Scenario C (0% assessed contribution increase)
Net effect of the proposed assessed contributions
and the Regular Budget Allocation by Country

Member States	Assessed Contributions			Country Allocations			Net Effect
	2010-2011	2012-2013	Difference	2010-2011	2012-2013	Difference	
Antigua and Barbuda	41,008	41,008	0	519,000	503,000	(16,000)	(16,000)
Argentina	5,985,304	4,488,512	(1,496,792)	3,645,000	3,535,000	(110,000)	1,386,792
Bahamas	143,528	115,568	(27,960)	937,000	908,000	(29,000)	(1,040)
Barbados	111,840	83,880	(27,960)	632,000	613,000	(19,000)	8,960
Belize	41,008	41,008	0	790,000	766,000	(24,000)	(24,000)
Bolivia	85,744	91,336	5,592	5,529,000	5,363,000	(166,000)	(171,592)
Brazil	14,824,392	18,530,024	3,705,632	11,397,000	11,053,000	(344,000)	(4,049,632)
Canada	25,650,504	22,315,808	(3,334,696)	553,000	536,000	(17,000)	3,317,696
Chile	2,000,072	2,216,296	216,224	2,471,000	2,397,000	(74,000)	(290,224)
Colombia	1,563,896	1,955,336	391,440	4,593,000	4,454,000	(139,000)	(530,440)
Costa Rica	348,568	411,944	63,376	2,065,000	2,003,000	(62,000)	(125,376)
Cuba	449,224	341,112	(108,112)	4,232,000	4,104,000	(128,000)	(19,888)
Dominica	41,008	41,008	0	575,000	559,000	(16,000)	(16,000)
Dominican Republic	383,984	479,048	95,064	3,780,000	3,666,000	(114,000)	(209,064)
Ecuador	383,984	480,912	96,928	6,624,000	6,424,000	(200,000)	(296,928)
El Salvador	195,720	212,496	16,776	3,317,000	3,218,000	(99,000)	(115,776)
France	538,696	408,216	(130,480)	361,000	350,000	(11,000)	119,480
Grenada	41,008	41,008	0	700,000	679,000	(21,000)	(21,000)
Guatemala	348,568	313,152	(35,416)	6,500,000	6,304,000	(196,000)	(160,584)
Guyana	41,008	41,008	0	2,155,000	2,090,000	(65,000)	(65,000)
Haiti	83,880	63,376	(20,504)	5,619,000	5,450,000	(169,000)	(148,496)
Honduras	83,880	95,064	11,184	4,954,000	4,804,000	(150,000)	(161,184)
Jamaica	229,272	173,352	(55,920)	2,099,000	2,036,000	(63,000)	(7,080)
Mexico	15,174,824	15,435,784	260,960	6,827,000	6,621,000	(206,000)	(466,960)
Netherlands	167,760	126,752	(41,008)	361,000	350,000	(11,000)	30,008
Nicaragua	83,880	63,376	(20,504)	4,435,000	4,301,000	(134,000)	(113,496)
Panama	303,832	294,512	(9,320)	1,602,000	1,554,000	(48,000)	(38,680)
Paraguay	231,136	173,352	(57,784)	3,182,000	3,086,000	(96,000)	(38,216)
Peru	1,030,792	1,282,432	251,640	6,398,000	6,205,000	(193,000)	(444,640)
Puerto Rico	206,904	156,576	(50,328)	181,000	175,000	(6,000)	44,328
Saint Kitts and Nevis	41,008	41,008	0	463,000	449,000	(14,000)	(14,000)
Saint Lucia	41,008	41,008	0	677,000	657,000	(20,000)	(20,000)
Saint Vincent and the Grenadines	41,008	41,008	0	643,000	624,000	(19,000)	(19,000)
Suriname	83,880	63,376	(20,504)	1,117,000	1,083,000	(34,000)	(13,496)
Trinidad and Tobago	283,328	335,520	52,192	1,614,000	1,565,000	(49,000)	(101,192)
United Kingdom	111,840	85,744	(26,096)	372,000	362,000	(10,000)	16,096
United States	110,805,480	110,805,480	0	361,000	350,000	(11,000)	(11,000)
Uruguay	337,384	398,896	61,512	1,332,000	1,291,000	(41,000)	(102,512)
Venezuela	3,839,840	4,074,704	234,864	3,588,000	3,480,000	(108,000)	(342,864)
Country Variable	0	0	0	5,640,000	5,472,000	(168,000)	(168,000)
	186,400,000	186,400,000	0	112,840,000	109,440,000	(3,400,000)	(3,400,000)

