World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
67th session

Budapest, Hungary, 11–14 September 2017

EUR/RC67/Inf.Doc./2

4 September 2017
170717
ORIGINAL: ENGLISH

Overview of the implementation of programme budget 2016–2017 in the WHO European Region

This document, which presents an overview of the implementation of programme budget 2016–2017 by the WHO Regional Office for Europe, is part of the Regional Office's commitment to its governing bodies to provide transparency and accountability.

The aim of this overview is to enable Member States to execute the functions of oversight and strategic direction for the Regional Office for Europe.

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Contents

Introduction

1. This document, which provides an update on implementation of programme budget (PB) 2016–2017 by the WHO Regional Office for Europe, complements document A70/58 on the WHO mid-term programmatic and financial report for 2016–2017, including the audited financial statements for 2016. The present report serves two purposes: to ensure that the Regional Office for Europe is accountable to its governing bodies and to identify areas that require guidance and direction from the Member States.

2. A glossary of terms and abbreviations used in the present report and in the wider WHO context is provided in Annex 1.

3. In May 2015, the Sixty-eighth World Health Assembly approved PB 2016–2017 (documents A68/7 and A68/7 Add.1) in resolution WHA68.1, setting out the programmatic priorities of WHO for the 2016–2017 biennium and serving as the key mechanism for corporate accountability of the Organization.

4. The work of the Regional Office for Europe is contained in PB 2016–2017. The 65th session of the WHO Regional Committee for Europe (RC65) approved the regional plan for implementation (RPI) of PB 2016–2017 (document EUR/RC65/14) in September 2015. The RPI specifies the contributions of the Regional Office to the PB 2016–2017 results, notably through the performance indicators, and details regional programmatic considerations by category and programme area.

5. The RPI, which corresponds to PB 2016–2017, forms a contract for joint accountability between the Regional Office and the Member States, and reflects the adjustments made to the PB approved by the Sixty-eighth World Health Assembly for the European Region within the delegated authority of the WHO Regional Director for Europe. The Secretariat will present a full assessment of the RPI to RC68 in September 2018. This document, together with the oversight reports submitted to the Twenty-fourth Standing Committee of the Regional Committee for Europe, show the progress made towards achieving the RPI at the end of the third quarter of the 2016–2017 biennium.

6. The current status of PB 2016–2017 for the Regional Office is characterized by realistic budget ceilings; adequate but misaligned funding, with technical implementation progressing according to plan; and slightly delayed financial implementation. The Secretariat continuously monitors performance to ensure that programmatic implementation remains on track.

Implementation of PB 2016–2017

Overview of technical progress

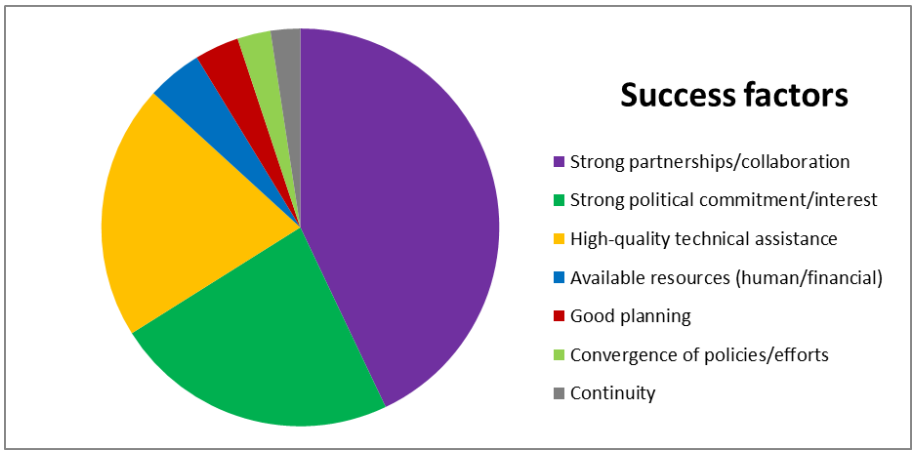
7. PB 2016–2017 is the second of three biennial budgets under the Twelfth General Programme of Work, which covers the period 2014–2019. The structure of PB 2016–2017 integrates a results chain with categories and programme areas [1] that provide an operational framework for WHO work as shown in Annex 2.

[1] Current reporting for PB 2016–2017 includes programme areas of former category 5 as well as programme areas under the new WHO Health Emergencies Programme.

8. For PB 2016–2017, the Regional Office has a portfolio of 1007 outputs.[2] These outputs represent the deliverables for the Secretariat at the regional and country levels. The present report summarizes the progress made towards achieving these regional outputs based on an assessment of the first 18-months of the biennium.

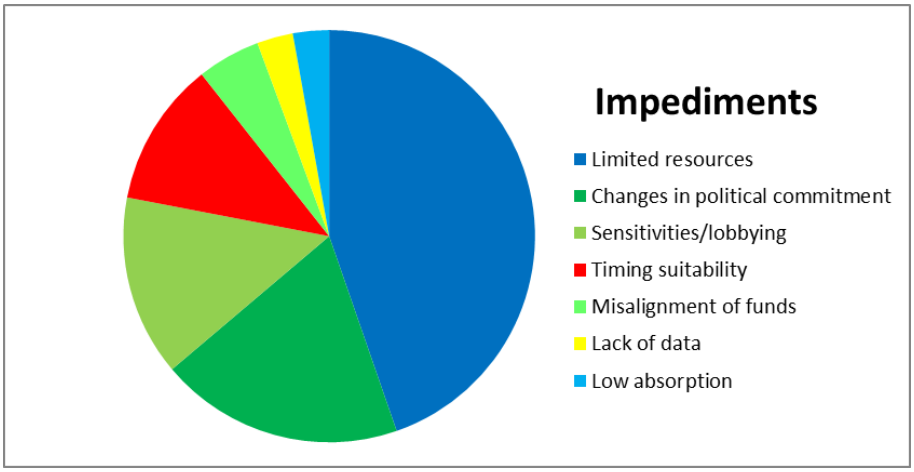
9. Recurring success factors contributing to progress made towards achieving the portfolio of outputs include: well-established partnerships; collaboration within the health sector and with other sectors; strong political commitment and engagement; and the availability of high-quality technical assistance (see Fig. 1).

Fig. 1. Success factors for PB implementation identified in the third quarter review



10. Conversely, the major impediments to achieving outputs identified during the assessment process include: limited availability of resources (financial and/or human); changes in political commitment; and strong sensitivity to or lobbying against recommended measures and actions (see Fig. 2).

Fig. 2. Impediments to PB implementation identified in the third quarter review



[2] The Sixty-ninth World Health Assembly approval of the WHO Health Emergencies Programme in May 2016 resulted in the creation of category E and the addition of its respective outcomes/programmes and outputs in the results hierarchy, as of 1 January 2017. A total of 75 outputs were added to the initial 932 outputs.

