Official Document No. 327

Proposed Program Budget

2008 - 2009

October 2007

Pan American Health Organization
Regional Office of the World Health Organization

A PAHO Planning Series Document

Official Document No. 327

Proposed Program Budget

2008-2009

PAN AMERICAN HEALTH ORGANIZATION /
REGIONAL OFFICE FOR THE AMERICAS OF THE
WORLD HEALTH ORGANIZATION

OCTOBER 2007

CONTENTS

(Click on links) *Page*

CONTENTS *(CONT.)*

Page

INTRODUCTION

1. PAHO is engaged with WHO in a results-based budgeting approach to determine the resource requirements to carry out its work. The cost of achieving PAHO's Region-wide Expected Results over a given period of time is expressed through an integrated budget comprising all funding sources.

2. PAHO receives its funding from three main sources:

(a) PAHO Regular Budget - comprises assessed contributions (quotas) from PAHO Member States plus miscellaneous income;

(b) Portion of the WHO regular budget approved for the Region of the Americas: referred to as the AMRO share;

(c) Voluntary Contributions - the majority of voluntary contributions received by PAHO are a result of direct negotiations with its donor partners; a lesser amount is channeled by donor partners to the region through WHO.

3. While funding sources from (a) and (b) above are considered unearmarked, voluntary contributions (c) can be categorized as either earmarked or unearmarked. Effective financing of the Proposed Strategic Plan 2008-2012 and associated Program Budgets will require careful management of the different sources and types of income to ensure complete funding of planned activities. Unearmarked funding, such as assessed contributions, provides a predictable and flexible resource base that facilitates financing of the Organization's core activities. Earmarked funding—which accounts for the majority of voluntary contributions currently negotiated—is less flexible, and thus may not be available for use in under-funded programmatic areas.

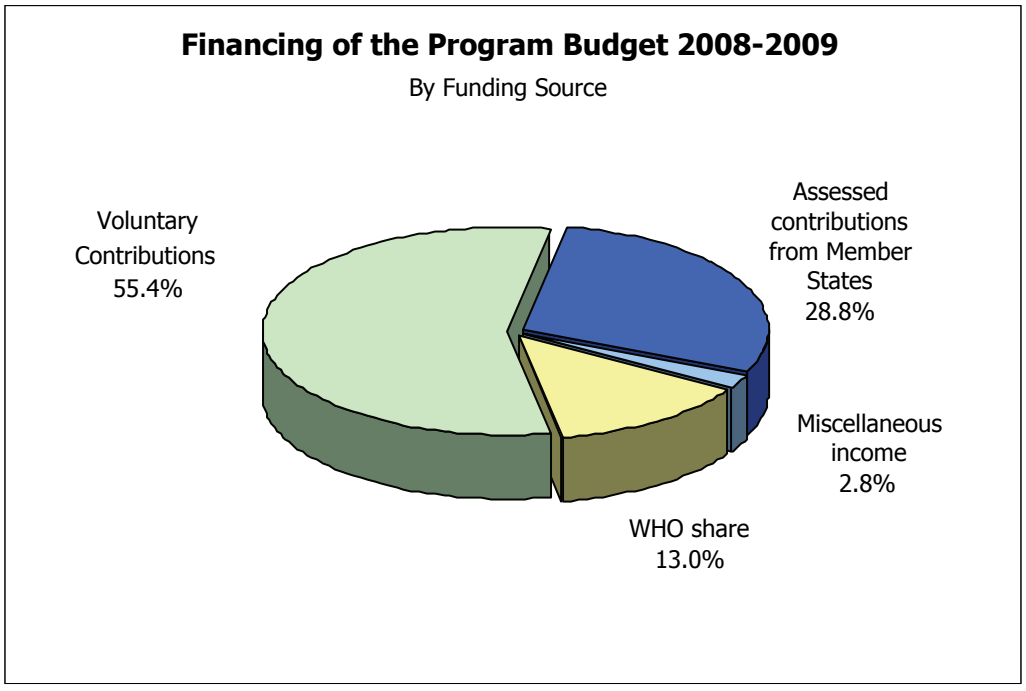
4. Earmarked funding continues to pose a challenge for ensuring alignment between the Organization's planned activities and actual resources mobilized. To the extent that donor partners can be persuaded to provide increased levels of unearmarked voluntary contributions—also being referred to as *negotiated core voluntary contributions* by WHO—the Organization will become more successful in fully financing its Strategic Plan and Program Budgets, consequently increasing the probability of achieving its expected results. To this end, the Bureau fully supports WHO's efforts in actively seeking to increase the proportion of the program budget financed with negotiated core voluntary contributions and will similarly continue its own efforts in this area.

