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Draft Proposed programme budget 2010–2011 – the WHO European Region's perspective

This paper seeks to emphasize the perspectives of the European Region related to its work in the biennium 2010–2011 as a part of achieving objectives set by the Medium-term Strategic Plan. The paper also explains the rationale behind the draft Proposed programme budget for the Regional Office and identifies current and future challenges for financing it, as well as possible strategies to overcome these. This paper should be read in conjunction with the global paper (EUR/RC58/8).

The Regional Committee is invited to comment and advise on the strategic orientations and the budget proposed in the paper, as well as issues related to financing.

A draft resolution is submitted to the Regional Committee for its consideration.

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Introduction

A change in business process and cycle

1. The process related to the Medium-term strategic plan (MTSP) and the Programme budget is a key instrument for advancing WHO's work agenda. It aims at improving performance, providing greater accountability and demonstrating results at all levels of the Organization. The cardinal reasons for the introduction of the MTSP were to improve performance and accountability by:

- ensuring greater consistency between bienniums towards achieving long-term results;
- extending the timescale of the plan from a two-year to a six-year period, better reflecting the more strategic nature of WHO's work;
- removing the vertical Area-of-Work structure that did not facilitate working together and across teams towards common objectives, and was a poor fit at country and regional levels in terms of achieving results and meeting the expectations of Member States; and
- reducing the heavy workload that had resulted from overlapping processes.

Development of the MTSP and the related Programme budget – a single integrated global process

2. The MTSP and the Programme budget are presented as a single document. The MTSP sets forth the measurable changes in terms of health gain, health systems and determinants of health expected under the 13 strategic objectives (SOs). For each SO, it:

- presents a **situation analysis** that discusses the challenges/opportunities and problems identified and provides the rationale and justification for deciding on the most appropriate set of strategic approaches for Member States and for the WHO Secretariat;
- outlines the **strategic approaches**, describing how the agreed objective will be achieved jointly by Member States and the WHO Secretariat;
- defines, for the WHO Secretariat, the six-year **organization-wide expected results** (OWERs), i.e. what the WHO Secretariat anticipates achieving or changing as a direct consequence of its own actions over the six-year period;
- identifies **performance indicators** (aligned, where applicable, to the Millennium Development Goals), with baselines and targets that are the yardsticks against which performance will be measured.

Changes introduced this biennium

3. For various reasons explained in some depth in the global document, the draft Proposed programme budget is now presented in three segments: WHO programmes, Partnerships and collaborative arrangements (PCO), and Outbreak and crisis response (OCR). Annex 1 shows the Regional Office for Europe's budget in this revised format from 2004–2005 to 2010–2011. In order to strengthen implementation capacity and consolidate growth, the WHO programmes segment of the draft Proposed programme budget for 2010–2011 has been established at the same nominal value as in the revised budget for 2008–2009.

4. In order to provide meaningful comparisons between bienniums, the Regional Office has undertaken a "crosswalk" exercise. The budget and expenditure data from previous bienniums implemented within the Area-of-Work structure, with 36 areas, is now presented within the framework of the 13 strategic objectives of the MTSP.

5. This biennium, following discussions on the topic during the Sixty-first World Health Assembly, a new OWER on climate change has been added in SO 8. Further attention needs to be given to the area of patient safety and this is recognized with the introduction of a new OWER in SO 10.

Regional orientations for 2010–2011

6. The work of the Regional Office in the coming biennium will be focused on four main areas:

- communicable diseases (SOs 1 and 2)
- noncommunicable diseases and environment (SOs 3, 6, 8 and 9)
- health systems, including social determinants of health (SOs 4, 5, 7, 10 and 11)
- governance and leadership, including country presence (SOs 12 and 13).

7. The Regional Office has undertaken substantial organizational adjustments this biennium in order to align its organizational structure to WHO's redefined strategic objectives and thus facilitate the implementation of the MTSP in the four main areas mentioned above. The Regional Office's approaches to achieving its objectives in each of those areas are presented below, along with changes in the focus of its work, and the proposed resource needs in 2010–2011, as well as comparisons with the current and previous bienniums. In this connection, and to obtain a more insightful picture of the nature of the Office's activities and achievements, the reader may also wish to refer to the Regional Director's biennial report on the work of WHO in the Region (EUR/RC58/4) and to the document entitled Implementation of the Regional Office's Country Strategy (2006–2007 period), Copenhagen, WHO Regional Office for Europe, 2008.

Communicable diseases (SOs 1 and 2)

SO 1: To reduce the health, social and economic burden of communicable diseases

SO 2: To combat HIV/AIDS, tuberculosis and malaria

8. The core portfolio of work regarding communicable diseases is covered by SO 1 and SO 2, but important cross-cutting or communicable disease-related activities will be coordinated with or developed under all the other SOs, such as: SO 3 (e.g. mental health and substance abuse), SO 4 (e.g. neonatal, reproductive and sexual health), SO 5 (e.g. disaster preparedness and response), SO 6 (e.g. risk factors and consequences of unsafe sex), SO 7 (e.g. health equity and human rights), SO 8 (e.g. environmental health and climate change), SO 9 (e.g. food safety and security), and SO 10 and SO 11 (e.g. health systems strengthening, blood safety, pharmaceuticals).

9. While communicable diseases are not among the leading causes of mortality and morbidity in the WHO European Region, they remain significant threats to human health and safety and international security. Vaccine-preventable, food-borne, zoonotic, health care-related and chronic communicable diseases contribute significantly to health care costs. They require substantial and sustainable resources for an appropriate level of preparedness, outbreak response and control to be maintained. Emerging and re-emerging epidemic-prone infections also cause significant public concern, and the ability of the Member States and of the Region as a whole to prevent and control them remains a fundamental objective of health systems.

10. All 53 WHO Member States in the European Region are also committed to achieving Millennium Development Goals 4 and 6, which specifically address reductions in child mortality resulting from vaccine-preventable diseases, as well as halting and reversing the trends of HIV/AIDS, tuberculosis, malaria and other major diseases, and achieving universal access to HIV/AIDS prevention, treatment and care. Disease-specific objectives have been set by World Health Assembly and Regional Committee

resolutions. WHO has a particular role in implementing the International Health Regulations (2005), which entered into force in 2007.

11. The overall level of effort in this area will remain comparable to that in 2008–2009, ensuring that gains achieved so far will be sustained, and with a shift towards strengthening preparedness for and response to communicable diseases by Member States within the wider framework of the International Health Regulations. Technical support for Member States in assessing and strengthening their core capacity for timely and appropriate detection of and response to health threats, as required by the International Health Regulations, will contribute to those efforts. There will also be a shift to further develop the health intelligence function to collect, analyse and disseminate information about epidemiological situations, health threats and health system responses to communicable diseases, and to conduct the operational research necessary to inform WHO's policy advice and policy-making by the Member States. Further development of synergies and long-term collaboration with the European Centre for Disease Prevention and Control remains an important priority.