NB: The figures in columns 3, 4, 6, 7, and 8 were modified.

Annex 4
Scenario D (4.3% assessed contribution increase)
Net effect of the proposed assessed contributions and the Regular Budget Allocation by Country

Member States	Assessed Contributions			Country Allocation			Net Effect
	2010-2011	2012-2013	Difference	2010-2011	2012-2013	Difference	
Antigua and Barbuda	41,008	42,768	1,760	519,000	519,000	0	(1,760)
Argentina	5,985,304	4,681,152	(1,304,152)	3,645,000	3,645,000	0	1,304,152
Bahamas	143,528	120,528	(23,000)	937,000	937,000	0	23,000
Barbados	111,840	87,480	(24,360)	632,000	632,000	0	24,360
Belize	41,008	42,768	1,760	790,000	790,000	0	(1,760)
Bolivia	85,744	95,256	9,512	5,529,000	5,529,000	0	(9,512)
Brazil	14,824,392	19,325,304	4,500,912	11,397,000	11,397,000	0	(4,500,912)
Canada	25,650,504	23,273,568	(2,376,936)	553,000	553,000	0	2,376,936
Chile	2,000,072	2,311,416	311,344	2,471,000	2,471,000	0	(311,344)
Colombia	1,563,896	2,039,256	475,360	4,593,000	4,593,000	0	(475,360)
Costa Rica	348,568	429,624	81,056	2,065,000	2,065,000	0	(81,056)
Cuba	449,224	355,752	(93,472)	4,232,000	4,232,000	0	93,472
Dominica	41,008	42,768	1,760	575,000	575,000	0	(1,760)
Dominican Republic	383,984	499,608	115,624	3,780,000	3,780,000	0	(115,624)
Ecuador	383,984	501,552	117,568	6,624,000	6,624,000	0	(117,568)
El Salvador	195,720	221,616	25,896	3,317,000	3,317,000	0	(25,896)
France	538,696	425,736	(112,960)	361,000	361,000	0	112,960
Grenada	41,008	42,768	1,760	700,000	700,000	0	(1,760)
Guatemala	348,568	326,592	(21,976)	6,500,000	6,500,000	0	21,976
Guyana	41,008	42,768	1,760	2,155,000	2,155,000	0	(1,760)
Haiti	83,880	66,096	(17,784)	5,619,000	5,619,000	0	17,784
Honduras	83,880	99,144	15,264	4,954,000	4,954,000	0	(15,264)
Jamaica	229,272	180,792	(48,480)	2,099,000	2,099,000	0	48,480
Mexico	15,174,824	16,098,264	923,440	6,827,000	6,827,000	0	(923,440)
Netherlands	167,760	132,192	(35,568)	361,000	361,000	0	35,568
Nicaragua	83,880	66,096	(17,784)	4,435,000	4,435,000	0	17,784
Panama	303,832	307,152	3,320	1,602,000	1,602,000	0	(3,320)
Paraguay	231,136	180,792	(50,344)	3,182,000	3,182,000	0	50,344
Peru	1,030,792	1,337,472	306,680	6,398,000	6,398,000	0	(306,680)
Puerto Rico	206,904	163,296	(43,608)	181,000	181,000	0	43,608
Saint Kitts and Nevis	41,008	42,768	1,760	463,000	463,000	0	(1,760)
Saint Lucia	41,008	42,768	1,760	677,000	677,000	0	(1,760)
Saint Vincent and the	41,008	42,768	1,760	643,000	643,000	0	(1,760)
Suriname	83,880	66,096	(17,784)	1,117,000	1,117,000	0	17,784
Trinidad and Tobago	283,328	349,920	66,592	1,614,000	1,614,000	0	(66,592)
United Kingdom	111,840	89,424	(22,416)	372,000	372,000	0	22,416
United States	110,805,480	115,561,080	4,755,600	361,000	361,000	0	(4,755,600)
Uruguay	337,384	416,016	78,632	1,332,000	1,332,000	0	(78,632)
Venezuela	3,839,840	4,249,584	409,744	3,588,000	3,588,000	0	(409,744)
Country Variable	0	0	0	5,640,000	5,640,000	0	0
	186,400,000	194,400,000	8,000,000	112,840,000	112,840,000	0	(8,000,000)