5. Table 1 below compares the financing of the proposed budget 2008-2009 with the approved budget for 2006-2007.

Table 1. Financing of the Program Budget 2008-2009

Source	2006-2007	2008-2009	% change
Assessed contributions from Member States	173,300,000	180,066,000	3.9%
+ Miscellaneous income	14,500,000	17,500,000	20.7%
= Total PAHO share (Regular Budget)	187,800,000	197,566,000	5.2%
+ WHO share (Regular Budget)	77,768,000	81,501,000	4.8%
= Total Regular Budget	265,568,000	279,067,000	5.1%
+ Estimated Voluntary Contributions *	265,544,000	347,000,000	30.7%
= Total Resource Requirements	531,112,000	626,067,000	17.9%

* Represents the combined total estimated voluntary contributions from PAHO donor partners as well as from WHO



6. The proposed budget for 2008-2009 of $626 million represents an increase of 17.9% compared to the $531.1 million budget approved for 2006-2007. The largest source of the increase comes from the estimated voluntary contributions of $347 million, representing a 30.7% increase, of which $197 million is estimated to come from WHO. The $197 million estimate was developed jointly with WHO/HQ and all of the other regions by teams of staff working together globally and grouped by Strategic Objective.

7. The regular budget share of the budget of $279 million represents an increase of $13.5 million, or 5.1%, compared to the biennium 2006-2007, and is all attributable to the projected increase in the cost of fixed-term staff. This increase is proposed to be funded by an increase to PAHO assessed contributions of 3.9%, a 20.7% increase to miscellaneous income, and the remainder from the 4.8% increase in the AMRO share of the regular budget ($81.5 million for AMRO approved by the World Health Assembly in May 2007).

8. The significant increase in the cost of international transactions to U.S. dollar-based budgets is being felt world-wide, and for PAHO it is no exception. A thorough analysis of current costs and trends points to an expected cost increase of between 13% - 15% for the 2008-2009 biennium. For the PAHO regular budget, this translates to roughly $37 million for cost increases alone, of which approximately $24 million are related to the cost of fixed-term staff.

9. An alternative, more optimistic scenario, which considers a curbing of the U.S. dollar devaluation effect over the short term, yields a projected cost increase of about 10% for the next biennium. In a Zero Real Growth scenario, this translates to roughly $23 million for the regular budget, of which approximately $17 million are related to the cost of fixed-term staff. However, an additional 12 fixed-term positions have been reduced so far in the biennium (in addition to the 41 positions abolished during 2004-2005) thus containing the estimated cost increase to about $14 million for fixed-term staff for 2008-2009, an increase of 8.3% compared with the budget component for fixed-term staff for 2006-2007.

10. Furthermore, the proposed increase of $13.5 million to the regular budget considers only the cost increase to fixed-term positions; it does not make provision for inflationary costs in the non-staff component of the program budget of an estimated $6.5 million. This translates into a real reduction in purchasing power of about 7% in comparison to the 2006-2007 biennium.