12. The Regional Office will support Member States' efforts to further reduce and prevent the health, economic and political burdens of communicable diseases in the European Region through the introduction, bringing up to scale, and sustaining of existing and newly developed evidence-based technologies and interventions, such as condom use, harm reduction for injecting drug users, immunizations, including the use of new and underutilized vaccines, early or rapid diagnosis or treatment of acute and chronic infections, and rational use of medicines. Building on the Member States' political commitment, the Regional Office will develop and provide evidence for action, country-specific policy advice and normative guidance, support the strengthening of institutional infrastructure and the introduction of reforms to achieve sustainable financing, and support policies and action aimed at ensuring a competent workforce and the rational organization of services. These will be the focus of the Regional Office's work in 2010–2011 and beyond.

13. Maintaining global, regional and national political commitment is an important role of WHO, carried out in close partnership with other stakeholders, including governments, United Nations agencies and other international organizations, academic and public health institutions, the private sector, civil society and patient groups. As part of strengthening the stewardship role of the health ministries, the Office will continue its work to further develop and maintain political commitment to communicable disease control interventions, to maintain existing partnerships and develop new ones within and outside the health sector, and to evaluate the performance of the health systems in view of reducing the current and future burden of communicable diseases. Advocating evidence-based prevention, treatment and control of existing and newly emerging communicable diseases of public health importance will remain an important part of the Regional Office's work.

14. In terms of service delivery interventions, the Office's emphasis in 2010–2011 will be on supporting Member States' progress towards specific objectives such as: universal access to HIV/AIDS prevention, treatment and care by 2010, the Stop TB partnership objectives for tuberculosis control by 2013, the elimination of malaria, measles, rubella and congenital syphilis, maintaining the Region's status as poliomyelitis-free, and the strengthening of sustainable and effective public health services, including laboratories, along with continual strengthening of health systems. It will support countries in implementing a broad range of strategies, from policy development to intersectoral action at all levels, with special focus on health systems strengthening.

15. Under the resource generation and health financing functions, the Office will assist Member States in accessing and making effective use of major international assistance funds such as the GAVI Alliance and the Global Fund to fight AIDS, Tuberculosis and Malaria, ensuring the availability and rational use of existing and new, safe and affordable diagnostics, vaccines, antimicrobial agents and other commodities for communicable disease prevention, treatment and control, and developing policies for the sustainable financing of public health services for communicable diseases within existing health systems. The existence of a competent and sufficient health workforce will remain essential for communicable disease prevention, treatment and control. Efforts such as the Regional Office's knowledge hubs will be used to

further promote sustainable in-service training programmes for health professionals working on communicable diseases.

16. The proposed 2010–2011 budget level for SO 1 and SO 2 has been estimated on the basis of the Regional Office's work in previous bienniums, including financial performance data (see annexes 1 and 2). There has been a steady increase in the budget in absolute figures over in the past several bienniums; however, in 2010–2011 this becomes a slight decrease, giving a total of US$ 69.3 million. This is a reflection of the changing disease burden trend in the European Region and of the strengthening of the Regional Office's work in the health systems area, that allows for a more comprehensive approach in addressing communicable disease-related interventions and is covered in other SOs, as indicated above. It is also a realistic reflection of the trends in the Regional Office's resource mobilization and implementation capacity in this area. At the same time, there has already been a substantial shift of focus towards strengthening direct country support work during 2008–2009, especially in high-disease-burden areas, by reinforcing WHO's presence in the countries in the area of communicable diseases (see Annex 3 on the country programmes), with some adjustments proposed in the same line in the programme budget 2010–2011. It should be noted that the 8.5% increase in the SO 1 budget in 2010–2011 is based on the total programme budget, which includes Partnerships. Partnerships represent a substantial share of the proposed programme budget in this particular SO, as seen in Annex 1.

Noncommunicable diseases and environment (NCE) (SOs 3, 6, 8 and 9)

SO 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment

SO 6: To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

SO 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

SO 9: To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

17. The core portfolio of the work regarding noncommunicable diseases and environment is covered by SOs 3, 6, 8 and 9; however, in 2010–2011, there will be more cross-cutting and integrated technical and policy development work with other strategic objectives, notably SOs 1 and 2 (communicable diseases), SO 3 (e.g. prevention of injuries), SO 4 (life-course, children's health, healthy ageing), SO 5 (e.g. disaster preparedness and response), SO 6 (e.g. risk factors such as lack of physical activity), SO 7 (equity and human rights, social determinants), SO 9 (e.g. food safety and security) and SO 10 (health systems).

18. The burden of noncommunicable diseases (NCDs) is high and the scope for action is compelling and relevant for all parts of the European Region. In the previous and current bienniums, Member States in the European Region have clearly expressed their commitment to act simultaneously on many NCD-related fronts by adopting the NCD strategy (*Gaining health: the European strategy for the prevention and control of noncommunicable diseases* (EUR/RC56/8)). Strategies and action plans addressing NCDs and injury prevention and control, counteracting the obesity epidemic, nutrition, physical activity and tobacco control define the Regional Office's actions in this area in the form of cost-effective interventions and the promotion of integrated and intersectoral work. Furthermore, country-specific support will be provided to help strengthen the health systems' capacity and role in the prevention and management of chronic diseases in an integrated way.

19. In order to ensure scaled up and sustainable efforts in this area in 2010–2011 and to support the development and implementation of NCD prevention, control and management strategies and plans at all levels, the Regional Office will strengthen and expand capacity at the regional level and, especially, at country level. This makes it possible to focus better on addressing the priorities and needs of the Member

States through the development and application of evidence-based guidance on effective and cost-effective interventions through country work, the preparation of planning and evaluation tools (including economic impact evaluations) and their use in country-led policy processes, the development and running of integrated surveillance and monitoring systems, policy analysis and documentation of good practices, training of staff in integrated ways of working, and the development of platforms for learning and sharing from experience. This will translate into more staff and resources dedicated to NCD prevention and control and more integrated delivery at country level.

20. Work will be increasingly geared towards addressing behaviour and lifestyles; specific disease prevention and management efforts in country-specific health system contexts will also be widely implemented. The Regional Office will strengthen its support to the Member States in harmonizing, coordinating, developing and maintaining surveillance and monitoring systems on NCD risk factors, information on disease impact, and policies and strategies to prevent and manage chronic diseases, mental health and violence and injuries. It is envisaged that the biennium 2010–2011 will bring major progress in tobacco control as more countries are expected to implement the Framework Convention on Tobacco Control. Work on promoting healthy lifestyles and NCD prevention will be addressed through health systems interventions, both in primary health care and through population-based services. Work on alcohol policies will be scaled up in response to the increasing demand from Member States. In the field of nutrition and physical activity, the Regional Office will continue implementation of the second Action Plan for Food and Nutrition Policy and follow-up at country level on the recommendations of the Ministerial Conference on Counteracting Obesity. The challenging areas of nutrition and food safety will also receive increased attention in the context of climate change and the simultaneous presence of malnutrition, which is now expanding further as a result of soaring food prices.

21. Addressing health inequalities and the social determinants of health as well as the special needs of vulnerable groups remains a high priority and it will be given further prominence in NCD prevention and control work.