11. Achievements in category 1 include the Regional Office's contribution to the first WHO Global Hepatitis Report, published in April 2017; 16 of 18 high-priority countries aligning their national targets with global targets and 12 of 18 countries aligning their national action plans with the Global End TB Strategy and the Tuberculosis Action Plan for the WHO European Region 2016–2020. In addition to maintaining malaria-free status, Member States in the European Region are also making efforts to achieve WHO certification of malaria elimination. The Regional Office is currently supporting Uzbekistan in the elimination and certification process. In the neglected tropical diseases programme area, the European Region is focused on monitoring emerging or re-emerging vector-borne diseases, and on controlling leishmaniasis and soil-transmitted helminthiasis. The vaccine sentinel surveillance network continues in countries supported by Gavi, the Vaccine Alliance, for new vaccines, rotavirus and invasive bacterial vaccine-preventable diseases. The contribution of the Regional Office to European Vaccine Action Plan (2015–2020) deliverables and objectives are on track, despite a decrease in the coverage of antigens, particularly in middle-income countries.

12. In category 2, the Regional Office provides widespread technical support on noncommunicable diseases (NCDs) to 19 countries in developing, implementing or evaluating national NCD plans; to five countries in including NCDs in national development agendas; and to four countries in organizing multisectoral dialogues on NCDs. In addition, a toolbox designed to support work in the area of NCDs has been developed. Fifty-one Member States in the Region have identified national data coordinators for road safety and 19 countries celebrated the fourth annual United Nations Global Road Safety Week in May 2017, in collaboration with WHO. Initiatives to prevent child maltreatment in the European Region include the publishing of handbooks, surveys on adverse childhood experiences, a prevention workshop and national policy dialogues in three countries.

13. In category 3, high points during the first half of 2017 include a focus on a perinatal audit, improving antenatal care and monitoring the implementation of Investing in children: the European child and adolescent health strategy 2015–2020 in order to improve the quality of care and child and adolescent health at the country level. Good progress has been made with regard to sexual and reproductive health and school health through regional meetings and by decreasing unmet needs in the Region. Collaboration with technical programmes and country offices on gender and rights issues continues to develop in a positive direction. The successful negotiation with partners on two health and migration projects will contribute to a better understanding of and guidance on how to increase capacity to address the health needs of refugees and migrants at the country level. The Sixth Ministerial Conference on Environment and Health, held in Ostrava, Czech Republic, in June 2017, successfully leveraged the European Environment and Health Process as a platform for the coordinated implementation of the 2030 Agenda for Sustainable Development and Health 2020. The Sixth Ministerial Conference also saw the adoption of the Ostrava Declaration, committing Member States to developing national portfolios of actions on environment and health by the end of 2018.

14. In category 4, a programme of work on the performance assessment of health systems has been developed, excellent progress in supporting policy-making and dialogues on universal health coverage at the country and regional levels has been achieved and Member States have been supported through financial protection monitoring and capacity-building in the areas of health financing and health systems strengthening. The Regional Office, through interdivisional collaboration, has finalized a blueprint for people-centred care for the European Region. A roadmap is being designed to help 11 countries in eastern Europe and

central Asian develop people-centred models of care with effective financing mechanisms. The first half of 2017 saw close consultations with Member States on medicine policy development, including pharmaceutical pricing and reimbursement policies to reduce out-of-pocket payments and to sustain equitable access to medicines. Good progress has been achieved through the various initiatives in e-health and innovation, resulting in increased visibility, quality of and demand and support for e-health strategy development. Interest in big data in health has also increased. The new strategy for WHO Collaborating Centres in the European Region has been approved and implementation is in progress.

15. With the WHO Health Emergencies Programme (WHE) as a standalone category, reporting on category 5 presently encompasses only programmes for antimicrobial resistance, food safety and polio eradication. Participation in the annual World Antibiotic Awareness Week expanded to 47 Member States in 2017 and 14 countries have received support in developing national antimicrobial resistance action plans. The Central Asian and Eastern European Surveillance of Antimicrobial Resistance network has expanded, and nine of the 19 participating countries have provided data to the network. Activities to implement poliovirus containment are under way and support to the European Regional Certification Commission for Polio Eradication has continued throughout 2017.

Implementation of WHE, including outbreak and crisis response

16. In the first half of 2017, the newly created WHE has seen progress in all programme areas. Additional funding received in 2017 accelerated activities with a focus on country preparedness and readiness. The human resources alignment process has been finalized and vacant positions are currently being filled, particularly at the country level, in order to strengthen capacity in line with the WHE country business model.

17. Support has been provided to Member States to strengthen and assess their International Health Regulations (IHR) (2005) core capacities in line with the IHR Monitoring and Evaluation Framework. By the end of June 2017, eight Joint External Evaluation missions and three follow-up simulation exercises have been completed. An after-action review tool has been developed, in consultation with the European Centre for Disease Prevention and Control, and is currently being piloted. Partnerships with public health institutes and with health security initiatives have been expanded and cross-regional collaboration with the WHO Regional Office for the Eastern Mediterranean is ongoing. Capacity-building activities have been provided in the area of risk communication in four Member States.

18. Technical assistance on infectious hazards management has contributed to the implementation of the Pandemic Influenza Preparedness Framework and the strengthening of capacities in five Member States, while 11 countries have benefitted from activities aimed at strengthening their public health laboratories. The Better Labs for Better Health initiative has contributed to capacity-building in priority countries.

19. All-hazards emergency preparedness assistance to countries, especially priority countries, has been scaled up: assessments of health system capacities for crisis management were conducted in two countries; two countries were assisted with the update of their national emergency response plans; four countries received support for the preparation of mass gathering events; and data for three countries were included or updated in the geographic information system-based tool for emergency preparedness. In line with the targets of the Sendai Framework for Disaster Risk Reduction 2015–2030, 200 experts from 20 countries

have been trained and more than 176 hospitals have been assessed under the Hospital Safety Index, aiming to increase resilience of critical health infrastructure. Close collaboration has been initiated on mass casualty management and on sharing information and experiences on medical support during and after terror attacks with six Member States.

20. In order to rapidly detect, verify and respond to public health events, the health emergency information and risk assessment team at the Regional Office operates at all times as the regional IHR Contact Point. In the past 18 months, over 20 000 signals have been screened and 2000 analysed in detail, with 55 deemed serious public health events requiring a WHO risk assessment. Forty-two events have been verified and responded to. Six staff members from the Regional Office have been deployed to support the response to health emergency events occurring outside the European Region.

21. The European Region has contributed to the development of the second edition of the Emergency Response Framework and the update of related Emergency Standard Operating Procedures. Both the dissemination of and capacity-building for the application of these tools is a priority and an essential part of regional work on emergency readiness.

22. The principles of the comprehensive emergency management cycle – particularly the grading of events, the Incident Management System and operational partnerships (including between sectors or clusters), the Global Outbreak Alert and Response Network and the Emergency Medical Teams – are integral to the way in which the Regional Office currently responds to two large-scale ongoing emergencies: the crisis in the Syrian Arab Republic, under the Whole of Syria approach, and the crisis in Ukraine.

23. Data collection and monitoring for these emergency operations continues. An Incident Management System is in place to carry out field work, to coordinate activities with partners, civil society and other relevant stakeholders, and to implement health operations, based on new standard operating procedures, with the support and guidance provided by the WHE emergency operations team at the regional level.

24. The WHO field office in Gaziantep, Turkey, under the Whole of Syria approach, leads the Health Cluster for northern Syria and coordinates the activities of more than 45 nongovernmental organizations active in northern Syria; it also ensures standardized service provision by all partners operating in northern Syria. The Gaziantep field office also provides humanitarian assistance to people in need inside Syria through cross-border operations authorized by United Nations Security Council resolutions 2139, 2165 and 2191.

