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PAHO BUDGET POLICY

Background

1. In January 1985, the Executive Board of the World Health Organization (WHO/EB) asked all Regional Committees to prepare regional program budget policies that would promote the optimal use of WHO resources at all levels, in order to maximize the effect of said resources on WHO's collective policies. In September of that year, the 31st Directing Council of the Pan American Health Organization (PAHO, WHO's Regional Office for the Americas) approved PAHO's Regional Program Budget Policy (RPBP) as an integral part of its Managerial Strategy for the Optimal Use of PAHO/WHO Resources in Direct Support of Member States pursuant to Resolution CD31.R10.

2. In 1998, World Health Assembly (WHA) Resolution WHA51.31 introduced a new method for allocating funds across Regions, which resulted in a significant reduction of WHO's allocation for the Region of the Americas over the 2000-2005 period. This action prompted the Subcommittee on Planning and Programming (PAHO's Governing Bodies' predecessor to the Subcommittee on Program, Budget, and Administration, or SPBA) to call for a process to review the Regional Program Budget Policy, geared towards developing one that would be aligned with the ensuing Strategic Plan 2003-2007 for the Pan American Sanitary Bureau (hereafter referred to as the "Strategic Plan").

3. During 2003, PAHO's 44th Directing Council also endorsed the Managerial Strategy for the Work of the Pan American Sanitary Bureau (Bureau) in the Period 2003-2007 (Document CD44/5), which identified the strategic management of resources as one of the corporate objectives of the organizational change then underway. Furthermore, the Managerial Strategy noted that it would be important for the budget policy to support the implementation of the Strategic Plan, with its emphasis on special population groups, priority countries, and technical objectives.

4. The current budget policy, approved in 2004, became effective during the 2006-2007 biennium. It embraced the call made by the countries for a different approach to how PAHO was allocating its resources, adopting three major principles to guide its development: equity, solidarity, and Pan Americanism. In particular, countries called for the incorporation of needs-based criteria to guide the allocation of the resources distributed among the countries. In addition, the current budget policy took into consideration several global and regional mandates, such as the following:

(a) the United Nations Global Compact (UNGC), which led to the development of the Millennium Development Goals (MDGs);

(b) the WHO General Programme of Work (GPW);

(c) increased country focus cooperation;

(d) subregional integration; and

(e) the call for international agencies to demonstrate value added.

5. In 2010, PAHO's Office of Internal Oversight and Evaluation Services (IES) conducted an evaluation of the Regional Program Budget Policy 2006-2011 (RPBP). Its overall finding was that the development and implementation of the RPBP has been a significant achievement and success both for the Pan American Sanitary Bureau as well as for the Member States. The RPBP provided a transparent, systematic, and consistent methodology for allocating PAHO's biennial Regular Budget resources among the three levels of the Organization (regional, subregional, and country).

6. Despite the RPBP's noted strengths and sound conceptual design, there have been challenges in ensuring adequate budgetary levels for all the countries, and for the regional entities. One of the main reasons for this can be attributed to the Country Budget Allocation (CBA) model itself. In the type of statistical modeling used in this model, such mathematical methods as *population smoothing* and *progressivity*[1] can have a significant distributive effect on results. Some of the methods used in the current CBA model are fairly aggressive, which has resulted in a significant redistribution of resources among countries. This meant that some countries benefitted significantly from the particular allocation of resources, while others—those with a relatively better health status, as measured by the Health Needs Index (HNI)—received budget reductions proportionate to the extent to which their health needs were better met than those of other countries. In addition, the minimum funding level that was built into the model has proven to be insufficient over time. In several cases, the reductions resulted in budgetary levels that were unable to sustain a minimum presence in the country.

[1] For more information on the statistical methods and terminology, please refer to paragraph 14 of Annex B.

7. The IES evaluation does point out the weaknesses mentioned above, making observations and recommendations for improvement in the following key areas:

(a) review the funding 'floor' assigned to the countries;

(b) review the traditional size of the PAHO/WHO Representative Offices in the countries;

(c) compare the effects of other population smoothing mechanisms;

(d) consider a funding ceiling;

(e) conduct a benchmarking study of needs-based solutions that have been adopted by other United Nations (UN) agencies;

(f) increase the variable portion of the Country Budget Allocation;

(g) update the HNI formula variables more often;

(h) extend the current policy into the 2012-2013 biennium;

(i) incorporate greater flexibility into future policies to better meet countries' needs;

(j) include the use of South-South cooperation; and

(k) protect the achievements made thus far.