NB: This scenario has been modified in its entirety to reflect an increment of 4.3% in the assessed contributions.

Annex 5
Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment (Rating by SO, RER and RER Indicator[6])

SO	RER	RER Ind.	Observations and Recommendations [7]
SO 1	1.1	1.1.1	This SO has a total of 22 indicators, of which 19 are "number-of-countries" type (NOCT) indicators. It has two maintenance indicators. The 2013 targets for two indicators had been achieved at the end of 2009, but two countries dropped from the 2007 baseline in one indicator (1.3.2- rabies). It is worth noting the reemergence of communicable diseases such as dengue, the impact of natural disasters and related climate change effects. In 2008–2009, this SO obtained $75.1 million (86%) of its PB ($86.6 million), of which 72% were from Other Sources. The budgetary implementation was 96%, and 75% of the RER indicators were achieved. As of December 2010, the SO had been awarded 86% of its PB ($79 million of $87.9 million); had 58% budgetary implementation, and 73% of the RER indicators were rated on track. Based on the assessment of this SO (both programmatic and budgetary), resources mobilized, and the priority of this SO in the SP (#2), it is reasonable to recommend an increase in the PB for 2012–2013 to slightly above the 2010–2011 levels, to ensure that 2013 targets are met. **Resources amounting to $90.5 million are suggested, in accordance with the planned amount for 2010–2011.**
To reduce the health, social, and economic burden of communicable diseases.		1.1.2	
		1.1.3	
		1.1.4	
	1.2	1.2.1	
		1.2.2	
	1.3	1.3.1	
		1.3.2	
		1.3.3	
		1.3.4	
		1.3.5	
	1.4	1.4.1	
		1.4.2	
		1.4.3	
	1.5	1.5.1	
	1.6	1.6.1	
		1.6.2	
	1.7	1.7.1	
		1.7.2	
		1.7.3	
	1.8	1.8.1	
	1.9	1.9.1	

[6] Color code: green, on track; yellow, at risk; red, in trouble.
[7] Criteria: implementation rate (budgetary and programmatic in 2008–2009 and 2010–2011, per PMA), prioritization in the Strategic Plan, contribution to the MDGs and to the Health Agenda for the Americas, and other commitments (i.e. regional and global commitments), and importance in the Country Cooperation Strategies (CCS).