25. From the beginning of January to the end of June 2017, WHO shipped more than 200 tonnes of essential medicines and medical supplies in 16 cross-border deliveries, which supported more than 1.1 million treatment courses for people residing in northern Syria. In order to revive disrupted immunization services, WHO has provided training on immunization procedures to more than 2800 health workers and has provided more than 1.4 million vaccinations inside Syria, more than 1.2 million against poliomyelitis alone. WHO has also supported the revitalization of vaccination services in primary health care facilities in Syria; from the beginning of March to the end of May 2017, the number of routine vaccination centres increased to 30. The aim is to launch vaccination services in up to 90 primary health care centres by the end of 2017.

26. Responding to increasing needs in mental health care and NCD management, WHO has trained more than 260 health care professionals in 2016 and 2017, including through online

training for those residing in besieged areas. In addition, by the end of 2017, WHO is planning to provide health care facilities in northern Syria with tailored kits for treatment of NCDs and to launch outreach services on mental health and psychosocial support.

27. WHO also continues its advocacy efforts to address key challenges of access to health care in Syria. Together with partners, WHO maintains a real-time database to monitor incidents of violence against health care facilities.

28. The WHO Country Office in Ankara, Turkey, leads health sector working groups, which provide guidance and coordinate humanitarian and development partners, and supports the Ministry of Health in dealing with protracted aspects of the Syrian refugee crisis. In line with the Regional Refugee and Resilience Plan, activities focus on strengthening the national health system to cope with an additional 3 million people by expanding culturally sensitive primary health care, providing immunization services and addressing mental health needs.

29. In 2017, WHO provided adaptation training to 750 Syrian doctors and 440 Syrian nurses, enabling them to integrate into the Turkish health system and to serve in refugee health centres and primary health care units across Turkey. To address the specific mental health and psychosocial support needs of Syrian refugees, WHO adapted the Mental Health Gap Action Programme guidelines to the Turkish context and trained 550 Syrian and Turkish doctors working within the national health system. Efforts have also focused on strengthening staff care policies and the coordination of referral systems of key mental health and psychosocial support workers in Turkey.

30. With regard to vaccine-preventable diseases, WHO has supported the Ministry of Health through two rounds of an immunization campaign targeting Syrians under five years old. As a result, 357 925 children were reached, recorded and provided with the necessary vaccine doses, prioritizing measles, mumps and rubella, pentavalent vaccine (DTaP-Hib-IPV) and hepatitis B. A third round is being planned for autumn 2017.

31. In Ukraine, WHO coordinates the Health and Nutrition Cluster, which in 2016 comprised a total of 45 partners, through its Country Office in Kyiv and its field offices in Donetsk, Luhansk and Severodonetsk. Cluster meetings, regularly organized at the national and subnational levels, aim to coordinate life-saving activities of different health and nutrition partners, to avoid duplication of efforts and to ensure equitable coverage of local beneficiaries.

32. Voluntary contributions received during 2016–2017 have allowed WHO to address critical gaps in essential and life-saving health services delivery among populations affected by conflict and to enhance access to essential quality health care services. However, the funding will run out at the end of 2017 and the situation is therefore critical.

33. Main achievements during the reporting period include the delivery of 1320 Interagency Emergency Health Kits to serve some 1 million people in both government controlled areas and non-government controlled areas. The Emergency Health Kits include medication for NCDs that are treated at primary and secondary health care levels. Around 220 primary and 25 secondary care health facilities, in government controlled and non-government controlled areas of Donetsk and Luhansk oblasts, are supported by WHO through the provision of medical supplies, and have provided direct life-saving interventions to some 150 000 patients.

34. In addition, 35 000 people have benefited from primary health care consultations through the re-establishment of four mobile clinics with psychosocial support. It is estimated that a high proportion of the general population (400 000 persons of the total population of 2.3 million people) living in the most affected parts of non-government controlled areas also benefit indirectly from the mobile clinics.

Overview of funding and financial implementation

By category

35. In the first 18 months of the 2016–2017 biennium, the Regional Office's total approved PB of US$ 245.8 million (US$ 235.4 million for the base programmes and US$ 10.4 million for polio eradication and outbreak and crisis response) has been increased by approximately US$ 59.9 million as a result of:

- an increase of US$ 55.5 million for emergency operations in response to the crisis in the Syrian Arab Republic being carried out by the field office in Gaziantep, Turkey, and the ongoing humanitarian crisis response in Ukraine; and
- an increase of US$ 13.4 million owing to the establishment of the WHO Health Emergencies Programme.

36. The overall situation at the end of June 2017 shows a well-financed approved PB (see Table 1). However, this positive financial situation is explained by the emergency response component, which is event driven. Base programmes are currently financed at 83% of the approved PB. The voluntary contribution projections are expected to improve the financial situation of base programmes as 2017 draws to a close.

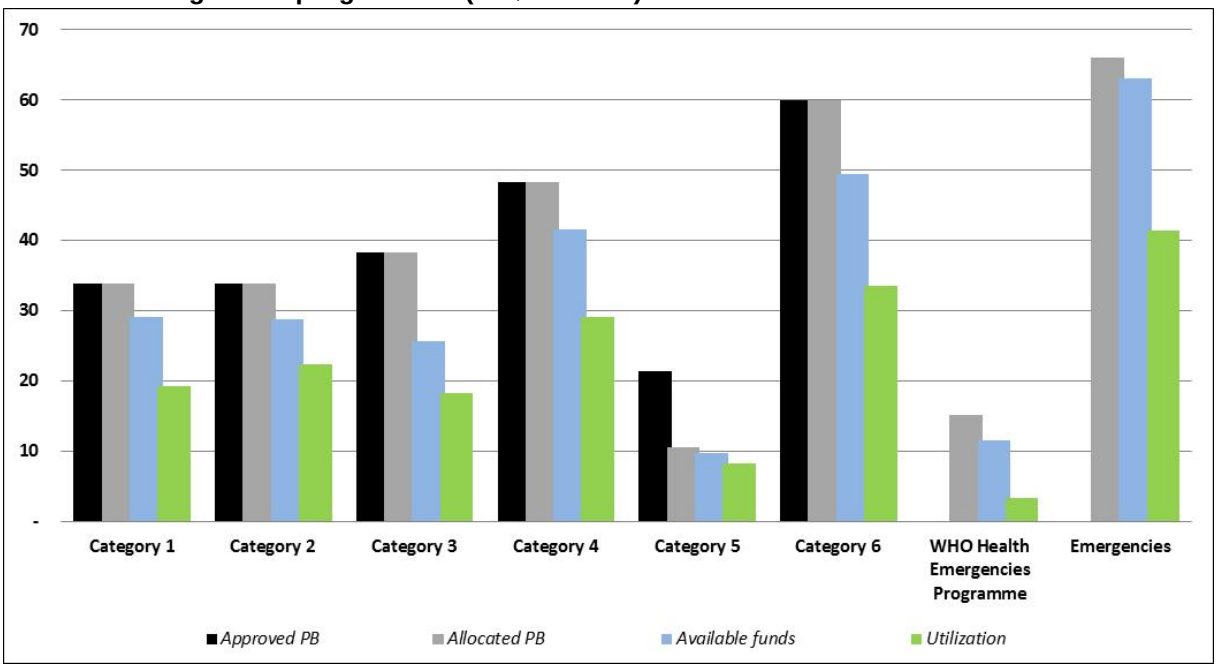
Table 1. Utilization and financing of PB 2016–2017 by category, as of 30 June 2017