8. The Proposed PAHO Budget Policy builds on the fundamental principles of the current policy, but it also introduces adjustments and new elements to address inherent weaknesses, as were noted in the IES evaluation report. In the CBA model, specific changes have been made in allocation concepts, as well as in specific formulaic criteria—while in all instances striving to maintain and improve upon fairness, transparency, and equity, and simultaneously allowing the policy to be workable within realistic, practical settings and still yield sensible, reasonable results.

9. It should be noted that the proposed budget policy takes into account and responds to each and every recommendation in the IES evaluation report, with the aim of providing an improved strategic managerial instrument that is key for the effective and optimal distribution of PAHO resources, in support of the Organization (i.e., PAHO) achieving its mandate.

10. As the Organization moves forward, it has been recognized that the landscape for the mobilization of resources for the Region of the Americas is continuously undergoing change. As compared with other regions of the world, the predominance of middle-income countries makes the Americas less attractive for many international donor partners. This reality places a greater level of stress on PAHO's Regular Budget—which, in turn, serves to ensure that the Organization's core work is properly funded at all levels in order to coherently bring about the required impact in the countries.

Planning, Programming, and Budget Preparation in PAHO

11. The Organization's planning, programming, and budgetary preparation—as well as monitoring and evaluation—are designed to be an integrated and continuous process, incorporating both long- and medium-term planning. Although separated into distinct phases, each component is intended to provide a framework and reference for the other phases.

12. Long-term strategic planning in health up to now largely occurred at the global level, with the WHO General Programme of Work (GPW) providing the framework for medium-term planning. The Region has developed its Health Agenda for the Americas which provides the long-term vision for improving health in the Region and the PAHO Strategic Plan as its medium-term planning framework which is aligned to WHO's GPW and responds to the Health Agenda for the Americas. The Strategic Plan is based on the results of analyses of both the external and internal environments, as well as previously adopted mandates at the global and regional levels, and the jointly determined needs of the countries. This medium-term plan specifies the strategic goals and objectives towards which the Organization is gearing its efforts in the Region, determining its strategic and programmatic orientations for that period.

13. To complement this process, medium-term planning also takes place at the country level, to clarify PAHO/WHO's strategic response to support an individual country in its efforts to achieve the collective global and regional goals over a four- to five-year period. This is the objective of the Country Cooperation Strategy (CCS) process that is being implemented widely throughout PAHO, as it seeks to define the strategic pursuit of cooperation with individual Member States within the framework of the Organization's collective mandates.

14. The short-term planning process is captured in the PAHO Program and Budget; it covers a two-year period called a "biennium," beginning with every even-numbered year (e.g., 2012-2013). The process centers on the development of two-year (biennial) program budgets to successfully execute the regional Strategic Plan and to contribute to the global objectives for that period. The process should place the needs of the countries at the very center and aim to focus the work done at all levels of the Bureau on the countries' needs.

15. This Organization-wide managerial process is results-based, clearly identifying the collective outcomes to be brought about in the countries during that period—to which the Bureau will contribute through integrated, multidisciplinary, and multilevel technical cooperation in selected programmatic areas of work. The objectively verifiable outputs at the country level, for which the Bureau will be held accountable at the end of the biennium, should be negotiated with countries and other partners at the national level.

The PAHO biennial Program and Budget must be as accurate a reflection as possible of the reconciliation of specific country requirements with the current regional and global policy decisions within each programmatic area of work.

16. The development of a short-term country program should be based on the medium-term Country Cooperation Strategy, wherever one is in place. In the absence of a CCS, the process should aim to determine PAHO's response over a two-year period to assist the country in achieving the Organization's collective goals. It should take into consideration the results of the evaluation from the last biennium, relevant national health priorities, and resources available both nationally and from other partners. In all cases, country-level programming provides a critical opportunity not only to strengthen strategic alliances, but also to strengthen the intersectoral nature of PAHO's work.

17. National participation in elaborating the Program and Budget is of primary importance in ensuring that the Organization's scarce multilateral resources are assigned to priority areas. Country participation occurs at three levels:

(a) First, it takes place within each country, through the continuous joint process of evaluating existing technical cooperation in light of changing circumstances, conditions, and needs. The Organization will support this joint endeavor by conducting periodic, in-depth policy and program reviews.

(b) Second, it occurs through the active participation of PAHO Member States in WHO's Governing Bodies. Acting as part of WHO's collective policy-making arm, PAHO Member States have an opportunity to comment on the amount of the WHO contribution to the Region of the Americas as well as on the regional contribution to the attainment of global outcomes.

(c) Third, Member States—through their participation in PAHO's Subcommittee on Program, Budget and Administration, not to mention PAHO's Executive Committee and Directing Council—determine the program of work, the level of resources available to the Organization, and the allocation of those resources to achieve the agreed-upon programmatic outcomes and targets in the Region.