22. The management of chronic diseases, including cardiovascular diseases, cancer and diabetes as well as mental health and injuries, calls for a reconfiguration of health systems and the rethinking of care and social services in different settings (hospital care, home care, palliative care). This is an area of substantial interest for Member States and it will receive increased attention in 2010–2011 through the evaluation of various models and technical and policy advice to the Member States. In the field of mental health, the emphasis will be on deinstitutionalization and the development of alternatives for social care homes; mental health and employment, with a focus on older people; and mental health policy and service development. Violence and injuries is an emerging field of work where higher demand for capacity building work at country level is expected in the coming biennium.

23. The overall work portfolio for all environment and health issues for 2010–2011 will be streamlined and close links will be established with related areas such as emergencies (SO 5), management of risk factors (SO 6), health determinants (SO 7), food safety (SO 9) and health systems (SO 10).

24. Environmental risks that will be addressed through SO 8 are important determinants of health and contribute significantly to the burden attributable to NCDs (such as cardiovascular and respiratory diseases associated with air pollution) as well as to communicable diseases (such as those resulting from microbiologically contaminated food and water) in the European Region. In addition to the high cost of implementing policies to reduce harmful exposures, policy-makers in the health and other sectors are also challenged, in taking policy decisions, by the high degrees of uncertainty involved, particularly when addressing emerging environmental concerns, such as those related to climate change or to the large-scale introduction of new technologies. In order to respond properly to these challenges faced by Member States, in the next biennium the Regional Office will develop and maintain an appropriate quality of environmental monitoring and surveillance and continue to support countries in strengthening their capacity to assess and manage risks, to develop mechanisms, to apply effective country-specific responses to environmental risks and challenges, and to engage other sectors whose decisions and activities are the main determinants of environmental exposures. The Office will provide the necessary support to Member States in implementing the commitments of the Fifth Ministerial Conference on Environment and Health,

which is to take place in late 2009. This work will contribute significantly to achieving Millennium Development Goal 7 on ensuring environmental sustainability, particularly in relation to reducing the proportion of people who do not have access to safe water and sanitation.

25. Technical assistance to Member States in the development and implementation of national policies that address environment and health is expected to increase in the next biennium, consolidating a trend begun in 2008–2009. These efforts at country level will concentrate on strengthening national capacity to implement methods and tools to monitor and address environmental health concerns, and to support decision-making in this field, including information systems, impact assessment tools and platforms for the exchange of knowledge and experiences. The capacity of countries to address emerging environmental issues such as climate change will be enhanced through greater engagement of the Regional Office in the country-specific programmes and actions. The further development of partnerships with key regional actors, such as the European Commission, the European Environment Agency and the United Nations Economic Commission for Europe will continue.

26. The Regional Office will continue to work on reducing or preventing the burden related to environmental risk factors through the introduction, bringing up to scale, and sustaining of existing and newly developed evidence-based policies and interventions, such as implementation of measures to meet the WHO air quality, drinking water and recreational water guidelines and the development of plans to increase the adaptive capacities of health systems to climate change. Actions will take into account cross-cutting aspects such as socioeconomic and gender inequities.

27. In the context of cross-cutting work linking noncommunicable diseases and environment with the health systems area, the emphasis of the Regional Office for 2010–2011 in the field of service delivery will be to provide policy and technical assistance to Member States to help them strengthen their health systems' capacity to develop effective information systems to monitor key environmental health indicators, and to ensure safe water and food and better preparedness for extreme weather events and climate change. As part of strengthening the health ministries' stewardship function, the Office will continue to support the development of national health systems' capacity to actively engage other sectors such as environment, transport, energy, agriculture in order to raise their awareness of the effects of decisions taken in their respective domains on health, and to steer sectoral policies in directions that are more supportive of health.

28. For the noncommunicable diseases and environment (NCE) area (SOs 3, 6, 8 and 9), the proposed budget level in 2010–2011 has been estimated on the basis of the Regional Office's work in previous bienniums, including financial performance data (see Annex 2). In response to the increasing challenges of the NCD burden in the European Region, the programme budget level for this area has risen significantly, in absolute figures, over the past several bienniums, especially 2008–2009 (see annexes 4 and 4a). Currently, the Regional Office is strengthening and consolidating its implementation capacity in order to respond properly to that sharp increase and to develop an adequate resource base in this traditionally not so "donor-attractive" area. The corresponding data clearly indicate that these challenges ought to be overcome, especially in the cases of SO 3 and SO 6 before any further increase in the programme budget level for this area is proposed. At the same time, an increase is proposed for SO 8 in order to reprioritize and accommodate climate change-related activities in the work of Regional Office. It is therefore proposed to maintain the level of the programme budget in the NCE area at nearly the same high level as in 2008–2009, i.e. US$ 47.8 million, with adjustment between corresponding SOs. It should also be noted that, as in the case of communicable diseases, strengthening the Regional Office's work in health systems, which also includes addressing social determinants of health, contributes to addressing challenges in the NCE area through a more comprehensive system-wide approach and in accordance with the Office's NCD strategy adopted by the Regional Committee in 2006. At the same time, it is essential to ensure that WHO's work in this area should not focus predominantly on intercountry activities but, rather, should gradually shift towards strengthening direct country support work so as to achieve a better balance (including through strengthened WHO country presence), especially in the Member States with high needs who have identified this as a priority for collaboration with the Regional Office. This is especially

relevant to SO 8, where almost all work has been focused on intercountry collaboration. These adjustments have been incorporated in the proposed programme budget for the NCE area.

Health systems, including social determinants of health (SOs 4, 5, 7, 10 and 11)

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 improve sexual and reproductive health and promote active and healthy ageing for all individuals

SO 5: To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact

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

SO 10: To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

SO 11: To ensure improved access to, quality and use of medical products and technologies

29. The increasing recognition of the central role of health systems is clearly described in the Eleventh General Programme of Work. Strengthening health systems is a prerequisite for achievement of the Millennium Development Goals. The increased emphasis placed on health systems strengthening in the MTSP is therefore in line with both global initiatives and the European Region's priorities, as seen in responses from our Member States and most clearly demonstrated in the European Ministerial Conference on Health Systems, which took place in Tallinn in June 2008. At the Conference, the Member States agreed on a new health systems charter that will be put to the Regional Committee for endorsement in September. The Charter commits WHO to provide direct country support to European Member States on health systems issues, and to coordinate cross-country work on implementation issues such as the development and use of performance assessment measures and techniques.

30. Within the Regional Office for Europe, the strategic objectives associated with health systems include not only SOs 10 and 11, which explicitly cover health system functions, but also SO 4, which is associated with the population at different stages of the life-course rather than a particular set of diseases, SO 5, which deals with the preparedness of health systems to respond to emergencies, and SO 7, which deals with the broader stewardship issues such as addressing social determinants of health through intersectoral collaboration. As indicated above, the Regional Office will fully incorporate its broad health systems approaches not only in these SOs but as support for SOs 1 to 9 as well, because the health system is the backbone for all health programme work.