Category	% funds available of approved PB	% funds available of allocated PB	% utilization of approved PB	% utilization of allocated PB	% utilization of available funds
1	86%	86%	57%	57%	66%
2	85%	85%	66%	66%	78%
3	67%	67%	48%	48%	71%
4	86%	86%	60%	60%	70%
5 (base)	45%	92%	39%	79%	86%
6	83%	83%	56%	56%	68%
WHE		77%		22%	28%
Subtotal base	**83%**	**82%**	**57%**	**56%**	**68%**
Subtotal emergencies		**95%**		**63%**	**66%**
Total		**85%**		**57%**	**68%**

37. The significant differences in PB financing between and within categories remains unchanged (see Table 1 and Fig. 3). Categories 1, 2 and 4 are the best financed categories in this biennium. These categories have received strong financial support from several donors, although the funds received were highly earmarked and designated for specific work, generating imbalances vis-à-vis programme areas within the categories. Category 3 is the

lowest funded category in the European Region for the 2016–2017 biennium with no prospect of improvement, as donor interest does not match the prioritization made by Member States.

Fig. 3. Approved and allocated PB 2016–2017, available funds and utilization by category for base and emergencies programmes (US$ millions)



38. The utilization of available funds remains even across all categories with the exception of the WHO Health Emergencies Programme, owing to its recent establishment. A more detailed analysis of financing and utilization within categories by programme area is presented in the next section.

39. Tables 2 and 3 show available funding and allocated budget utilization of the seven major WHO offices – headquarters and the six regional offices. There is a direct correlation between the available funding of the major office and the utilization of the PB.

Table 2. Utilization of PB 2016–2017 by major office, as of 10 July 2017

Major office	Utilization (% allocated PB)	Utilization (% available funds)
African Region	65%	78%
Eastern Mediterranean Region	62%	76%
European Region	61%	72%
Headquarters	64%	72%
Region of the Americas	52%	69%
South-East Asia Region	69%	77%
Western Pacific Region	61%	77%

40. Table 4 summarizes the financial situation for PB 2016–2017 by programme area. Sixteen of 35 programme areas have secured 80% or more of their funding for allocated budgets.

Table 3. Level of allocated PB funds by category and WHO major office (excluding undistributed funds), as of 10 July 2017

Category	African Region	Region of the Americas	East Mediter-ranean Region	European Region	South-East Asia Region	Western Pacific Region	Head-quarters	Total
1	91%	99%	67%	86%	96%	74%	106%	94%
2	58%	50%	56%	85%	79%	66%	88%	73%
3	79%	37%	68%	67%	80%	72%	104%	85%
4	87%	69%	60%	86%	84%	80%	100%	88%
5	82%	92%	85%	95%	94%	84%	71%	82%
6	97%	121%	80%	83%	88%	96%	85%	89%
WHE	51%	23%	40%	77%	71%	80%	86%	66%
Total	82%	71%	80%	85%	89%	79%	89%	84%

WHE: WHO Health Emergencies Programme.

41. Programme area 3.5 (health and the environment) continues to have the largest funding gap, which is approximately US$ 7.7 million or 37% of its budget. This was also highlighted in the findings of the 18-month assessment, where the decreasing level of voluntary contribution funding for category 3 was noted as the major impediment to technical implementation.

42. Excluding category 6, three other programme areas (1.2 tuberculosis; 3.1 reproductive, maternal, newborn, child and adolescent health; and 4.4 health systems, information and evidence) have funding gaps of more than US$ 2.4 million in each area, despite the high prioritization of these programme areas by Member States.

43. The main reasons for lower utilization of the PB in some programme areas are as follows:

(a) the unpredictability of funding has impeded the timely recruitment of much-needed human resources, which has also been mentioned in self-assessments as an impediment to timely technical implementation of several programmes;

(b) the unpredictability of funding has made it more challenging to plan activities and available funding has therefore been “rationed” throughout the biennium;

(c) the favourable euro to US dollar exchange rate has resulted in approximately 8–10% lower actual staff costs compared with planned costs in a number of duty stations which, while appearing as low financial utilization, has not affected planned technical implementation; and

(d) the planning of country-based activities and major regional events usually takes time and this has resulted in an apparent accelerated financial utilization rate in the second half of the biennium.

Table 4. Financing and utilization of PB 2016–2017 by programme area, as of 30 June 2017 (US$ thousands)

Programme area	Approved PB	Allocated PB	Funds available	Unfunded allocated PB	Utilized PB	% funds available of allocated PB	% funds utilized of allocated PB	% funds utilized of available PB
1.001 HIV	6,900	7,400	5,021	-2,379	3,101	68%	42%	62%
1.002 TUB	10,800	11,500	9,085	-2,415	6,105	79%	53%	67%
1.003 MAL	3,100	861	581	-280	284	68%	33%	49%
1.004 NTD	600	539	536	-3	389	99%	72%	73%
1.005 VPD	12,400	13,500	13,809	309	9,325	102%	69%	68%
Category 1 subtotal	**33,800**	**33,800**	**29,031**	**-4,769**	**19,203**	**86%**	**57%**	**66%**
2.001 NCD	19,200	23,900	21,804	-2,096	17,221	91%	72%	79%
2.002 MHS	5,200	4,200	3,018	-1,182	1,974	72%	47%	65%
2.003 VIP	6,900	2,000	1,610	-390	1,306	80%	65%	81%
2.004 DIS	500	1,100	711	-389	597	65%	54%	84%
2.005 NUT	2,100	2,700	1,546	-1,154	1,235	57%	46%	80%
Category 2 subtotal	**33,900**	**33,900**	**28,688**	**-5,212**	**22,333**	**85%**	**66%**	**78%**
3.001 RMC	6,500	6,900	4,022	-2,878	3,283	58%	48%	82%
3.002 AGE	1,400	1,400	771	-629	611	55%	44%	79%
3.003 GER	1,000	1,100	883	-217	554	80%	50%	63%
3.004 SDH	7,900	7,800	6,602	-1,198	3,660	85%	47%	55%
3.005 HEN	21,500	21,100	13,356	-7,744	10,149	63%	48%	76%
Category 3 subtotal	**38,300**	**38,300**	**25,634**	**-12,666**	**18,256**	**67%**	**48%**	**71%**
4.001 NHP	15,000	16,393	15,342	-1,051	10,160	94%	62%	66%
4.002 IPH	15,400	15,807	13,862	-1,945	9,604	88%	61%	69%
4.003 AMT	7,100	5,200	4,292	-908	3,067	83%	59%	71%
4.004 HIS	10,700	10,800	8,022	-2,778	6,277	74%	58%	78%
Category 4 subtotal	**48,200**	**48,200**	**41,517**	**-6,683**	**29,108**	**86%**	**60%**	**70%**
5.001 ARC	8,200	2,704	2,608	-96	2,608	96%	96%	100%
5.002 EPD	8,000	5,554	5,257	-297	4,030	95%	73%	77%
5.003 ERM	4,100	1,275	1,235	-39	1,236	97%	97%	100%
5.004 FOS	1,000	1,000	583	-417	450	58%	45%	77%
Category 5 subtotal	**21,300**	**10,532**	**9,683**	**-849**	**8,323**	**92%**	**79%**	**86%**
6.001 GOV	33,100	32,891	26,676	-6,215	18,466	81%	56%	69%
6.002 TAR	2,800	2,413	1,888	-525	1,348	78%	56%	71%
6.003 SPR	4,600	2,730	2,264	-466	1,489	83%	55%	66%
6.004 ADM	16,400	16,787	14,523	-2,264	9,581	87%	57%	66%
6.005 COM	3,000	5,079	4,111	-968	2,596	81%	51%	63%
Category 6 subtotal	**59,900**	**59,900**	**49,462**	**-10,438**	**33,479**	**83%**	**56%**	**68%**
E.001 IHM	0	3,759	3,179	-581	1,071	85%	28%	34%
E.002 CPI	0	6,202	4,443	-1,758	940	72%	15%	21%
E.003 HIM	0	1,639	832	-807	321	51%	20%	39%
E.004 EMO	0	2,153	1,881	-272	533	87%	25%	28%
E.005 RED/MGA	0	1,381	1,260	-121	424	91%	31%	34%
WHE subtotal	**0**	**15,135**	**11,596**	**-3,539**	**3,290**	77%	**22%**	**28%**
Base subtotal	**235,400**	**239,767**	**195,611**	**-44,156**	**133,992**	**82%**	**56%**	**68%**
5.005 POL	7,400	7,400	6,883	-517	4,550	93%	61%	66%
5.006 OCR	3,000	58,533	56,066	-2,466	36,895	96%	63%	66%
Emergencies subtotal	**10,400**	**65,933**	**62,950**	**-2,983**	**41,445**	**95%**	**63%**	**66%**
PB total	**245,800**	**305,700**	**258,561**	**-47,139**	**175,437**	**85%**	**57%**	**68%**