18. While the Program and Budget is approved biennially, there is a corporate-wide assessment exercise every six months to ensure that the technical cooperation program responds to changing country situations and needs—as well as with respect to resource availability both in the countries and in the Organization. This review process is undertaken jointly between the countries at the national level, and the technical and support entities at the regional level.

19. The process of preparation, execution, and monitoring the PAHO Program and Budget offers a range of opportunities to promote effective coordination both within and among the Organization's technical entities, as well as coordination among the Organization's various functional and organizational levels.

Architecture of the PAHO Program and Budget

20. The scope of PAHO's work as a specialized, multilateral health agency encompasses collective normative functions as well as the common public health objectives of its Member States as a whole, in addition to technical cooperation functions aimed at supporting national health development in the individual countries. The former includes, among other things, setting the vision and strategic directions for health development in the Americas, establishing norms and standards agreed upon by the Member States, monitoring health situations, and identifying best practices in research. Country-specific technical cooperation functions, on the other hand, are primarily those that are directly related to building institutional capacity in the countries and to designing and implementing integrated technical programs that will address specific health situations.

21. The Organization's work is reflected in its Program and Budget, through three interrelated perspectives:

A. programmatic categories,
B. functional levels, and
C. organizational levels.

A. *Programmatic Categories*

22. Programmatic categories constitute the highest-level programmatic classification of the Organization's work; they reflect its response to global and regional health needs. The number and contents of the programmatic categories represent choices made vis-à-vis the Organization's work over a given period of time, and the Organization must review these regularly to ensure that they respond to the changing needs of the environment over time. Programmatic categories are typically set by the WHO General Programme of Work and are then adapted by the PAHO Strategic Plan. Subsequently, they guide the formulation of programs at both the functional and organizational levels.

23. Programmatic categories are the basic building blocks for planning, programming, budgeting, and reporting in both WHO and PAHO within the results-based management (RBM) process. Priority-setting must influence the allocation of all resources among and within the programmatic categories. The articulation of the PAHO Program and Budget with the WHO global planning process—through the PAHO

Strategic Plan—makes the alignment of PAHO's and WHO's respective programmatic categories a critical element in the managerial process.

B. *Functional Levels*

24. Functional levels represent the scope of technical cooperation activities that the Organization undertakes in support of its mandates. There are four functional levels: country, inter-country, subregional, and regional. The first three can be grouped into one category called "direct technical support to countries," while the Regional level stands on its own.

Direct Technical Support to Countries (Country Level, Inter-country Level, and Subregional Level)

(a) ***Country****:* Technical cooperation programs are aimed at meeting the needs of a particular country in its pursuit of the Organization's collective mandates and of its national health development goals. Technical support for these activities is primarily provided by the PAHO country offices, but PAHO's regional Pan American Centers and other regional entities also provide support.

(b) ***Inter-Country****:* The inter-country level of cooperation addresses the needs of groups of two or more countries that may have an affinity based on geographical considerations, disease profiles, and other factors. Inter-country cooperation differs from subregional cooperation (see below) in that it is not necessarily part of a specific political subregional integration process, since the specific set of countries supported may or may not lie within the same political subregion. This work is aimed at providing specific competencies needed to back-up priority programs in countries. The resources are typically located physically in PAHO's country offices.

(c) ***Subregional****:* Technical cooperation programs are aimed at meeting the needs of a group of countries in their pursuit of the subregional health development goals within the framework of the Organization's collective mandates. Technical support for this level can be provided and coordinated by any type of organizational office. These programs encompass all or some countries belonging to one of the legally established intergovernmental integration mechanisms: the Caribbean Community (CARICOM), the Southern Cone Common Market (MERCOSUR), the Central American Integration System (SICA), the Andean Community of Nations (CAN), or the North American Free Trade Agreement (NAFTA), as well as others such as the Amazon Cooperation Treaty Organization (ACTO) and the Union of South American Nations (UNASUR). This approach of technical cooperation work supports the health agendas of the various

intergovernmental integration mechanisms. It must be developed with the countries, through the mechanisms responsible for planning and executing the respective health agendas. Clearly defined outcomes and outputs should be agreed upon with the groups of countries. The subregional level of cooperation is conducted physically by all organizational levels within the Organization and provides direct technical support of individual country needs as expressed in the respective agendas of the intergovernmental integration mechanisms.

(d) ***Regional****:* The regional level of cooperation comprises programs with a technical component aimed at meeting the needs of all Member States, not only in terms of normative work but also of their attaining regional public health goals and targets. While this component has traditionally been carried out organizationally by various regional entities, as well as by the regional Pan American Centers,[2] it can also be carried out from country offices.