11. It should also be noted that the proposed budget level, in addition to not allowing for inflationary non-staff costs, does not make provision for several significant administrative costs expected to be incurred over the next few years; these include, for instance, UN mandatory implementation of International Public Sector Accounting Standards (IPSAS), PAHO's expected involvement with the Global Management System (GSM) project being implemented by WHO, and expenditure related to the Master Capital Investment Plan. Correspondingly, it is also important for Member States to keep in mind that additional funding for required expenditure such as IPSAS, GSM and the Master Capital Investment Plan will need to be prioritized from within the budget designated for regional program activities which is already being reduced in nominal terms and further eroded by inflation.

12. The purchasing power of the operating budget for program activities has suffered over the last several biennia given that budget approvals by Member States have only considered budget increases to meet net fixed-term staff cost increases (despite continued reductions in the number of staff). The erosion is particularly acute for the regional level (such as regional centers and entities based in Washington) where the ratio of fixed-term staff costs to activity costs is typically higher than in countries because of the nature of the work. As the cost of fixed-term positions continues to rise, it becomes increasingly difficult for the Bureau to strive for further efficiencies by continuing to streamline operations and realign program areas.

13. The situation explained above is compounded by the fact that the Regional Program Budget Policy will progressively allocate a larger share of the budget to the countries over the next two biennia, as was the case for 2006-2007—the first implementation biennium of the Budget Policy. The further reduction of the regular budget for regional activities creates a challenge for carrying out the statutory and normative work and for the ability of regional entities to respond to backstopping needs of countries.

14. To better understand these dynamics and their effect on the budget, Table 2 below serves to illustrate the interplay among the principle attributes of the budget; namely, its financing, its major cost types, and its distribution among functional levels as stipulated in the Regional Program Budget Policy (Refer also to Table 3).

Table 2. Distribution of the Proposed Regular Budget 2008-2009

	In thousand of U.S. dollars			
	2006-2007	**Change**	**2008-2009**	**Percentage**
To be financed from:				
Assessed Contributions	173,300	6,766	180,066	3.9%
Miscellaneous Income	14,500	3,000	17,500	20.7%
WHO/AMRO	77,768	3,733	81,501	4.8%
Total	**265,568**	**13,499**	**279,067**	**5.1%**
By major cost type:				
Post	168,802	13,998	182,800	8.3%
Non-post	91,766	(499)	91,267	-0.5%
Retirees' Health Insurance	5,000	-	5,000	0.0%
Total	**265,568**	**13,499**	**279,067**	**5.1%**
By Functional Level:				
Regional	144,876	3,942	148,818	54.3%
Sub-regional	16,676	1,687	18,363	6.7%
Country	99,016	7,870	106,886	39.0%
Subtotal	**260,568**	**13,499**	**274,067**	**100.0%**
Retirees' Health Insurance	5,000	-	5,000	
Total	**265,568**	**13,499**	**279,067**	

15. In the present proposal, as illustrated in Table 2, the projected post cost increase of $14 million in the regular budget is greater than the proposed budget increase of $13.5 million; thus, the proposal includes a reduction in the non-post component of the regular budget of $0.5 million to offset the unfunded portion of the cost increase. In doing so, the assessment increase to Member States remains at the 3.9% level presented to the SPBA and the Executive Committee. When added to the $6.5 million of inflationary costs to non-post costs that are not being provided for in the proposal, the total real reduction in the non-post component of the budget amounts to $7.0 million ($0.5 million + $6.5 million), or about 8% of the total non-post budget.

16. Given the regular budget situation, effective resource mobilization becomes increasingly important for the Organization. And since voluntary contributions provided by donor partners are generally earmarked for specific objectives and are less predictable, the Secretariat will continue to make every effort to manage these contributions in light of the overall expected results contained in the Strategic Plan and Program Budget. Thus, regular budget funds become essential for securing many of the statutory and normative core functions.

17. Finally, in consideration of the expressed concern of several Member States regarding their ability to accept assessment increases, the Bureau is prepared to take the "optimistic" scenario forward in projecting cost increases for the proposed 2008-2009 program budget; it should be understood, however, that the economic reality may worsen and may require significant adjustments to planned programmatic targets contained in the Region-wide Expected Results.