44. Under the oversight of senior management, the monitoring and readjustment of plans take place regularly to ensure timely implementation of the approved PB. Measures in place to accelerate implementation include:

(a) the redistribution of funds and work within and between divisions and arrangements for the joint delivery of country outputs;

(b) concerted efforts by programme managers and country offices with large projects to implement before the end of the biennium;

(c) a clear process and timeline for the reallocation of unutilized flexible resources to underfunded areas that have the capacity for implementation;

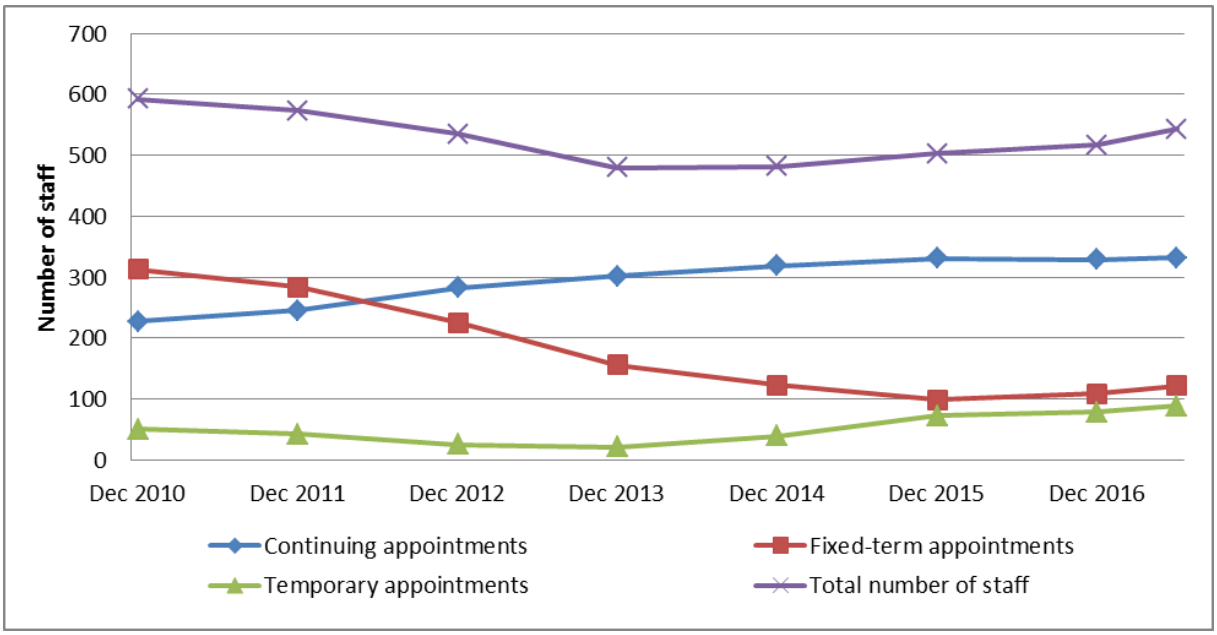
(d) increasing the capacity in administrative areas, with a view to modulating the rate of implementation in the second half of 2017, when implementation tends to accelerate; and

(e) reviewing administrative processes with the aim of streamlining and achieving efficiency gains.

Human resources (HR) capacity to implement PB 2016–2017

45. With regard to implementation of the 2016–2017 HR plan, the number of staff of the Regional Office for Europe has increased by 5% in the first half of the 2016–2017 biennium (see Fig. 4). There has been a steady increase in the number of temporary positions as a result of the unpredictable nature of financing of base programmes and also as a staffing model for crisis response operations.

Fig. 4. Trends in the number of staff of the Regional Office for Europe by contract type, from December 2010 to December 2016



46. In the 2016–2017 HR plan, 68 positions were identified as priorities for recruitment and 55 of these positions have been filled, with a further four positions under selection. Nine positions are on hold owing to a funding gap. Currently, 61 “other priority” selections are

being processed, many of which are project-related positions that are funded by highly specified voluntary contributions.

47. In the 18-month assessment, an insufficient number of staff in some programmes was highlighted as a main impediment to accelerating progress towards achieving PB results. The lack of financial resources and their unpredictability have made the planned and smooth recruitment of staff a challenge. Several programmes rely significantly on services provided by consultants and all programmes are seeking greater collaboration with partners and WHO collaborating centres as additional sources of human resource capacity to implement the PB.