31. The work of the Regional Office in improving reproductive, maternal, child and adolescent health remains important. In 2010–2011, particular focus will be put on assisting those Member States at greatest risk of not meeting the MDG 4 and 5 targets on maternal and child mortality to implement global, regional and national strategies and programmes in this area, with the establishment of effective health systems being a basic requirement for achieving the agreed goals and targets. Emphasis will be put on developing comprehensive policies and strategies with regard to maternal, newborn, child and adolescent health, sexual and reproductive health, and healthy aging. This work will be closely linked to other efforts to strengthen health systems, particularly the renewed efforts to strengthen the primary level of care and improve quality and access to care at all levels. The Office will also work to build national capacities to undertake research and take advantage of national and international evidence to improve these dimensions of health.

32. SO 5 aims to reduce the health consequences of emergencies, disasters, crises and conflicts, and to minimize their social and economic impact. Work in this area includes technical efforts to strengthen health security and close collaboration with technical experts across strategic objectives, with emphasis on strengthening the national capacities of Member States to prevent, mitigate and respond to the health consequences of crises.

33. SO5 implementation can be divided into core activities, and crisis response, recovery and transition activities. The core activities are focused on supporting Member States in health systems crisis preparedness planning, and providing technical support and recommendations on disaster mitigation and reduction interventions, as well as expert advice and capacity building on the analysis of disrupted health systems in a post-crisis situation. Regional training courses, exercises based on lessons learned and intercountry exchange of expertise on health system preparedness and response also form part of core activities.

34. Should a serious health crisis or a humanitarian emergency occur in the European Region, the Regional Office's response will be implemented through the WHO country offices and supported by WHO headquarters. All humanitarian action will be closely coordinated with other United Nations agencies and partner nongovernmental organizations, in line with WHO's designated role as health cluster lead agency in the broader context of the United Nations humanitarian reform process. In a response situation, the Office will support its Member States' national health systems' capacities, focusing on the WHO core functions in emergencies, which are:

- to measure ill-health and promptly assess health needs of populations affected by crises
- to support Member States in coordinating health actions
- to ensure that critical gaps are filled
- to build local capacities for health systems preparedness and response.

35. In the event of a crisis in the European Region, the additional resources required to respond to the acute health needs will be mobilized through United Nations joint donor appeals. This is also the case for recovery and transition operations. The proposed change to the WHO budget structure in 2010–2011 reflects this division and thus affects the way resources for SO 5 are portrayed. The proposed reduction in the budget envelope for SO 5 is a result of the fact that, with the recently endorsed WHO standard operating procedures for emergencies and the business rules that accompany them, funds raised for response, recovery and transition operations will not be subject to any budgetary ceiling. These "non-core" activities will not appear in the planned budget. Another part of the decrease can be attributed to the phasing out of the north Caucasus programme, which will be substantially reduced during the next biennium.

36. The overall objective of SO 7 is to support countries in strengthening the stewardship function, implementing policies and strengthening institutional capacity to address the social determinants of health and health inequities. Across Europe, as health inequities within and between countries increase, systematic and effective responses need to be put in place. In financial terms, the overall budget for this SO is relatively small compared to those of other SOs, though the nature of the work is cross-cutting, and complements the technical assistance provided under other SOs (particularly SO 10, but also SOs 3, 4, 6 and 9).

37. Addressing the social determinants of health and implementing SO 7 require a highly performing health system. The Regional Office has therefore emphasized providing leadership for intersectoral action through strengthened governance and stewardship in 2008–2009. The outcomes of the European Ministerial Conference on Health Systems in 2008 and the findings published in the report of the WHO Global Commission on Social Determinants of Health (to be released in August 2008) will further contribute to shaping the work of the coming biennium. Based on the increasing numbers of requests for technical assistance, the Regional Office's work will be scaled up in 2010–2011, with greater focus on intensifying direct country assistance, particularly by mainstreaming decision support tools and increasing the capacity for stewardship of socially determined health inequities through health systems and health in all policies. The nature of country-level assistance varies greatly between high, middle and lower income countries, and countries of all income levels are requesting assistance. This will require joint actions with other strategic objectives teams.

38. Concerning SOs 10 and 11, the Office's actions will continue to be focused primarily on direct support to countries, which is expected to increase in the context of Member States' efforts to fulfil the

commitments of the Tallinn Charter. SOs 10 and 11 are very broad and incorporate aspects of the four health system functions: service delivery (they now explicitly include work on patient safety), stewardship, resource creation/human resources/pharmaceuticals and technologies, and financing. Taken together, these SOs aim to improve the organization, management, quality and delivery of health services, and to promote access to them in a manner that does not force an untenable trade-off between people's physical/mental well-being and their financial condition.

39. In the work on service delivery, the Regional Office will provide assistance to Member States to help them develop country-specific strategies and policies, establish performance monitoring systems, promote regional exchange of experiences, and build national capacity to expand access, improve quality and reduce inequities. Particular emphasis will be put on integrating services and improving the coherence between population-based and personal health services.

40. To support better stewardship of health systems, the Office will work with Member States in: developing effective health system policies that are aligned to current challenges and take anticipated changes into account; building capacities in health system performance assessment; strengthening the effectiveness of regulatory functions; and improving the effectiveness of intersectoral collaboration at various levels of governance. The work on stewardship will incorporate gender-based analysis into performance assessment and ensure that such concerns are taken into account in the implementation of all strategies and programmes.

41. The Regional Office also aims to improve the resource generation function by supporting Member States in ensuring the existence of an available, competent, responsive and productive health workforce in order to improve health outcomes. The Office will support Member States in their efforts to achieve an appropriate mix of health workers responsive to current and future population needs and to improve the management of the workforce. It will also focus on support for implementing, monitoring and evaluating new workforce development programmes at the country level in order to improve workforce retention, motivation and performance. Special emphasis will be put on the issue of health worker migration in the European Region.

42. The Regional Office will focus on horizontal issues related to the regulation and quality of medical products and technologies, including vaccines. This will include efforts to strengthen institutional capacity to manage the supply, regulation and use of medicines and medical products, in order to achieve equitable access to safe and efficacious products, and ensure that these are appropriately used. It also includes optimizing the safety of immunization and the use of quality-assured vaccines, and the appropriate use of clinical technologies (blood and transplantation services). While transitional countries are focusing primarily on increasing access to essential medicines, reducing out-of-pocket payments, and improving the regulation and quality of medical products on their markets, the more affluent countries are concentrating on increasing the efficiency of pharmaceutical spending and the way medical products are used, as well as on stimulating research and development on underserved disease areas. The Regional Office will also support Member States in their national policy-making through the timely provision of appropriate information and specific technical assistance in these areas. Its efforts in strengthening this dimension of country health systems will be closely coordinated and developed with the disease-oriented programmes (with special focus on HIV/AIDS, tuberculosis, the integrated management of childhood illness and NCDs).

43. The Office also foresees maintaining a strong focus on health financing policy, an area that has been given increased attention in 2008–2009 in response to demand from Member States. Work will consist primarily of providing technical leadership, support and capacity strengthening in the area of health financing policy, and strengthening the information base on country health expenditures as a global public good to promote evidence-based policy-making. In those Member States where donor agencies and partners are active, the Regional Office will continue to support policy-makers in assessing the advice they receive and working closely with the partners to ensure a coherent approach.