C. *Organizational Levels*

25. There are the three types of physical presence that make up the PAHO structure, namely PAHO/WHO Representative Offices, subregional offices (e.g., the Caribbean Program Coordination Office or the United States-Mexico Border Field Office in El Paso, Texas) and Regional Offices (both at PAHO Headquarters and in decentralized field offices). Work performed at any of the three organizational levels can contribute to one or more programmatic categories and/or functional levels.

26. The PAHO Program and Budget is funded from various funding sources: PAHO Regular Funds provided through the quota contributions of its Member States, the share of WHO regular funds to the Region of the Americas from its quota contributions, and Voluntary Contributions (VCs) mobilized by both WHO and PAHO. All funds support programs or projects within the one Program and Budget, so that the logical relationship among all technical interventions can be appreciated.

27. PAHO/WHO's role should be mainly catalytic: mobilizing scientific, technical, and managerial resources from appropriate national partners, as well as assisting in the design of effective interventions. As such, the program and budget must be seen as a flexible, strategic management instrument. It must be able to respond to changing environments, such as disasters and emerging health needs, and to take into consideration the impact of economic downturns and sociopolitical challenges in a timely manner. The Program and Budget must serve as a framework for mobilizing resources and galvanizing collaborative efforts with other sectors and agencies.

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[2] PAHO's Regional Pan American Centers concentrate on one or selected technical areas through a range of functions, such as research, normative work, and technical cooperation. A few of them also provide services. Some centers serve the Region as a whole, while others serve selected subregions.

Resource Allocation Criteria

28. PAHO resources must be distributed among the three perspectives embedded within its Program and Budget: programmatic categories, functional levels, and organizational levels. Currently, a major reform process is underway in WHO that is dealing with, among other important issues, the roles and responsibilities of the different levels of that Organization as a whole; this, in turn, may have an impact on funding the different functional and organizational levels within PAHO. Furthermore, in the absence of an effective assessment of the optimal proportionality among PAHO's different functional and organizational levels, the Organization sees no firm basis for recommending changes among them. However, with the aim of strengthening cooperation with countries, the Organization will continuously—through both internal and external assessments—strive to achieve and maintain the optimal functional and organizational structure to enable it to bring about the greatest level of impact in the countries, while effectively responding to collective regional and subregional mandates.

Allocation among Programmatic Categories

29. The distribution of resources among programmatic categories is typically the first step, as this reflects at the highest level the relative needs of PAHO's Member States as collectively decided by the Governing Bodies. These programmatic budget levels need to be consistent with the support needed to achieve collective priorities at both the global level (e.g., the GPW) and the regional level (e.g., the Strategic Plan). The funding levels of the programmatic categories then set the tone for the Organization's work. This will be then be carried out by the various functional and organizational levels.

Allocation among Functional and Organizational Levels

30. The functional and organizational levels are what determine either the approach or the type of technical cooperation that needs to be delivered (functional level), as well as by whom (organizational level), in order to achieve the agreed-upon mandates. An initial distribution of funds across the four functional levels, commensurate to those set by the current policy, is proposed. Namely, the regional level (together with the inter-country level) would receive 53% of funds; the subregional, 7%; and the country level, 40%. The new inter-country level will be shown separately (it is currently reflected within the regional level). Together with the adjusted regional level, it will add up to no more than 53%. A thorough discussion on the desired construct of the technical cooperation to be delivered during a given biennium should give way to allocating budget planning ceilings among the various management entities that make up the organizational level. The distribution among functional and organizational levels should be dynamic, allowing for budget ceiling adjustments throughout the planning process; it should take into account changes in the environment and new information, but always with the

objective of improving results in countries. This approach is considered to be at the heart of the country focus strategy; over time, evaluation results should guide adjustments in the weighting of resources for these different approaches to specific technical work.

Allocation among Countries

31. The approach to the allocation of funds among countries is firmly rooted in the principles of equity and solidarity. The first is reflected in the use of needs-based criteria for resource allocation among countries; the latter is recognized in the provision of a basic level of funding for cooperation by and with all countries at the regional and subregional levels, as well as with each other.