18. The Annexes provide different Region-wide views of the program budget by the 16 Strategic Objectives, as well as additional details on the distribution of the Country Allocation by country as stipulated by the Regional Program Budget Policy. Where there are comparisons made to the 2006-2007 budget, it should be noted that a crosswalk methodology (developed by WHO) has been applied to convert the 2006-2007 budget from 38 Areas of Work to 16 Strategic Objectives.

Table 3. Application of the Regional Program Budget Policy

	2006-2007	2008-2009	2010-2011
Country	38.0%	39.0%	40.0%
Subregional	6.4%	6.7%	7.0%
Regional	55.6%	54.3%	53.0%
	100.0%	100.0%	100.0%

STRATEGIC OBJECTIVE 1

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

Scope

This Strategic Objective (SO) focuses on prevention, early detection, diagnosis, treatment, control, elimination, and eradication measures to combat communicable diseases that disproportionately affect poor and marginalized populations in the Region of the Americas. The diseases to be addressed include, but are not limited to: vaccine-preventable, tropical (including vector-borne), zoonotic and epidemic-prone diseases, excluding HIV/AIDS, tuberculosis and malaria.

REGION-WIDE EXPECTED RESULTS

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

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.1.1	Number of countries achieving more than 95% vaccination coverage at national level (DPT3 as a tracer)	17	20
1.1.2	Proportion of municipalities with vaccination coverage level less than 95% in Latin America and the Caribbean (DPT3 as a tracer)	38% (5,729)	35% (5,277)
1.1.3	Number of countries supported to make evidence-based decisions for the introduction of new and underutilized vaccines	9	10
1.1.4	Number of essential child and family health interventions integrated with immunization, for which guidelines on common program management are available	4	6
1.1.5	Number of countries that have established either legislation or a specified national budget line in order to ensure sustainable financing of immunization	30	32
1.1.6	Number of countries that have included the new vaccines (RV, NEUMO, INF, YF, HPV) in their national epidemiological surveillance system	0	5

RER 1.2 **Member States supported through technical cooperation to maintain measles elimination and polio eradication; and achieve rubella, congenital rubella syndrome (CRS) and neonatal tetanus elimination**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.2.1	Number of countries using oral polio vaccine (OPV) according to an internationally agreed timeline and process for cessation of its routine use	35	35
1.2.2	Percentage of final country reports or updates on polio containment certified by the Regional Commission for the Americas	100%	100%
1.2.3	Number of countries with sustained surveillance of acute flaccid paralysis	39/39	39/39
1.2.4	Number of countries that have implemented interventions to achieve rubella and Congenital Rubella Syndrome (CRS) elimination	36/39	39/39
1.2.5	Number of countries achieving neonatal tetanus (NNT) elimination	38/39	39/39

RER 1.3 **Member States supported through technical cooperation to provide access for all populations to interventions for the prevention, control, and elimination of neglected communicable diseases, including zoonotic diseases**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.3.1	Number of countries maintaining dracunculiasis eradication certification	40	40
1.3.2	Number of countries that are implementing WHO Global Strategy for further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities	0/25	5/25
1.3.3	Population at risk (in millions) of lymphatic filariasis in four endemic countries receiving mass drug administration (MDA) or preventive chemotherapy	2.4	4.7
1.3.4	Coverage of at-risk school-age children in endemic countries with regular treatment against schistosomiasis and soil-transmitted helminthiasis (STH)	38%	50%
1.3.5	Number of countries in Latin America and the Caribbean that have eliminated human rabies transmitted by dogs	11/21	12/21
1.3.6	Number of countries in Latin America and the Caribbean that maintain surveillance and preparedness for emerging or re-emerging zoonotic diseases (e.g. avian flu and bovine spongiform encephalopathy)	10/33	13/33