Resource situation

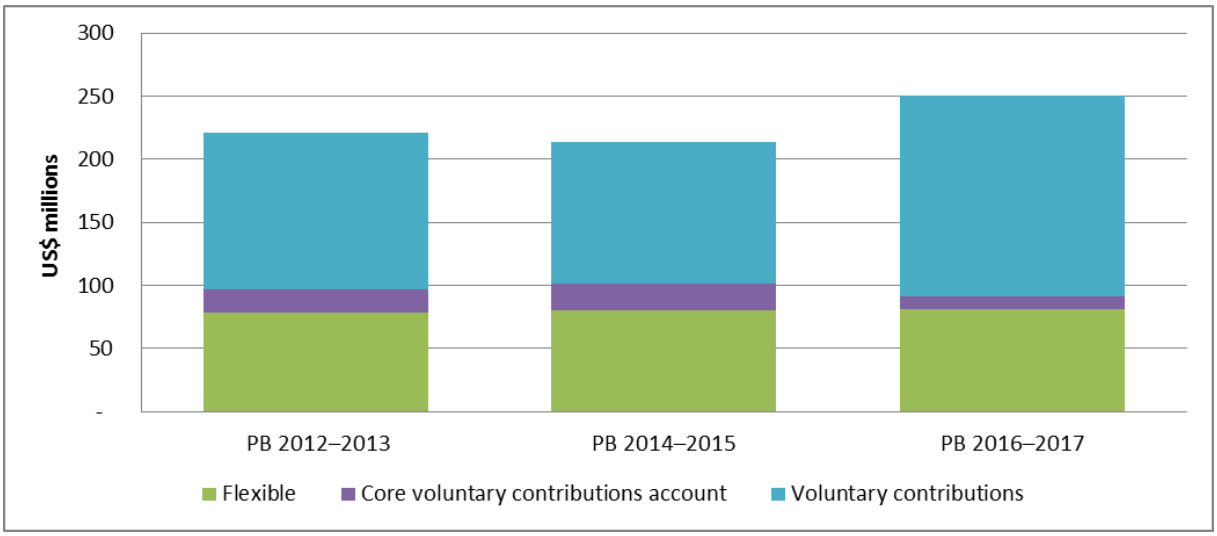
Financial resources for the Regional Office for Europe

48. Overall, the European Region has seen higher levels of resources compared with previous bienniums, but there is also a high level of earmarking to very specific programme areas. The level of flexible resources for PB 2016–2017 compared with the two previous bienniums has been reduced and is expected to continue to decrease in the next biennium. Voluntary contributions continue to be mobilized regionally and to be concentrated among very few donors, resulting in relatively high levels of vulnerability.

49. In terms of flexibility and alignment, while more voluntary contributions have been received overall for both the base and emergencies components of PB 2016–2017, the European Region has faced a reduction in the flexibility of the funds received; this has particularly impacted PB base programmes. At the end of June 2017, the allocated base budget of the Regional Office was funded at 83%, including undistributed funds and projected voluntary contributions, compared with 86% at the end of June 2015. As the Region continues to receive voluntary contributions, the current financing of PB 2016–2017 is still expected to increase towards the end of the biennium.

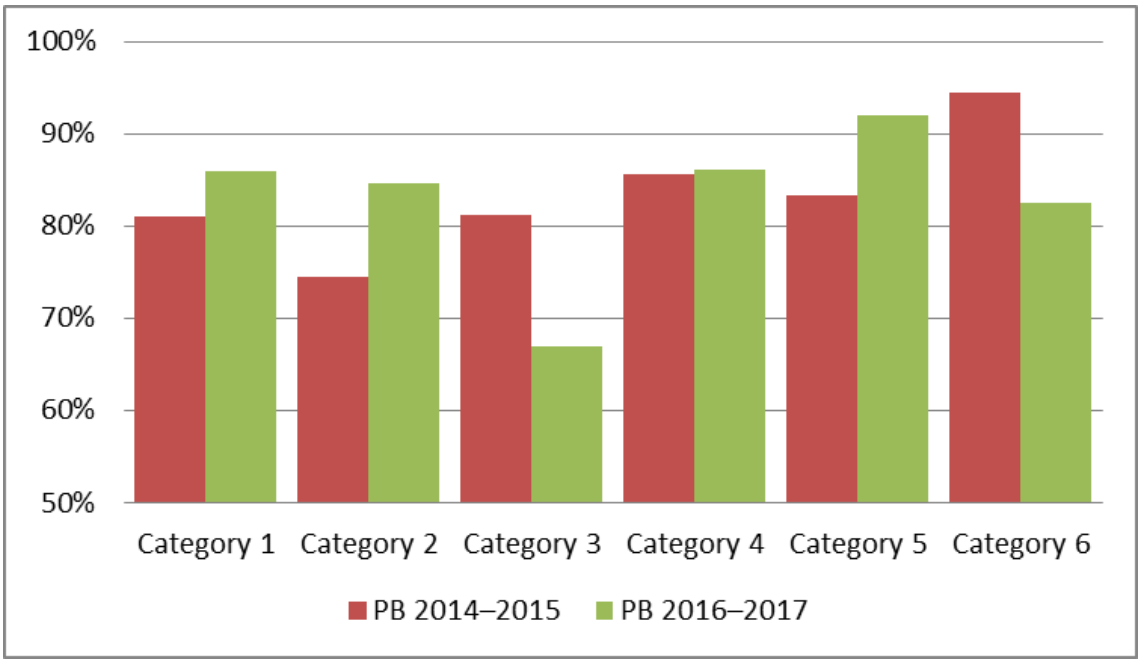
50. About 38% of the Regional Office's financial resources are flexible funds – 8% lower than in the previous biennium (see Fig. 5). PB 2016–2017 was based on the assumption that at least the same amount of flexible funds would be available as for PB 2014–2015.

Fig. 5. Financing of PB 2012–2013, PB 2014–2015 and PB 2016–2017, by type of funds



51. The remaining 62% of the Regional Office's financial resources consist of voluntary contributions that are highly specified for a project, country or disease or a combination of the three. There are several large country projects (for example, in Bosnia and Herzegovina, Greece, the Republic of Moldova and Ukraine) with highly specified funding for a specific programme area. This high level of earmarking has limited the capacity of the Regional Office to manage its available funds and to keep underfunded areas operational, particularly within categories 3 and 6 (see Fig. 6).

Fig. 6. Financing of PB 2014–2015 and PB 2016–2017, by category

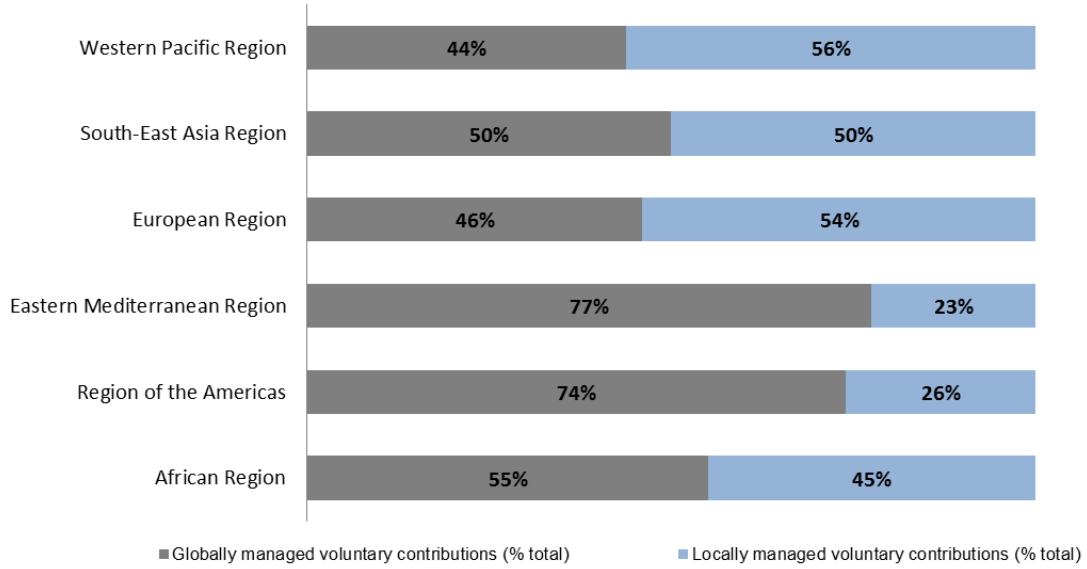


52. Within categories, the relatively high financing levels continue to hide pockets of poverty, owing to the high level of earmarking of voluntary contributions and reduced flexible funding. A significant drop in financing for category 3 compared to the previous biennium (see Fig. 6) has been a challenge in 2016–2017. This was reflected in the 18-month assessment, with category 3 having the highest number of outputs at risk. This is also the category with the single largest gap in the financing of staff salaries.