32. Country-level funding will be divided into two parts: core and variable funding.

(a) ***Core Funds*** will comprise three components: the floor component, the needs-based component, and the results-based component. (*i*) The floor, or fixed allocation, will ensure a minimum level of country presence for all Member States where a physical presence has been accepted and established. (Calculations based on current costs require 42% of the total country budget; calculation of the "floor" based on future costs may result in a slightly different percentage.). (*ii*) A needs-based allocation will distribute funds among countries, following criteria based on economic and health needs. (The needs-based allocation will represent the difference between 90% and the percentage set aside for the floor component.). (*iii*) A results-based component will support countries in attaining programmatic targets collectively agreed upon by Member States (initially set at 5%). Countries that have an official PAHO/WHO Representative Office will start with a budget allocation to cover a base level of five staff, plus general operating costs. A few countries with only a Program Officer presence will receive a floor component commensurate with those costs. To those Member States that have the highest per capita income and no country presence, a nominal budget level will be assigned to ensure a minimum level of cooperation. The remaining core funding—based on both the needs-based component and the results-based component—will be distributed based on established parameters (specific details of the factors and the distribution calculation of these components are provided in Annex B). Core funds are initially set to 95% of the total country allocation: 90% is distributed between the floor and the needs-based components, with 5% for the results-based component. The core portion (95%) may be modified (jointly with the variable portion) in any given biennial program and budget planning exercise, with proper justification and approval by the Member States.

(b) ***Variable Funds*** will provide flexibility in the allocation process. These represent pooled resources that can be used to support any country, above and beyond its assigned allocation. Variable funds are currently the source of funding for

initiatives supporting Technical Cooperation among Countries (TCC). They will continue to be used as a targeted and strategic short-term boost in resources geared towards meeting priorities where funding is a constraint. The use of these funds will be tracked and monitored separately. Variable funds are initially set at 5% of the total country allocation but may be modified (jointly with the core portion) in any given biennial program and budget planning exercise, with proper justification and approval by the Member States.

Mobilization of Additional Resources

33. Additional mobilized resources typically come in the form of Voluntary Contributions negotiated with partners. This policy does not attempt to govern these resources, as they fall outside the absolute control of an internal budget policy. However, it does allow for other budget resources that do fall within the scope of the policy—particularly through the new results-based component, which can be directed strategically to complement VCs mobilized by the Organization. Furthermore, the Organization has a continuing responsibility to mobilize the necessary resources required to meet its objectives, achieve its outcomes, and deliver outputs related to national, subregional, and regional health goals.

34. The Organization's regular budgetary resources are insufficient to carry out its entire mandate; thus, the Organization must mobilize additional sources within the framework of one single, integrated program budget. In the case of National Voluntary Contributions (whereby Member States voluntarily provide resources for implementation in their own country), their continuity and growth is encouraged by the Organization as an added source of funding. Through National Voluntary Contributions, technical cooperation can be scaled up in countries above and beyond what can be achieved with the Organization's limited multilateral budget resources.

35. The Organization should also seek to mobilize resources—be they human, institutional, or financial. These additional resources should be aimed at supporting regional, subregional, and country technical cooperation activities—but always in accordance with regional policies and objectives and responsive to the mandates of the Organization's Governing Bodies.

36. Criteria for accepting funds from other sources include the following:

(a) their purpose must be in line with the Organization's technical policies and priorities, as well as its managerial strategies. In general, other sources should supplement the Regular Budget for scaling up efforts to achieve the stated national, subregional, or regional results, or to initiate complementary activities;

(b) the conditions attached to their use must be in accordance with the Organization's policies and rules;

(c) if resources are to be used within any Member State, the purpose must be in accordance with the national policies and priorities of that Member State; and

(d) consideration must be given, both by the Organization and the Member State, to the cost of administering those external resources—as well as to any long-term costs implied if the results are to be sustained.

37. The coordination of resource mobilization efforts within the Organization is critical if optimal use is to be made of the limited resources obtained from bilateral and multilateral partners.

Execution, Monitoring, and Evaluation of the Program and Budget

38. The approved regional Program and Budget should be implemented through the development and execution by all organizational entities of entity-specific biennial work plans. These work plans, like the biennial Program and Budget to which they contribute, should reflect the linkages to the high-level programmatic categories contained both in the Program and Budget and in the Strategic Plan.

39. At the country level, the development and execution of the work plans are the joint responsibility both of the countries and of the Bureau. Countries make a commitment to carry out agreed-upon national activities, which the Organization's resources and technical cooperation both complement and support. Through regular meetings, agreed-upon procedures, and other effective project management mechanisms, the Bureau and the national authorities collaborate to achieve the expected outcomes and outputs and, ultimately, to the country making its own national contribution to achieving regional health goals.

40. Flexibility should be built into the execution phase to allow for responses to sudden changes in national or regional conditions and to the appearance of previously unforeseen needs. Conditions that warrant reprogramming must be clearly defined, and a process for the review and approval of the modified work plan established.

41. In times of sudden and urgent need in one country, resources from other countries as well as from the level of the Bureau can be targeted to meeting that particularly urgent national need.