44. Since the 2004–2005 biennium, the Regional Office has substantially increased the collective financial envelope to the traditionally underfunded area of health systems, more than doubling the

allocation in 2008–2009 to US$ 87.7 million for the WHO programme segment (see Annex 1), or US$ 95.4 million based on the total revised budget as shown in Annex 4. Given the explanations above, it is proposed to maintain the priority that has been given to health systems and to consolidate the Regional Office's work, with a planned budget of US$ 81.5 million in 2010–2011. This maintenance of priority will allow the necessary continuation of work on governance and stewardship of health systems, financing of health systems, delivery of personal and population-based services, health workforce, and pharmaceuticals and technologies, in order to provide policy support for actions to improve system performance, involving work on health gain and equity in health, financial protection and equitable distribution of the financing burden, responsiveness, and overall system efficiency, typically through related priority intermediate objectives such as improving access to and quality/safety of care, equity in health spending or increased population awareness of how to improve health.

45. As far as health systems SOs are concerned, a number of developments are proposed. While maintaining the importance set on improving reproductive, maternal, child and adolescent health, some reduction is proposed in the budget for SO 4, mainly related to the changes in approach explained above, and reflecting the Office's resource mobilization and implementation capacity established over previous years. For SO 5, the proposed programme budget relates only to the WHO programmes segment and covers activities in preparedness, response and recovery only. When Outbreak and crisis response (OCR) is eventually included, it is anticipated that the level of effort of the Regional Office will be in line with the current biennium. Under the revised standard operating procedures for emergencies, as previously mentioned, funds for response operations and for health recovery and transition will not be subject to any budgetary ceiling. Therefore, in order for the budget to be maintained, the additional resources required to respond to health needs in acute events will need to be mobilized through joint donor appeals. Some increase is proposed to SO 7 and SO 11 because of increased needs and challenges in addressing these areas and the relatively small share of those SOs in the total programme budget.

Governance and leadership, including country presence (SOs 12 and 13)

SO 12: To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

SO 13: To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

46. In addition to advancing the global health agenda through WHO's leadership, the scope and purpose of SO 12 and SO 13 lie in assisting, underpinning and enabling work delivered through the other strategic objectives.

47. SO 12 is outward-looking in nature and covers issues of leadership, governance, WHO's presence in and support for countries, collaborative work with partners and effective alliances with sister agencies. In leading, directing and coordinating its work in the coming biennium, the Regional Office will continue to strengthen its strategic analyses, partnership building, external relations and communication functions, and consolidate the achievements of its country strategy. This includes ensuring an effective WHO presence in the countries, close relationships with the ministries of health, collaboration with partners, and the provision to Member States of specific and tailored services that are both relevant and of high quality. Despite the substantial progress made over past bienniums (see Annex 3), various aspects of the Regional Office's country presence such as workforce capacity and infrastructure require further strengthening as, historically, the Office has not had sufficient resources to provide a full portfolio of technical competences in country offices, as is the case in some other WHO regions. In furtherance of its mission to serve all 53 Member States, the Regional Office intends to continue searching for and applying appropriate modalities for collaboration with the Member States where WHO does not have country offices, such as through biennial collaborative agreements or memoranda of understanding.

48. The work to strengthen strategic, operational and specific cooperation with other partners in the field will continue, this being one of the main strategic directions of the Regional Office's work. Where

appropriate, it will support national authorities in coordinating the interventions of the different organizations in the country's health sector. It will also continue to develop its policy, strategy and actions with regard to partnership building. Even greater emphasis will be placed on collaboration with a clear outcome at country level, linking up with efforts to strengthen value-based health system governance and increasing the efficiency of health systems for better health outcomes. Moreover, relations with the European Union will continue to be of special strategic importance in the WHO European Region.

49. Guidance and governance of the Regional Office is also covered under this objective. The Regional Office implements its work through the guidance exercised by its governing body mechanisms. Regular and transparent reporting by the Regional Office ensures accountability in the implementation of the agreed expected results. The Office will continue to support the Member States in exercising effective governance through efficient communication, and preparation and conducting of statutory governing body meetings: sessions of the Regional Committee and the Standing Committee of the Regional Committee.

50. SO 13 is more inward-looking. Its purpose is to ensure continuous improvements in the provision of flexible, more efficient and cost-effective support to the WHO's technical and policy work at regional and country level, thus supporting the flexible and responsive delivery of results. It comprises all areas of administration, including the financial aspects, human resources management, and strategic and operational planning, monitoring and evaluation.

51. Work will continue to improve human resources management and promote a stimulating and supportive environment for staff, while ensuring high performance and technical excellence. The overarching aim is to ensure that Member States' needs and expectations are met by technically competent and managerially skilled WHO staff at all levels.

52. Considerable emphasis will be put on ensuring that the results-based management framework better supports country needs through clearly articulated expected results and strategies to achieve them. Work has begun in 2008–2009 to improve the programme planning process through the establishment of horizontal, interdisciplinary teams as a natural consequence of the cross-cutting nature of the 13 strategic objectives. Improvements are still needed to ensure synergies in both planning and implementation, including effective cooperation and coordination of work through and with the network of WHO collaborating centres. The Regional Office's strategic and analytical capacity will increasingly need to develop, especially in the context of implementing the Global Management System in the 2008–2009 biennium. Current efforts aimed at improving the performance of the Regional Office through a more strategic and responsible delivery of results will continue in 2010–2011 with more emphasis on qualitative technical monitoring, as well as monitoring of measurable corporate key performance indicators, peer review assessments and critical evaluation of outcomes and work. This places the Office in a better position to respond to changing or emerging needs and to correct performance challenges.

53. Decisions on the use of financial resources and their management to ensure the efficient and effective implementation of the Regional Office's strategic and operational priorities will continue to receive significant attention from the management team. The implementation of the Global Management System in 2009 is expected to greatly facilitate financial monitoring and decision-making and to streamline and generally improve all administrative processes. The biennium 2010–2011 is expected to be a consolidating period during which the staff will gradually improve their skills in the use of the new system. Some savings are expected to be made within the administration and it is proposed to use part of those savings to strengthen analytical capacities and to provide more value-added services to technical units.

54. The Regional Office's premises and running costs in its all locations are also covered under these SOs.

55. The proposed 2010–2011 budget level for this area (SOs 12 and 13) has been estimated on the basis of thorough analyses of the Regional Office's work in the previous bienniums, including financial

performance data. Notwithstanding substantial efficiency savings, and in contrast to the situation in some other SOs, the need for and allocation of resources in the area of leadership and governance, and the increased demands for accountability have meant that planned cost levels have been exceeded over several bienniums (Annex 2). This has been the result of several developments such as the strengthening of WHO's country presence, increases in fixed costs and running costs for WHO offices in all locations, which were not always predictable, and increased investment in the transparency and accountability of the Regional Office, as well as intensified work with the governing bodies.

56. One of the reasons for the comparatively larger increase in these areas is explained by the nature of the work, which, as it does not involve technical activities related to country and intercountry work, entails a much higher share of staff salary costs in the total budget of these SOs compared to SOs 1 to 11. Further explanation related to the increase of the costs in these SOs is provided below. The corresponding data clearly indicate that the challenges caused by earlier inadequate estimates need to be overcome in 2010–2011 and beyond. It is therefore proposed to increase the level of the programme budget for this important area in line with previous trends. This would imply increasing SO 12 and SO 13's share of the budget by 6%, to 28.6% of the total proposed budget for the Regional Office for 2010–2011, a figure that is below the benchmark used for effective management by comparable organizations.