Programmatic and Budgetary Analysis by Strategic Objective End of 2010 Assessment *(cont.)*			
SO	**RER**	**RER Ind.**	**Observations and Recommendations**
SO 2 To combat HIV/AIDS, tuberculosis, and malaria.	2.1	2.1.1	This SO has 24 indicators, of which 22 are "number-of-countries" type (NOCT) indicators. It has five maintenance indicators. In 2008–2009, this SO obtained $34.9 million (46%) of its PB ($75.1 million), of which 76% was from Other Sources. The budgetary implementation was 93%, and 89% of the RER indicator targets were achieved. As of December 2010, the SO had been awarded $19.7 million (26.2%) of its PB ($75.1 million); had 47% budgetary implementation and 96% of RER indicators were rated on track. Based on the assessment of this SO (both programmatic and budgetary), and resources mobilized in the previous and current biennium, it appears that the budget for this SO was overestimated since the 2008–2009 biennium. Furthermore, the rate of resource mobilization for this SO has been low. The funding available to countries from other mechanisms (i.e. the Global Fund) and partnerships established should also be taken into consideration. Based on the above, it is reasonable to decrease the PB for this SO in 2012-13 to a more realistic amount **($56.1 million recommended).** This amount takes into consideration the importance of this SO (priority #3 in the SP), its contribution to MDG #6, and a trend of reduced funds available to countries from other sources in the future (i.e. indications that the withdrawal of the Global Fund). Taking into account this scenario, the Organization will need to assign the necessary resources to maintain the rate of programmatic implementation to achieve the 2013 targets under this SO.
		2.1.2	
		2.1.3	
		2.1.4	
		2.1.5	
		2.1.6	
		2.1.7	
	2.2	2.2.1	
		2.2.2	
	2.3	2.3.1	
		2.3.2	
		2.3.3	
	2.4	2.4.1	
		2.4.2	
		2.4.3	
		2.4.4	
		2.4.5	
		2.4.6	
	2.5	2.5.1	
		2.5.2	
		2.5.3	
		2.5.4	
	2.6	2.6.1	
		2.6.2	

Programmatic and Budgetary Analysis by Strategic Objective End of 2010 Assessment *(cont.)*			
SO	**RER**	**RER Ind.**	**Observations and Recommendations**
SO 3 To prevent and reduce disease, disability, and premature death from chronic noncommunicable conditions, mental disorders, violence, and injuries	3.1	3.1.1	This SO has 27 indicators, of which 26 are "number-of-countries" type (NOCT) indicators. This is SO has the most number of RER indicators at risk and in trouble. In 2008–2009, this SO had ($21 million) 75% of its PB ($28 million), of which 40% was from other sources. The budgetary implementation was 90%, and 96% of the 2009 RER indicator targets had been achieved. As of December 2010, this SO had been awarded 54% of its PB ($17.4 million of $31.9 million), had 45% budgetary implementation, and 48% of the RER indicators were on track. Based on the assessment of this SO (both programmatic and budgetary), the challenges in achieving the targets, considering the priority of this SO in the SP (#4), and the fact that chronic noncommunicable diseases represent a major challenge in the Region, the budget for this SO should increase in 2012–2013 **($36 million suggested).** While this SO is not directly related to MDGs, the Member States' recognition of the burden these diseases place in the Region has led to their being addressed at the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases.
		3.1.2	
		3.1.3	
		3.1.4	
		3.1.5	
	3.2	3.2.1	
		3.2.2	
		3.2.3	
		3.2.4	
		3.2.5	
		3.2.6	
		3.2.7	
	3.3	3.3.1	
		3.3.2	
		3.3.3	
		3.3.4	
		3.3.5	
	3.4	3.4.1	
		3.4.2	
		3.4.3	
		3.4.4	
		3.4.5	
	3.5	3.5.1	
		3.5.2	
		3.5.3	
	3.6	3.6.1	
		3.6.2	

Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment *(cont.)*

SO	RER	RER Ind.	Observations and Recommendations
SO 4 To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood, and adolescence, and to improve sexual and reproductive health and promote active and healthy aging for all individuals.	4.1	4.1.1	This SO has a total of 15 indicators, of which 13 are "number-of-countries" type (NOCT) indicators. In 2008–2009, this SO obtained $24.7 million (67%) of its PB ($37.2 million), of which 54% were from Other Sources. The budgetary implementation was 85%, and 100% of its RER indicator targets were met. As of December 2010, this SO had been awarded 56% of its PB ($21.35 million of $37.1 million), had achieved 59% budgetary implementation, and 73% of its RER indicators were rated as being on track. Considering the above, and that this SO's priority ranks as #1 in the SP, its contribution to MDGs 4 and 5, and the request from Member States to align the budgetary allocation with the programmatic priorities, the PB for this SO in 2012–2013 should be increased **($42.5 million suggested)**. In light of this increase and of the importance of the public issues addressed in this SO, the Organization will need to increase efforts to improve the rate of implementation in the current and next biennium, in order to ensure that the resources are fully implemented and that the 2013 targets achieved. Given its priority, this SO should have the highest percentage increase.
		4.1.2	
		4.1.3	
	4.2	4.2.1	
		4.2.2	
	4.3	4.3.1	
	4.4	4.4.1	
		4.4.2	
	4.5	4.5.1	
		4.5.2	
	4.6	4.6.1	
		4.6.2	
	4.7	4.7.1	
		4.7.2	
	4.8	4.8.1	
SO 5 To reduce the health consequences of emergencies, disasters, crises, and conflicts, and to minimize their social and economic impact.	5.1	5.1.1	This SO has 17 RER indicators, of which 6 are "number-of-countries" type (NOCT) indicators; 9 are maintenance indicators. In 2008–2009, this SO obtained $49.3 million, 41% of its PB (from funds mobilized to respond to emergencies in the Region), of which 92% were from Other Sources. It met its budgetary implementation and 100% of its RER indicator targets. As of December 2010, this SO had been awarded 65% of its PB ($22.7 million of $35 million); it had achieved 75% budgetary implementation and 88% of its RER indicators were rated as being on track. An additional $27.1 million were awarded from OCR funds. Based on the above and the fact that this SO benefits from OCR funds, the budget can remain at the same level as in 2010–2011 **($35 million)**.
		5.1.2	
		5.1.3	
	5.2	5.2.1	
		5.2.2	
	5.3	5.3.1	
		5.3.2	
	5.4	5.4.1	
		5.4.2	
	5.5	5.5.1	
		5.5.2	
		5.5.3	
	5.6	5.6.1	
		5.6.2	
		5.6.3	
	5.7	5.7.1	
		5.7.2	

Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment *(cont.)*

SO	RER	RER Ind.	Observations and Recommendations
SO 6 To promote health and development, and to prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions	6.1	6.1.1	This SO has 14 RER indicators and all are "number-of-countries" type (NOCT) indicators; 1 indicator already has achieved the 2013 target. In 2008–2009, this SO obtained $14.2 million (89%) of its PB ($16 million), of which 56% was from Other Sources. The budgetary implementation was 93%, and 60% of its RER indicator targets were met. As of December 2010, this SO had been awarded 69% of its PB ($11 million of $15.96 million); it had achieved 53% budgetary implementation, and 57% of its RER indicators were rated as being on track. This SO will face challenges in the current and future BWP in maintaining gains and achieving future targets (especially in the area of tobacco control). In addition, because it compliments **SO3** (prevention and control chronic noncommunicable diseases), it is recommended that it be granted a slight increase in 2012–2013 (**$17 million)**.
		6.1.2	
		6.1.3	
	6.2	6.2.1	
		6.2.2	
		6.2.3	
	6.3	6.3.1	
		6.3.2	
		6.3.3	
		6.3.4	
	6.4	6.4.1	
	6.5	6.5.1	
		6.5.2	
	6.6	6.6.1	
SO 7 To address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor, gender-responsive, and human-rights-based approaches.	7.1	7.1.1	This SO has 12 RER indicators, of which 10 are "number-of-countries" type (NOCT) indicators; 1 indicator has already achieved the 2013 target. In 2008–2009, this SO had been awarded $17.4 million (100%) of its PB, of which 58% was from Other Sources. Its budgetary implementation was 95%, and 94% of its RER indicator targets had been met. As of December 2010, this SO had been awarded 61% of its PB ($12.7 million of $20.96 million); it had achieved 70% budgetary implementation, and 83% of its RER indicators were rated as being on track. Notably, two indicators were rated as being in trouble (7.1.1, implementation of strategy to address policy recommendations of the Commission on Social Determinants of Health and 7.6.3, health of ethnic/racial groups). Based on the above, this SO's priority (#5), the fact that it addresses cross-cutting health issues (determinants of health) of the Strategic Plan, and its importance within the Health Agenda for the Americas (area of action #2), it is reasonable to recommend an increase in the PB for 2012-2013 **($22.7 million suggested)**. This SO is considered as one of the top priorities in the Country Cooperation Strategies.
	7.2	7.2.1	
		7.2.2	
		7.2.3	
	7.3	7.3.1	
	7.4	7.4.1	
	7.5	7.5.1	
		7.5.2	
		7.5.3	
	7.6	7.6.1	
		7.6.2	
		7.6.3	

Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment *(cont.)*

SO	RER	RER Ind.	Observations and Recommendations
SO 8	8.1	8.1.1	This SO has 13 RER indicators, of which 5 are "number-of-countries" type (NOCT) indicators. This SO had the most RER indicators at risk in December 2010 (per PMA). In 2008–2009, this SO obtained $19.1 million (76%) of its PB ($25 million), of which 31% was from Other Sources. Its budgetary implementation was 91%, and 84% of its RER indicator targets had been met. As of December 2010, this SO had been awarded 79% of its PB ($19.8 million of $24.93 million); it had achieved 53% budgetary implementation, and 31% of its RER indicators were rated as being on track. Considering the challenges involved in maintaining gains and achieving future targets for this SO (as per December 2010 PMA), and in light of the impact of disasters and related climate issues, as well as its contribution to MDG 7 an increase in its PB 2012-2013 is justified **($26.5 million recommended).**
To promote a healthier environment, intensify primary prevention, and influence public policies in all sectors so as to address the root causes of environmental threats to health		8.1.2	
		8.1.3	
		8.1.4	
	8.2	8.2.1	
	8.3	8.3.1	
		8.3.2	
	8.4	8.4.1	
		8.4.2	
	8.5	8.5.1	
		8.5.2	
	8.6	8.6.1	
		8.6.2	
SO 9	9.1	9.1.1	This SO has 14 RER indicators; all are number of country. There is 1 maintenance indicator. In 2008-2009, this SO obtained $15.8 million (75%) of its PB ($21 million), of which 35% was from other sources. The budgetary implementation was 97% and 76% of its RER indicator targets were met. As of December 2010, this SO had been awarded $19.3 million (92% of its PB ($20.94 million); had 43% budgetary implementation and 64% of the RER indicators were rated on track. Based on the above, and challenges faced in achieving some of the RER indicator targets, the contribution of this SO to MDG1 (through the establishment of the Pan-American Alliance for Nutrition and Development for the MDGs), and the fact that the Organization is the main actor working in the area of food safety and nutrition, an increase in the PB is recommended for this SO **($22.5 million).**
To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development		9.1.2	
	9.2	9.2.1	
	9.3	9.3.1	
		9.3.2	
		9.3.3	
	9.4	9.4.1	
		9.4.2	
		9.4.3	
		9.4.4	
		9.4.5	
	9.5	9.5.1	
		9.5.2	
	9.6	9.6.1	