42. Resource management is a shared responsibility between Member States and the Bureau. However, the Bureau retains final responsibility for administering the funds included within the Organization's budget—and ultimately, for accounting for those

funds to the Governing Bodies, who represent the collective voice of the peoples of the Region.

43. Progress made in implementing the biennial Program and Budget, regardless of the source of funds, should be monitored at least every six months at the level of each organizational entity. Yearly analyses of progress made across the different organizational levels should alert the Director's Office to any difficulties being encountered in implementation, so as to facilitate the development—in a timely manner—of remedial technical or managerial interventions aimed at bringing about the expected outcomes and outputs.

44. Evaluations must be an integral aspect of the managerial cycle and, as in the other phases of the Program and Budget, should be undertaken jointly with the countries insofar as this is possible. It is often difficult to evaluate the impact of the Organization's work, given various factors:

(a) the nature and complexity of health problems;

(b) the fact that PAHO's technical cooperation mainly supports the country's efforts to achieve their national health objectives; and

(c) the fact that there are often several partners involved.

45. The Organization should use available approaches to determine the effectiveness and efficiency of its programs. Routine self-assessments need to be complemented by in-depth evaluations of the degree to which program objectives have been attained, while objectively determining the factors that contribute to bringing about the desired outcomes. It is crucial to ensure that future program budgets benefit from the lessons learned in the cooperation process and reflect the countries' needs and resources more accurately.

Opportunities for Implementing, Monitoring, and Evaluating the Budget Policy

46. Country Cooperation Strategies are being developed for all countries, and these will be updated whenever there are changes in the countries' situation or in the Organization's policies. The strategies developed will identify, among other things, the mix and level of technical resources required to contribute significantly to the country's efforts to address its health priorities.

47. The Organization-wide approach to reviewing agreements, programs, and projects funded by other sources ensures that the activities it supports adhere to its current policies and mandates, and that the Organization can manage the project both effectively and efficiently.

48. Annual reviews of biennial work plans facilitate:

(a) making mid-term adjustments to the program being implemented, and

(b) refining proposals to fit the Organization's priorities as well as the changing environment.

49. The increased use of analytical frameworks for these will improve both the rigor of the Organization's programming as well as the quality of its qualitative and quantitative reports.

50. The serial review of the Program and Budget by the Governing Bodies allows for focusing at different times on its technical aspects, policy orientation, and resource allocation. In this regard, the role of the Subcommittee on Program, Budget, and Administration is critical for ensuring sound proposals.

51. The proposed PAHO Budget Policy should be developed in alignment with the PAHO Strategic Plan, as the latter provides the programmatic and strategic direction for the Organization's work. In order to craft a new budget policy based on input from the evaluation of the former policy, and make it relevant for a particular planning period, the Organization recommends evaluating a budget policy after the completion of its initial two biennia (i.e., after four years). This will allow for the new policy to be developed in good time so that it can support the start of the first Program and Budget of the subsequent Strategic Plan.

52. Annex A illustrates the structure of the Program and Budget and the matrix relationship that exists between the Organization's functional levels and programmatic categories.

53. Annex B is dedicated exclusively to the Country Budget Allocation model, describing in detail its components and their rationale. It also includes three tables: one illustrating the conceptual model, and two showing the results of applying the model criteria.

Action by the Pan American Sanitary Conference

54. The Conference is requested to examine the proposed PAHO Budget Policy, to present any comments necessary for completing this important process, provide final approval of the Policy, and adopt the accompanying resolution in Annex C.

Annexes

Structure of the Program and Budget

Contribution of Functional Levels to Programmatic Categories			
Functional Level	**Programmatic Category* (example)**		
	Noncommunicable Diseases	**Communicable Diseases**	**Health Systems**
Country *	$ $ $ $	$ $ $ $	$ $ $
Inter-Country *	$ $	$ $	$ $
Subregional *	$ $	$ $	$ $
Regional	$ $ $	$ $ $	$ $ $ $

* Direct technical support to countries
$ Dollar signs represent the likely variance in investment among the different functional levels

Allocation of PAHO/WHO Budget Resources among Countries

1. The distribution of PAHO budget resources to and among country offices, while ensuring that all countries' needs are properly met in a fair and equitable manner, is indeed a challenge in a Region as diverse as the Americas—where an exceedingly broad spectrum exists in terms of both socioeconomic conditions and health needs, not to mention population size. The Country Budget Allocation (CBA) model within the proposed Budget Policy not only strives to preserve the same principles of equity and solidarity that were incorporated into the current policy, but has also added the ability to capture inequality within countries. The proposed Budget Policy also introduces two new normative elements designed to:

(a) emphasize the notion of the 'ability to engage' by setting standards for a minimum level of country presence; and

(b) strengthen and support the achievement of programmatic results collectively agreed upon by all Member States.