General considerations on the draft Proposed programme budget 2010–2011

Regional budget overview

57. As mentioned above, the draft Proposed programme budget is now presented in three segments. The financial overview shown in Table 2 of the global document does not include the Outbreak and crisis (OCR) segment, which will be determined closer to the time of programme implementation. Annex 1 of this document provides an overview of the regional budget according to the three segments from 2004–2005 through to the proposed draft budget for 2010–2011, and gives information on the percentage change in the budget of WHO programmes between bienniums. The figure for partnerships for the 2010–2011 biennium (US$ 10.1 million or 3.6% of the total regional budget) is an initial estimate and is therefore subject to change. The Regional Office's envelope for the WHO programme segment is set at US$ 268 million. However, this includes the budget for the European Observatory on Health Policies and Systems, which, while being a partnership arrangement, is hosted by the Regional Office. This is not currently included in the global list of partnerships, which has been placed outside of WHO programmes; however, its inclusion in that list is being considered.

58. Table 1 below is based on Table 3 of the global document and extends it to draw comparisons using the resource validation mechanism introduced last biennium.[1] It should be recalled that this mechanism, as introduced in 2006, excluded WHO's response to emergencies and the poliomyelitis eradication initiative. As explained in the global document for 2010–2011, in addition to the poliomyelitis eradication initiative, there are other partnerships that are now excluded globally and, in 2010–2011, the Regional Office's proportion of the WHO programme segment is 6.9%. Although this is within the approved range established by the validation mechanism for the Regional Office (6.2% – 7.5%), that mechanism is not directly applicable to the new structure of the proposed programme budget for 2010-

[1] See documents EBSS-EB118/2006/REC/1 and EB118/7. The validation mechanism provides an objective and transparent relative resource indication (a range) across headquarters and the regions for all sources of funds and is used to appraise and analyse the outcome of the results-based budgeting and planning processes of the MTSP and its associated programme budgets. It is based on principles of equity in support to countries in greatest need and it validates the results-based resource requirement. While it is an important and transparent point of reference, it does not determine actual resource allocations. It has three components: a fixed component comprising normative and statutory functions carried out at different levels of the Organization; an engagement component reflecting regional functions whose cost varies in relation to the number of countries served; and a needs-based component reflecting relative health and socioeconomic status along with a population factor.

2011 for the reasons outlined above. Calculated against the total programme budget, the Regional Office for Europe's portion of the proposed programme budget for 2010–2011 is 5.6%.

Table 1. Proposed programme budget 2010–2011 by major office and by budget segment, with comparison to the averages, and minimum and maximum range of the resource validation mechanism

			Proposed programme budget 2010–2011						Resource validation mechanism		
Major Office	**Approved total PB 2008–2009 US$ million**		**Total programme budget**		**WHO programmes**		**Partnerships and collaborative arrangements**		**Average**	**Minimum**	**Maximum**
Headquarters	**1175.9**	27.8%	**1530**	31.0%	1108	28.5%	422	40.2%	28.0	25.2	30.8
Africa	**1193.9**	28.2%	**1451**	29.4%	1026	26.4%	425	40.5%	28.0	25.2	30.8
The Americas	**278.5**	6.6%	**277**	5.6%	272	7.0%	5	0.5%	7.0	6.3	7.7
South-east Asia	**491.5**	11.6%	**568**	11.5%	459	11.8%	109	10.4%	12.1	10.9	13.3
Europe	**274.8**	6.5%	**278.1**	5.6%	268	6.9%	10.1	1.0%	**6.9**	6.2	7.5
Eastern Mediterranean	**465**	11.0%	**485.4**	9.8%	433	11.1%	52.4	5.0%	10.2	9.1	11.2
Western Pacific	**347.9**	8.2%	**348.4**	7.1%	322	8.3%	26.4	2.5%	7.9	7.1	8.7
	4227.5	100.0%	**4937.9**	100.0%	**3888**	100.0%	**1049.9**	100.0%	100	90	110

A weakening US dollar

59. Table 4 in the global document shows the estimated impact of exchange rate changes on the proposed programme budget 2010–2011 as a whole. The decision to calculate separately the potential impact of the US dollar is supported by the Standing Committee of the Regional Committee (SCRC), as this approach segregates the impact of the Organization's growth from that of the exchange rate.

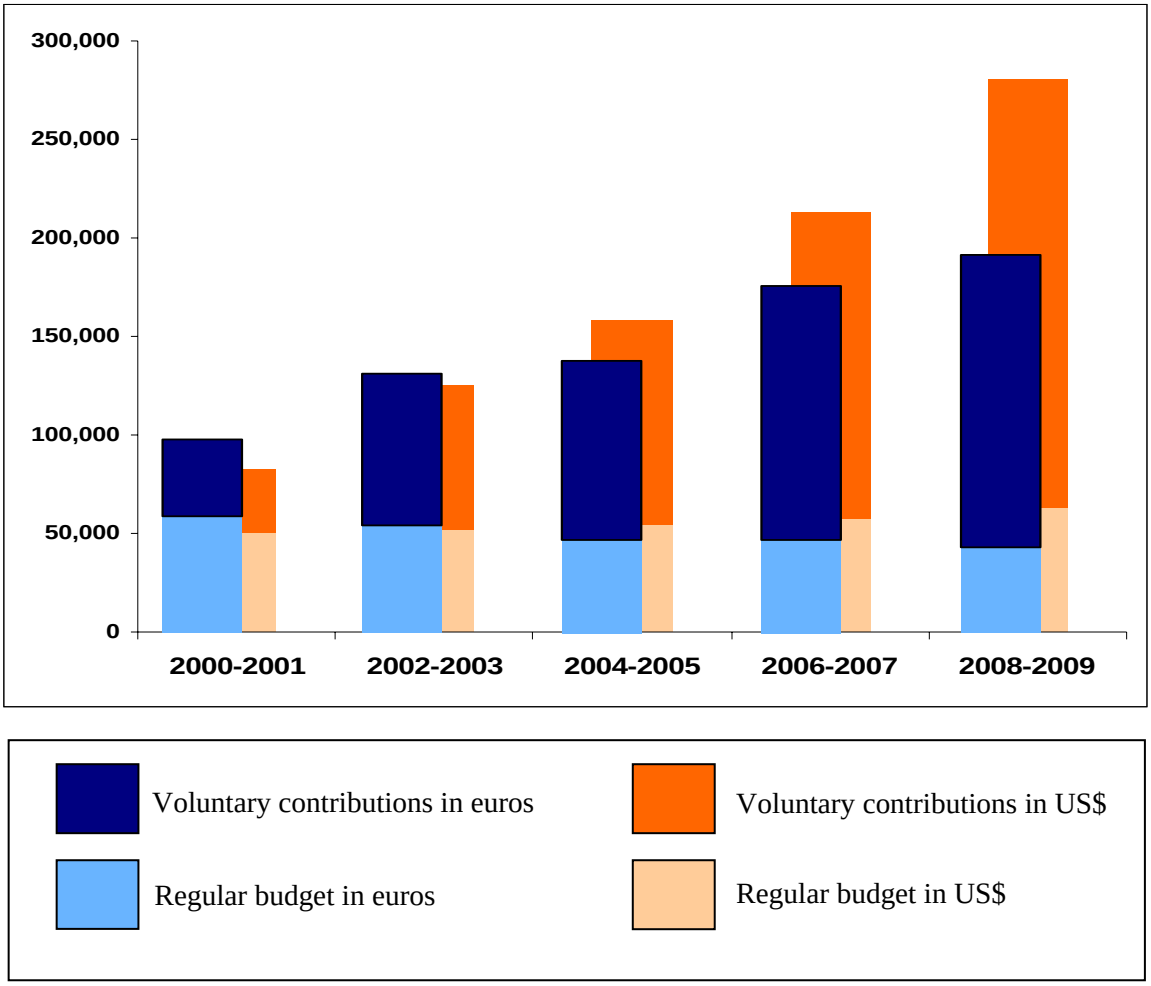
How is the European Region affected by exchange rates?