53. The Regional Office has experienced a backwards trend in terms of predictability of financial resources. At the start of the 2012–2013 biennium, the programme budget was financed at 43%, yet for 2014–2015 and 2016–2017, it was only 37% and 29%, respectively.

54. At the same time, the European Region is relatively vulnerable when compared with other major offices (see Fig. 7): it has the second highest dependence on locally managed voluntary contributions, which are often less predictable than the global multiyear agreements and grants. In the first 18 months of this biennium, the Regional Office has initiated 110 donor proposals and agreements, which takes significant effort by programme managers and heads of country offices. There continues to be a need for greater dialogue and transparency in the mobilization, coordination and distribution of globally mobilized funds to the regional and country levels of the Organization.

Fig. 7. Voluntary contributions by major office for PB 2016–2017, as of 30 June 2017



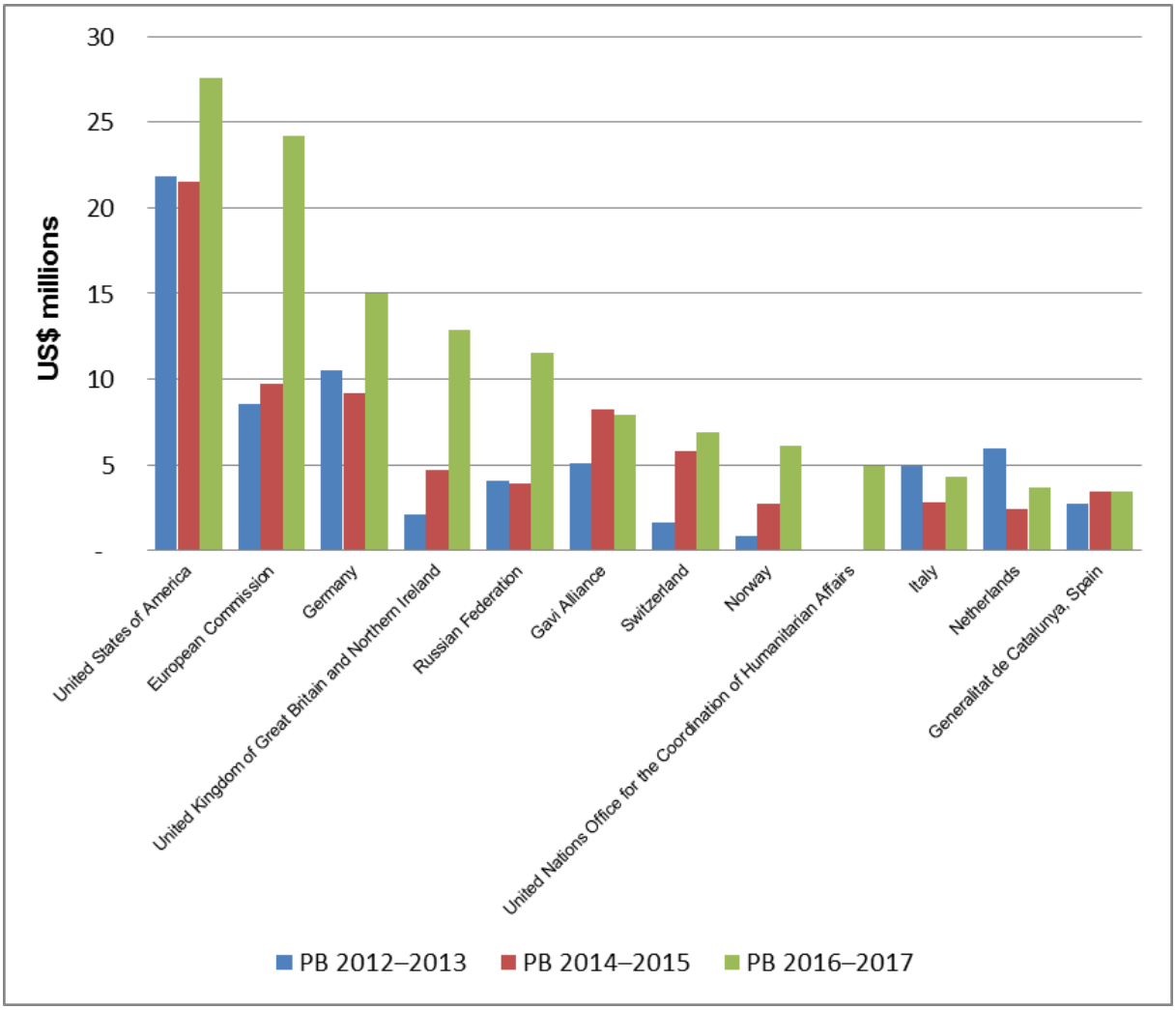
55. Reliance on only a few donors continues to be a challenge for the Regional Office. In the current biennium, 116 donors contributed either directly to the European Region or through corporate resource mobilization efforts. The top 12 of these donors represented 78% of the total voluntary contributions received (Fig. 8). A large portion of the increase in voluntary contributions received this biennium is also directly earmarked for the outbreak and crisis response actions ongoing in Ukraine and Syria and in Turkey to support the Syrian crisis and for refugees.

56. The Regional Office would like to express its appreciation to Member States who have strengthened their financial support to the Organization through voluntary contributions and is committed to continuing its efforts to reduce the earmarking of these funds.

57. As part of the organizational efforts to increase transparency, the European Region has mainstreamed the use of the WHO Programme Budget Web Portal (http://open.who.int) as a tool for discussion between WHO staff and their counterparts. Additionally, WHO has joined the International Aid Transparency Initiative, which has prompted the Regional Office to review and strengthen its operational practices and its risk assessment and compliance practices.

58. The figures presented in this section represent available funding in the Organization's Global Management System at the major office level for the current and previous bienniums. Member States may wish to note the cut-off dates for the figures presented in this report and those presented on the WHO Programme Budget Web Portal. The Web Portal is updated on a quarterly basis.

Fig. 8. Top donors to the Regional Office for Europe



Summary and conclusions

59. Eighteen months into the biennium, the following observations can be made about PB 2016–2017.

(a) The 18-month assessment of the RPI of PB 2016–2017 shows good progress towards achievement of the targets set for the biennium. This is a result of strengthened joint priority-setting by the Regional Office and the Member States and a joint commitment to achieve the defined outcomes.

(b) The Regional Office focuses on optimal deployment of effort and resources to ensure that the European Region remains on course for the achievement of the set PB goals and that it provides value for money. Partnerships, collaborations within and outside the health sector, strong political commitment and engagement, and high-quality technical assistance are the primary success factors in an environment of insufficiently flexible and aligned funding, which has led to challenges, particularly in implementing the 2016–2017 HR plan.

(c) In 2016–2017, there has been a greater focus on country programme implementation. The European Region has continuously worked to strengthen country offices and to define more explicitly roles, responsibilities and accountabilities at both the regional and country levels.