Programmatic and Budgetary Analysis by Strategic Objective End of 2010 Assessment *(cont.)*			
SO	**RER**	**RER Ind.**	**Observations and Recommendations**
SO 10 To improve the organization, management, and delivery of health services.	10.1	10.1.1	This SO has seven RER indicators; all are "number-of-countries" type (NOCT) indicators. In 2008–2009, this SO obtained $34.4 million, 7% above its PB ($32 million), of which 63% were from Other Sources. Its budgetary implementation was 85%, and 80% of its RER indicator targets had been met. As of December 2010, this SO had been awarded 42% of its PB ($16.95 million of $40 million); it had achieved 46% budgetary implementation, and 86% of the RER indicators were rated as being on track. Based on the above, it is reasonable to maintain the same level of PB in 2012–2013 **($40 million)** for this SO. While the SO is priority #7 in the Strategic Plan, the countries have identified as one of the main priorities in their Country Cooperation Strategies. Moreover, this SO is directly related to 3 of the 8 areas for action in the Health Agenda for the Americas.
		10.1.2	
		10.1.3	
		10.1.4	
	10.2	10.2.1	
		10.2.2	
	10.3	10.3.1	
SO 11 To strengthen leadership, governance and the evidence base of health systems.	11.1	11.1.1	This SO has 14 RER indicators, of which 12 are "number-of-countries" type (NOCT) indicators; 1 is a maintenance indicator. In 2008–2009, this SO obtained $31.1 million (89%) of its PB ($35 million), of which 42% was from Other Sources. Its budgetary implementation was 97%, and 71% of its RER indicator targets had been met. As of December 2010, this SO had been awarded 71% of its PB ($30.6 million of $42.84 million); it had achieved 50% budgetary implementation, and 86% of is RER indicators were rated as being on track. Based on the above, it is reasonable to hold the same level of PB for this SO (priority #11) in 2012–2013. This SO also complements SO10 (health services), SO13 (human resources for health), and SO14 (social protection and health financing).
		11.1.2	
	11.2	11.2.1	
		11.2.2	
	11.3	11.3.1	
		11.3.2	
		11.3.3	
		11.3.4	
	11.4	11.4.1	
		11.4.2	
	11.5	11.5.1	
		11.5.2	
		11.5.3	

Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment *(cont.)*

SO	RER	RER Ind.	Observations and Recommendations
SO 12 To ensure improved access, quality and use of medical products and technologies.	12.1	12.1.1	This SO has 9 RER indicators; all are "number-of-countries" type (NOCT) indicators. One indicator already has achieved the 2013 target. In 2008–2009, this SO obtained $19.2 million (87%) of its PB ($22 million), of which 69% was from Other Sources. Its budgetary implementation was 90%, and 88% of its RER indicator targets had been met. As of December 2010, this SO had been awarded 103% of its PB ($19.45 million compared to $18.96 million). It had achieved 57% budgetary implementation, and 67% of its RER indicators were rated as being on track. This SO's budget for 2010–2011 was reduced by about 14%, compared to its budget for 2008–2009. Based on the level of resource mobilization and the implementation rate in 2010–2011, it appears that this SO was under-budgeted in 2010–2011. Hence, a slight budgetary increase is recommended for 2012–2013 **($20 million)**. **T**his SO is related to "Harnessing Knowledge, Science and Technology," area for action #7 of the Health Agenda for the Americas.
		12.1.2	
		12.1.3	
		12.1.4	
		12.1.5	
	12.2	12.2.1	
		12.2.2	
	12.3	12.3.1	
		12.3.2	
SO 13 To ensure an available, competent, responsive, and productive health workforce to improve health outcomes.	13.1	13.1.1	This SO has 13 RER indicators; all of them number-of-countries" type (NOCT) indicators. In 2008–2009, this SO obtained $14.8 million (64%) of its PB ($23 million), of which 41% was from Other Sources. Its budgetary implementation was 92%, and 68% of its RER indicator targets were met. As of December 2010, this SO had been awarded 61% of its PB ($12.26 million of $19.95 million); it had achieved 57% budgetary implementation, and 69% of the RER indicators were rated as being on track. Considering the challenges this SO has had in meeting its targets (in terms of end-of-biennium 2008–2009 assessment and December 2010 PMA), and its priority in the SP (#6), it is recommended that its PB be increased in 2012–2013 **($21.5 million).** This SO's PB was reduced from $23 million in 2008–2009 to about $20 million in 2010–2011. This SO also is related to "Strengthening the Management and Development of Health Workers," area for action # 6 of the Health Agenda for the Americas.
		13.1.2	
	13.2	13.2.1	
		13.2.2	
	13.3	13.3.1	
		13.3.2	
	13.4	13.4.1	
		13.4.2	
		13.4.3	
		13.4.4	
		13.4.5	
	13.5	13.5.1	
		13.5.2	