Adjustments to Model Concepts

2. The following paragraphs articulate the main adjustments made to the current CBA model.

Increased Objectivity

3. Objectivity is considered both a desirable and necessary aspect of the model and has been enhanced by the addition of two important elements:

(a) the needs-based formula, which is central to the model, has been expanded to incorporate a third variable—the Gini coefficient—designed to capture the inequality factor within countries; and

(b) a results-based component has been designed to support and accelerate the achievement of programmatic targets in countries collectively agreed upon by the Member States.

A Standard for Minimum Country Presence

4. The issue of sustaining a minimum presence in a country and the related subject of modalities of technical cooperation received considerable attention in the discussions going forward with the new Budget Policy. One of the weaknesses of the current model is its low minimum threshold, which resulted in the inability to fully provide for realistic

funding to all countries hosting a physical PAHO country presence. In the proposed model, funding for a minimum country presence—wherever a physical presence currently exists—is provided, both for minimum staffing and basic operational requirements, to ensure engagement between the Bureau and Member States at the country level. This measure proportionally increases the floor component (to approximately 42% of the total country budget at current costs) within the model and makes it comparable to the needs-based component (approximately 48% at current costs).

Concerns over Mathematical Rigidity Addressed

5. One of the concerns with the current model is that some of the mathematical methods used in the CBA model, such as the handling of population sizes and progressivity, are quite aggressive. As such, they have led to unrealistic and unsustainable budget levels in some countries. The statistical dimension of the CBA model has been adjusted with new mathematical techniques that soften the model's distributive power (specific details are provided later in this Annex).

The Country Budget Allocation Model

6. The CBA model takes on the complex task of balancing socio-economic conditions, health status, health inequalities, population size, country presence, and the achievement of results—thus containing a fair degree of complexity. It can best be explained by separating it into three dimensions:

(a) needs-based,

(b) statistical, and

(c) normative.

Needs-Based Dimension

7. A needs-based parameter is used to ensure the presence of objectivity when measuring relative need among countries. In considering a parameter, the overall health conditions in a country, together with its relative economic status —including the degree of distributive inequality present both within and across its population— would best capture any given country's relative health need. This is done by using the Health Needs Index *expanded* (HNI*e*), a surrogate marker of the degree of health needs currently present in a given country. This HNI*e* incorporates three broad dimensions of health and its determinants, through three well-known summary measures: life expectancy at birth (life expectancy, e_0); gross national income per capita, adjusted by purchasing power parity (income per capita, i$); and the Gini coefficient (Gini index). The Gini coefficient, a new element in the formula, captures the income distribution inequality factor, which is also known to serve as an adequate proxy for reflecting inequality in health within a

country. (It should be noted that Gini coefficient data is more readily available today than it was in 2004 when the current policy was approved.) Thus, the HNI*e* serves as a composite index designed to guide a more equitable allocation of PAHO funds.

8. For each country, an arithmetic mean of its two most recent estimates of life expectancy and income per capita—as presented in PAHO's Regional Core Health Data System—is computed, and its most recent estimate of the Gini coefficient is taken. For a given country *i*, the HNI*e* is then calculated according to the formula below where *actual* is the country's current value, *min* is the minimum value observed in the regional data series and *max* is the maximum value observed in the regional data series.

Health Needs Index *expanded*$_i$

$$= \frac{\frac{(leb_{i\,actual} - leb_{\min})}{(leb_{\max} - leb_{\min})} + \frac{(\log ipc_{i\,actual} - \log ipc_{\min})}{(\log ipc_{\max} - \log ipc_{\min})} + \left[1 - \left(\frac{(Gini_{i\,actual} - Gini_{\min})}{(Gini_{\max} - Gini_{\min})}\right)\right]}{3}$$

leb = life expectancy at birth
log*ipc* = logarithmic transformation of income per capita

9. As noted from the formula, each index's component—namely, life expectancy, income per capita, and Gini coefficient for a given country—is computed by applying a standard statistical transformation procedure, where upon a relative value is assigned. This can range from zero, for the most needy country, to 1 for the least needy country. It is noteworthy that, following a well-established recommendation,[3] a logarithmic transformation of the income distribution is computed instead of its actual value. The purpose here is to appropriately reflect the lower end of the income distribution, i.e., the poorer countries. The Health Needs Index *expanded* is thus comprised of the sum of the values of its three components, after they have been assigned the same weight (1/3, or one-third).

10. The distribution of the Health Needs Index *expanded* is used subsequently to define a quantile distribution —specifically quintiles— and to classify countries according to these quantiles of relative health needs. (See Table 2 for an illustrative example of the application of the HNI*e* using the latest official data.)