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.3.7	Number of countries with Domiciliary Infestation Index by T. infestans (Southern Cone) and R. prolixus (Central America) under 1%	3/21	11/21
1.3.8	Number of countries with total Chagas screening of blood banks to prevent transmission by transfusion	14/21	20/21
1.3.9	Number of onchocerciasis-endemic countries with foci where transmission has been declared interrupted and which are undergoing a 3-year post-transmission interruption surveillance period	1/13	2/13

RER 1.4 **Member States supported through technical cooperation to enhance their capacity to carry out communicable diseases surveillance and response, as part of a comprehensive surveillance and health information system**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.4.1	Number of countries with enhanced surveillance for communicable diseases of public health importance, according to PAHO/WHO assessment guidelines	13/39	15/39
1.4.2	Number of countries adapting generic surveillance and communicable disease monitoring tools or protocols to specific country situations	2/35	15/35
1.4.3	Number of countries that submit the joint reporting forms on immunization surveillance and monitoring to the PASB, in accordance with established timelines	15/35	18/35
1.4.4	Number of countries routinely implementing antimicrobial resistance (AMR) surveillance and interventions for AMR containment	14/35	17/35

RER 1.5 **New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed, validated, available, and accessible**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.5.1	Number of consensus reports published on subregional, regional or global research needs and priorities for a disease or type of intervention	0	3
1.5.2	Number of new or improved interventions and implementation strategies whose effectiveness has been evaluated and validated	1	2
1.5.3	Number of countries which have developed their operational research capacity in partnership with regional and global scientific institutions	3/33	5/33

RER 1.6 **Member States supported through technical cooperation to achieve the core capacities required by the International Health Regulations for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.6.1	Number of countries that have completed the assessment of core capacities for surveillance and response, in line with their obligations under the International Health Regulations (2005)	3/35	35/35
1.6.2	Number of countries that have developed national plans of action to meet minimum core capacity requirements for early warning and response in line with their obligations under the International Health Regulations	0/35	32/35
1.6.3	Number of countries whose national laboratory system is engaged in at least one internal or external quality-control program for communicable diseases	20/39	24/39
1.6.4	Number of countries participating in training programs focusing on the strengthening of early warning systems, public health laboratories or outbreak response capacities	38	38

RER 1.7 **Member States and the international community equipped to detect, contain and effectively respond to major epidemic and pandemic-prone diseases (e.g. influenza, dengue, meningitis, yellow fever, hemorrhagic fevers, plague and smallpox)**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.7.1	Number of countries that have national preparedness plans and standard operating procedures in place for pandemic influenza	22/35	28/35
1.7.2	Number of international support mechanisms established for surveillance, diagnosis and mass intervention (e.g. international laboratory surveillance networks and vaccine-stockpiling mechanisms for meningitis, hemorrhagic fevers, plague, yellow fever, influenza, smallpox)	5	6
1.7.3	Number of countries with basic capacity in place for safe laboratory handling of dangerous pathogens and safe isolation of patients who are contagious	22	25
1.7.4	Number of countries implementing interventions and strategies for dengue control (Communication for Behavior Impact [COMBI])	15	17

RER 1.8 **Regional and Subregional capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern**

Indicator #	RER Indicator text	Baseline 2007	Target 2009
1.8.1	Number of PASB entities (regional headquarters and country offices) with the global event management system in place to support coordination of risk assessment, communications and field operations	1/30	10/30
1.8.2	Number of countries with at least one participating partner institution in the Global Outbreak Alert and Response Network, and other relevant regional networks	26	30
1.8.3	Proportion of requests for support from Member States during an emergency or epidemic, for which PASB mobilizes a comprehensive and coordinated international response (including disease-control efforts, investigation and characterization of events, and sustained containment of outbreaks)	100%	100%
1.8.4	Median time (in days) for verification of outbreaks of international importance, including laboratory confirmation of etiology	7 days	5 days