Programmatic and Budgetary Analysis by Strategic Objective
End of 2010 Assessment *(cont.)*

SO	RER	RER Ind.	Observations and Recommendations
SO 14 To extend social protection through fair, adequate, and sustainable financing.	14.1	14.1.1	This SO has 10 RER indicators; of which 9 are "number-of-countries" type (NOCT) indicators. As of the December 2010 PMA, this SO had the second largest number of RER indicators at risk. In 2008–2009, this SO obtained $4.9 million (32%) of its PB ($15 million), of which 23% was from Other Sources (the SO relies mainly on Regular Budget funds). Its budgetary implementation was 94%, and 77% of its RER indicator targets were met. As of December 2010, this SO had been awarded 50% of its PB ($5 million of $10.27 million); it had achieved 50% budgetary implementation, and only 20% of its RER indicators were rated as being on track. Considering the challenges this SO has had in meeting its targets, its complementarity to SO10 (health services), and its contribution to the Health Agenda for the Americas (area for action #3, "Increasing Social Protection and Access to Quality Health Services") it is recommended that this SO's PB be increased in 2012–2013 **($10.2 million suggested)**.
	14.2	14.2.1	
		14.2.2	
		14.2.3	
	14.3	14.3.1	
		14.3.2	
		14.3.3	
	14.4	14.4.1	
		14.4.2.	
	14.5	14.5.1	
SO 15 To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the United Nations system, and other stakeholders to fulfill PAHO/WHO's mandate to advance the global health agenda, as set out in WHO's Eleventh General Programme of Work and in the Health Agenda for the Americas.	15.1	15.1.1	This SO covers enabling functions to support the achievement of other SOs. It has 15 RER indicators, of which 4 re "number-of-countries" type (NOCT) indicators. In 2008-2009, this SO obtained $69.7 million; its budgetary implementation was 98%, and 90% of its RER indicator targets were met. As of December 2010, this SO had been awarded 83% of its PB ($61.8 million of $74.9 million); its budgetary implementation was 58%, and 80% of the RER indicators were rated on track (green). No changes in the PB are proposed for this SO.
		15.1.2	
		15.1.3	
		15.1.4	
		15.1.5	
	15.2	15.2.1	
		15.2.2	
		15.2.3	
		15.2.4	
		15.2.5	
		15.2.6	
	15.3	15.3.1	
		15.3.2	
		15.3.3	
		15.3.4	

Programmatic and Budgetary Analysis by Strategic Objective End of 2010 Assessment *(cont.)*			
SO	**RER**	**RER Ind.**	**Observations and Recommendations**
SO 16 To develop and sustain PAHO/WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	16.1	16.1.1	This SO has 30 RER indicators. It covers the enabling functions to support the work undertaken under SOs 1-15. This SO does not have any "number-of-countries" type indicators. In 2008-2009, this SO obtained $113.1 million; its budgetary implementation was 98%, and 94% of its RER indicator targets were met. As of December 2010, this SO had been awarded $99.3 million; its budgetary implementation was 56%, and 90% of the RER indicators were rated on track (green). A reduction in the PB for this SO is suggested, in order to decrease the amount of funds assigned to enabling functions in accordance with the target established in the Strategic Plan (reduce to 15% the budget of this SO in relation to the total budget by 2013).
		16.1.2	
		16.1.3	
		16.1.4	
		16.1.5	
	16.2	16.2.1	
		16.2.2	
		16.2.3	
		16.2.4	
		16.2.5	
		16.2.6	
	16.3	16.3.1	
		16.3.2	
		16.3.3	
		16.3.4	
		16.3.5	
	16.4	16.4.1	
		16.4.2	
		16.4.3	
	16.5	16.5.1	
		16.5.2	
		16.5.3	
		16.5.4	
		16.5.5	
	16.6	16.6.1	
		16.6.2	
		16.6.3	
		16.6.4	
		16.6.5	
		16.6.6	

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