60. While the programme budget is expressed in US dollars, regional expenditures are predominantly in euros and Danish kroner. Consequently, the budgetary framework for 2008–2009 prepared in 2006 has been directly impacted by the unfavourable US dollar to euro and Danish kroner exchange rates. Since 2006, there has been 31% devaluation in the US dollar against the euro and 24% devaluation with respect to the Danish kroner. The total impact on the Regional Office's budget for the current biennium is estimated to be in the magnitude of US$ 25 million. Moreover, local currency inflation in the Region in the 35 locations where the Office has a country presence has resulted in an average increase of 40% in running costs coupled with increases in local salary costs for the same scale of operation. As none of these factors were taken into consideration when the 2008–2009 budget was planned in 2006, naturally, the impact of the exchange rate has significantly affected the programme budget 2008–2009 in the European Region. Moreover, there is no established mechanism for global adjustment. Under these circumstances, it is most challenging to deliver on the commitments made in the programme budget 2008–2009 while maintaining an unchanged budgetary envelope. No adjustments have been made to the 2008–2009 situation in the current programme budget prior to using it as a baseline for 2010–2011. It should be noted that the enabling strategic objectives SO 12 and SO13 are most impacted by the situation.

61. Fig. 1 below highlights the US dollar to euro exchange rate trend between the 2000–2001 and the 2008–2009 bienniums and its impact on the budget of the European Region. The graph shows that, although the Regional Office's budget grew dynamically over the past decade when expressed in US dollars, its growth in euro terms was rather limited. For instance, while it grew by 32% in US dollars from 2006–2007 to 2008–2009, this effectively meant an increase of 8.5% in euros.

62. The weak US dollar also had a profound impact on the level of assessed contributions in the Regional Office. Despite an increase in assessed contributions from US$ 49 million in 2000–2001 to US$ 63 million in 2008–2009, when expressed in euros, they actually decreased by 27% over that period – from €54.6 million to €39.8 million.

Fig 1. – Diminishing value of the US dollar against the euro between 2000–2001 and 2008–2009 in the budget of the Regional Office for Europe



63. As part of the operational planning conducted in November 2007, anticipating a considerable impact of the devaluation of the US dollar, the Regional Office undertook a detailed review of budget averages for salaries[2] and running costs. Analysis of actual salary expenditures for the period January to June 2008 showed that even the revised conservative budget averages do not hold and the planned budget averages for several levels within both the professional and the general service categories are already being exceeded.

64. The Office's subsequent request for an increase in the 2008–2009 budget has been partially approved – the regional budget was increased by US$ 5.3 million (or 1.9%). Of this, US$ 1.7 million relates to SO 1 partnerships and, therefore, does not address the Region's needs within the WHO programmes segment.

65. The Regional Office has recently undertaken a further extensive analysis.[3] Based on this, the budget ceilings between SOs were redistributed and adjusted to the 2008–2009 WHO programmes

[2] Budget averages for salaries are planning units used for budgeting purposes and are different from actual salary expenditures.

[3] The analysis included (i) an evaluation of historic implementation patterns; (ii) a review and reprioritization of activities and staffing needs, whenever possible, adjusted to the changing needs of countries, incorporating strategic directions and priorities; (iii) income projections; and (iv) the significant US dollar exchange impact on the Office's budget.

segment. This demonstrated the need for a further increase of US$ 12.3 million, thus bringing the total WHO programme budget for the European Region to US$ 280 million and the total budget including partnerships to US$ 292 million, as shown in Annex 5.

66. At the time of this document going to print, the Regional Office's request has not yet been considered. Should the requested increase receive the Director-General's approval, it would be appropriate to consider corresponding implications for the level of the WHO programme segment for the 2010–2011 biennium. In the case of a negative scenario, the Office will need to revisit and adjust the scope and scale of its commitments and deliverables.

Financing mechanisms – issues and challenges

Unequal relative share of assessed contributions

67. In exercising its governance role, the SCRC noted that the European Region, for a number of historical reasons, had become disadvantaged in fulfilling its mission in its 53 Member States because of the low share of total assessed contributions. The introduction of the resource validation mechanism was seen in the Region as a concrete step forward, representing an objective method of assessing regional needs and a worthy replacement for WHA51.31, which had previously attempted to deal with that particular challenge.

68. Subsequently, the MTSP and its associated budget for 2008–2009, as presented to the Regional Committee for Europe at its fifty-sixth session in 2006 (EUR/RC56/10), followed the historical path in distributing the proposed increase in the assessed contributions for WHO globally and thus did not rectify the above-mentioned imbalance. Following the debate on the programme budget during that Regional Committee session, the Chairperson of the SCRC wrote to the Director-General on behalf of the Member States in the Region, expressing the strong concerns voiced during that session. The Director-General considered the situation and responded favourably. Subsequently, within the reduced proposed programme budget presented to World Health Assembly in May 2007, the Regional Office's percentage of the total assessed contributions envelope increased from 6.36% to 6.6% between the two bienniums, as shown in Table 2. Hence, from the 2006–2007 level of US$ 58.1 million, the Office's budget for assessed contributions rose to US$ 63.3 million,[4] an increase of US$ 5.1 million, of which US$ 2.3 million was generated from the Director-General's intervention, which was very much welcomed by the Region.

Table 2. Comparison of 2006–2007 and 2008–2009 global and regional budget – assessed contributions (AC) and voluntary contributions (VC)[5] (US$ 000)

2006-2007	**AC**		**VC**		**Total**	
Endorsed – Global	915 315		2 398 126		3 313 441	
Endorsed – EURO	58 180	**6.36%**	142 395	**5.94%**	200 575	**6.05%**
2008-2009	**AC**		**VC**		**TOTAL**	
Endorsed – Global	958 840		3 268 640		4 227 480	
Endorsed – EURO	63 283	**6.60%**	211 480	**6.47%**	274 763	**6.50%**
% change		**0.24%**		**0.53%**		**0.45%**

69. Even this increase was not sufficient to offset the negative impact of the weak US dollar vis-à-vis the euro as presented above. In addition, as shown in Table 3 below, the historical variation and inequity in the relative share of assessed contributions between major WHO offices, especially for locations with a similarly sized WHO programme budget, remain unresolved. This imbalance needs further attention and remedy.