(d) As a result of improved priority-setting, the RPI of PB 2016–2017 set realistic budget ceilings by programme area and, with the exception of the outbreak and crisis response programme area, budget levels have not limited the delivery of technical work.

(e) Although the available and projected funding of the base PB appears adequate, it continues to be misaligned, as seen in the significant variation between well-financed and underfinanced categories and programme areas.

(f) The 2016–2017 biennium has seen a considerable increase in highly specified voluntary contributions. However, this increase has been partially offset by a reduction in flexible funding received from the global level. While specified funding has been targeted to highly prioritized areas, the reduction in flexible funding accentuates the gap in those programme areas that traditionally do not attract voluntary funding.

(g) The predictability of the flexible funding allocated to the European Region from the corporate level needs to be improved in terms of both the timing and the amount of funds for distribution. The reduction of 8% in flexible funding late in the biennium has further delayed actions by the Regional Office, particularly on the implementation of the HR plan. This poses challenges for the timely implementation of technical work and the utilization of financial resources for this and future bienniums.

(h) The allocation of globally mobilized voluntary contributions from headquarters to the regional and country levels needs to be improved in terms of predictability, amounts and alignment with regional priorities. The Regional Office continues to rely heavily on locally mobilized resources.

(i) Despite having a large donor base, the Regional Office relies heavily on a small number of key donors. Nevertheless, the Regional Office appreciates the positive trend in voluntary contributions emanating from Member States and other partners, which demonstrates trust in the work of WHO.

(j) The financial implementation of the approved PB 2016–2017 is slightly delayed, although implementation of available funding is on track. The Secretariat continuously monitors performance to ensure that corrective actions are put in place in a timely manner so as to bring PB 2016–2017 to a successful close.

Annex 1. Glossary of terms and abbreviations

Administrative support funds (AS): part of programme support costs, which can be used to fund only category 6.

Allocated budget: the budget as revised and approved by the WHO Director-General, subsequent to World Health Assembly approval.

Assessed contributions (AC): regular contributions made by all Member States, calculated on the basis of an assessment key determined by the United Nations. When the World Health Assembly endorses the appropriation resolution, it decides how AC funds should be used. In past programme budgets, this was at the level of strategic objectives, with 13 appropriation sections. In the current programme budget, it is by category and programme area.

Base programmes: the part of the programme budget for which WHO has full, exclusive managerial control.

Biennial collaborative agreements (BCAs): agreements between WHO and Member States in the European Region that outline the focus of work during the biennium.

Core voluntary contributions account (CVCA): a mechanism to receive, allocate and manage resources provided to WHO by donors and which are flexible at the programme budget (across categories 1–5) or category levels.

Country-specific mode (CS): used for outputs that are specifically tailored to an individual country.

Flexible resources: resources managed by the Organization with a high degree of flexibility, including allocating, spending, according priority and filling budget financing gaps. They are also known as **corporate resources** or **flexible funds** and include AC, AS, CVCA and POC funds.

Geographically dispersed office (GDO): part of the Regional Office with a specific technical focus and located outside Copenhagen, Denmark.

Global Management System (GSM): the enterprise resource planning system used by WHO; the software provider is Oracle.

Health impact: the final achievement of the results chain, defined as improvements in both the level and the distribution of health in European populations.

Human resources (HR): the HR plan links results with staff and resources.

Intercountry mode (IC): used for outputs that will benefit all countries in the Region.

Millennium Development Goals (MDGs): United Nations development goals with an agreed deadline of 2015 for their achievement.

Output: an element in the results chain representing deliverables by the Secretariat, such as guidelines, norms and standards, policy options, capacity-building packages and technical advice, required by Member States to achieve a health impact.

Post occupancy charge (POC): included in the staff costs charged to each project or workplan to recover any direct costs associated with project staff that are not otherwise covered. This is a WHO-wide charge that is applied to all salaries. In order to avoid double-counting, the POC is applied outside the PB.

Priority outcome: element in the results chain deemed to be a priority by Member States. The measure of achievement of a priority outcome is "the number of Member States that have …".

Programme budget (PB): the biennial WHO programme budget as presented to the World Health Assembly before the start of the biennium. Budget envelopes are often adjusted during the biennium, resulting in the so-called "allocated budget".

Results chain: describes and illustrates the transformation of inputs (money, staff, information, etc.) into public health impacts, expressed in terms of the overarching goal of improving the level and distribution of health in the European population.

Secretariat: the staff and organizational, managerial and physical structures of WHO.

Specified voluntary contributions (VCS): VC that are closely earmarked by the contributor as for what and how they can be used.

Sustainable Development Goals (SDGs): United Nations development goals with an agreed deadline of 2030 for their achievement.

Utilization: a measure of the PB comprised of the expenditures and the encumbrances combined. Expenditures are funds paid out upon delivery of goods or services. Encumbrances are funds reserved to cover future financial commitments.

Voluntary contributions (VC): contributions other than AC, AS and CVCA.

World Health Organization (WHO): the term is used to cover the Member States and the Secretariat.

Annex 2. PB 2016–2017 by category and programme area

Category		Programme area	
1	**Communicable diseases**	1.1 HIV	HIV/AIDS
		1.2 TUB	Tuberculosis
		1.3 MAL	Malaria
		1.4 NTD	Neglected tropical diseases
		1.5 VPD	Vaccine-preventable diseases
2	**Noncommunicable diseases**	2.1 NCD	Noncommunicable diseases
		2.2 MHS	Mental health and substance abuse
		2.3 VIP	Violence and injuries
		2.4 DIS	Disability and rehabilitation
		2.5 NUT	Nutrition
3	**Promoting health through the life-course**	3.1 RMC	Reproductive, maternal, newborn, child and adolescent health
		3.2 AGE	Ageing and health
		3.3 GER	Gender, equity and human rights mainstreaming
		3.4 SDH	Social determinants of health
		3.5 HEN	Health and the environment
4	**Health systems**	4.1 NHP	National health policies, strategies and plans
		4.2 IPH	Integrated people-centred health services
		4.3 AMT	Access to medicines and health technologies and strengthening regulatory capacity
		4.4 HIS	Health systems, information and evidence
5	**Preparedness, surveillance and response**	5.1 ARC	Alert and response capacities
		5.2 EPD	Epidemic- and pandemic-prone diseases (including antimicrobial resistance)[3]
		5.3 ERM	Emergency risk and crisis management
		5.4 FOS	Food safety[4]
E	**WHO Health Emergencies Programme**	E.1 IHM	Infectious hazard management
		E.2 CPI	Country health emergency preparedness and the IHR
		E.3 HIM	Health emergency information and risk assessment
		E.4 EMO	Emergency operations
		E.5 MGA	Emergency core services
6	**Corporate services/ enabling functions**	6.1 GOV	Leadership and governance
		6.2 TAR	Transparency, accountability and risk management
		6.3 SPR	Strategic planning, resource coordination and reporting
		6.4 ADM	Management and administration
		6.5 COM	Strategic communications
	Polio and outbreak and crisis response	5.5 POL	Polio eradication
		5.6 OCR	Outbreak and crisis response

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[3] In PB 2018–2019, antimicrobial resistance is a new separate programme area 1.6 under category 1.
[4] In PB 2018–2019, food safety is moved to category 2, to become a new separate programme area 2.6.