[4] Prior to the DG's 2% contingency withholding.
[5] Total VC in Table 2 includes response to emergencies and the poliomyelitis eradication initiative.

Table 3. Proposed programme budget 2010–2011 by major office for WHO programmes segment with comparison to assessed contributions (AC)[6] (US$ millions)

	Proposed programme budget 2010-2011		Assessed contributions	
Major Office	**WHO programmes**		**Total AC per major Office**	**% of total AC**
Headquarters	1108	28.5%	325	33.9%
Africa	1026	26.4%	213.3	22.2%
The Americas	272	7.0%	81.5	8.5%
South-east Asia	459	11.8%	103.9	10.8%
Europe	268	6.9%	63.3	6.6%
Eastern Mediterranean	433	11.1%	91.6	9.6%
Western Pacific	322	8.3%	80.2	8.4%
	3888	100.0%	958.8	100.0%

70. While, within the framework of the integrated budget, the Organization continues to call for more unspecified voluntary contributions, the assessed contributions nevertheless represent the sustainable funds on the accounts at 1 January of any new biennium and therefore continue to play a vital role for the Organization.

How can the financing situation for the Regional Office be improved?

71. The global proposed programme budget document describes the new financing and management mechanism: the core voluntary contributions (CVC) account. Oversight of this account is exercised by the Advisory Group on Financial Resources (AGFR), which makes recommendations to the Director-General. As reported to the Sixty-first World Health Assembly in May this year in Programme budget 2006–2007: performance assessment (A61/19), this group is expected to play an increasingly important role in monitoring the availability and utilization of resources and the delivery of results against the MTSP objectives and in providing advice on any steps that may be necessary to ensure effective implementation and the achievement of results at all levels of the Organization.

72. As is recognized in the above-mentioned report, the funding of the WHO global programme budget in 2006–2007 was, to a large extent, earmarked and unevenly apportioned between programmes and major offices; hence there is still room for improvement in distributing resources within the Organization to equitably address financial needs and performance, as well as to ensure equitable levels of carry-over funding.

73. As reported to the Programme Budget and Administration Committee (PBAC) at its eighth meeting in May this year, carry-over funds from one biennium to another are essential to ensure continued implementation into the next biennium and avoid excessive programmatic disruption. The financial rules stipulate that staff costs must be covered for at least 6 months, although 12 months would be more prudent, given the limited predictability of voluntary contributions. Within a given programme, depending on the assessed-contributions-to-voluntary-income mix, it is estimated that the voluntary contribution "carry-over comfort zone" is in the range of 25–40% of the previous biennium's expenditure, and technical areas carrying over less than 25% of the previous expenditure level are considered to be "in trouble". The level of the Regional Office's carry-over funds for the 2008–2009 biennium was 24.5% of 2006–2007 expenditures.

[6] If the current allocations of assessed contributions are maintained.

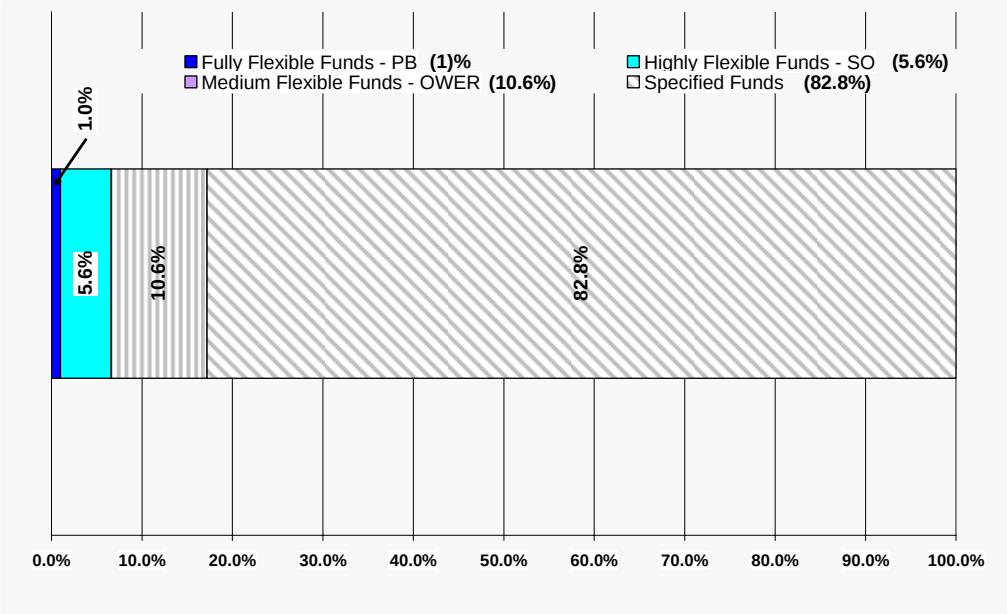
74. The progress made by the AGFR in monitoring the CVC account to improve the alignment of funds to the programme budget has been very positive.

75. The CVC account could be explored among possible mechanisms for addressing the remaining imbalance within allocation of assessed contributions (explained above), so that the Regional Office can move from its current position at the bottom of the league to be more in line with other regions.

A need for more flexible funding

76. This will not, however, mitigate the overall need for more flexible funding to align resources to results within an effective financing mechanism for achieving the strategic objectives. Fig. 2 below, which was presented to the above-mentioned PBAC meeting, shows the levels of specification of voluntary contributions received globally in 2006–2007.

Fig. 2 – Levels of specification of voluntary contributions received in 2006–2007 (global)



77. As can be seen, fully flexible funding represents only 1% of the funds received, with a further 5% being highly flexible. The major part, some 82.8% of funds, are highly specified and this leads to expenditures that differ from original intent and can lead to distortion in implementing the priorities set by the Governing Bodies. It therefore remains essential to further explore opportunities to ease the earmarking of voluntary contribution funds.

Financing governance and leadership, including country presence (SOs 12 and 13)

78. As previously mentioned in this document and well covered within the global document, the financing of SO 12 and SO 13 is a major challenge. In the Proposed programme budget 2010–2011, the Regional Office's combined needs, based on the unadjusted programme budget 2008–2009 ceilings in SOs 12 and 13, equate to US$ 79.5 million. The available assessed contribution funding, including funds that have been allocated from the global programme support costs (PSC), are not sufficient to cover the needs. It remains critical to identify the additional resources necessary for funding these two objectives in the current and next biennium. The Regional Office management team undertakes regular analyses and monitoring of the situation with a view to identifying the best corporate solutions to cover gaps in SOs 12 and 13, as well as across other SOs.

79. The decrease in assessed contributions for WHO expressed in euros over these years, as explained above, means that Member States have realized significant "savings" in their respective local currencies by paying their assessed contributions in US dollars. Globally, these savings are estimated to be close to

US$ 70 million per year. This could potentially represent an opportunity to ease the increasingly challenging financial situation of the Regional Office should Member States consider mobilizing part of these savings in the form of flexible contributions to WHO.