[3] Anand S, Sen A. The income component in the HDI-alternative formulations. Occasional Paper. United Nations Development Programme, Human Development Report Office, New York; 1999. Also: Sen A. Assessing human development. Special contribution, in: United Nations Development Programme. Human Development Report 1999: Globalization with a human face; Oxford University Press; New York, 1999.

Statistical Dimension

11. The statistical dimension in the CBA model includes three mathematical techniques commonly used in resource allocation *formulae* of this nature.

12. The **first** is *classification,* which groups countries with a similar degree of health needs as defined by the Health Needs Index *expanded* (HNI*e*). Although an index is considered an acceptable measure for determining the relative status of countries, the direct application of a single index alone is not considered the most appropriate means for the outright allocation of funds among countries. The underlying statistics have different degrees of confidence, and even the increments in the HNI are not consistently weighted across the scale. This model attempts to avoid over-interpreting the HNI by using the classification method based on quantiles—or in this case, quintiles, since there are five groups all using the standard statistical formula for this purpose. The countries that fall within a given quintile will all receive the same treatment with respect to the application of needs-based criteria. The method of classification used in the proposed model (i.e., quantiles) is the same as was used in the current model.

13. In order to preserve the principle of equity, the proposed model allocates resources progressively to quintiles, based on relative need. In other words, for any two countries with the same population, the country falling within a quintile reflecting greater need will be allocated a proportionately higher share of resources than the country falling within a quintile of lesser need.

14. To achieve this, a **second** technique called *progressivity* is used to assign the degree of change in the relative health-needs weighting among groups of countries. The proposed CBA model implements a method where progressivity is proportional to the distance among the groups' HNI*e*-weighted means (i.e., centroids). Compared to the current model, this method takes advantage of the natural distribution of health needs among the groups of countries, in order to soften the degree of change from one group of countries to the next group of greater need. It is important to note that the formula's progressivity element has a significant impact on the model's distributive power. A softer method of progressivity was chosen for the proposed model, given that the current model's progressivity method is considered to be too aggressive and—in some cases—has contributed to unsustainable country budget allocation levels.

15. The **third** technique is *population handling*, also known as *smoothing.* This is a mathematical technique used to temper the impact that a wide range of country population distribution has on statistical modeling. The model presented assumes that, all other factors being equal, a country with a larger population will require more resources than a country with a smaller population. However, the model also assumes that the multiplier effect that exists in the type of cooperation in which PAHO engages with

Member States is such that smaller countries will need more resources per capita than will larger countries. These assumptions are built into the model by adjusting the actual population statistics, using a statistical handling method. Population handling effectively reduces the range of the populations before using them to calculate resource levels. The method of population handling used in the proposed model is the *adjusted log population squared*, or ALPS. The population handling method used in a formula also has a significant distributive effect. The ALPS method has a softer distributive effect than does the method used in the current model (i.e., square root of the population). Thus, it is being proposed for the same reasons mentioned earlier with respect to the progressivity technique. It should be noted that the ALPS method is used in WHO's current resource allocation policy.

The Normative Dimension

16. The normative dimension in a model is the set of criteria that serves to implement the desired practical and logical parameters that fall outside the realm of mathematical *formulae*. For example, the proposed model includes normative criteria to establish minimum standards of country presence, as well as added results-based objectivity. In the proposed model, the concept of core and variable funding portions are maintained. However, the core portion—which contains the floor and needs-based components—has been expanded. It now includes a more robust floor component that incorporates standards for minimum country presence, which contain both a minimum staffing component and a minimum operating budget. This raises the minimum funding level significantly from the current policy's floor level. It is designed to address the 'engagement' factor between the Bureau and the Member State. Member States that have the highest per capita income and no physical country presence will receive a nominal budget allocation to ensure a minimum level of cooperation.

17. A new normative criterion being introduced is the results-based component, which provides the ability to redirect a predetermined level of resources (proposed at 5% of the total country-level share) during a given biennium. This is geared towards strengthening and supporting countries in achieving programmatic targets and results collectively agreed upon by Member States (e.g., the targets and results outlined in the Strategic Plan). This component sits alongside the floor and needs-based components within the country budget's core portion.

18. Finally, the variable portion that exists in the current policy is being kept in the proposal. The variable portion offers a degree of flexibility that allows the Organization to make use of a small percentage of funding in a strategic and catalytic manner when dealing with unexpected circumstances that arise during the biennium—particularly for countries in the greatest need. This will be funding targeted at providing a short-term boost in country resources to accelerate progress being made towards the achievement of

collective global and regional mandates as well as priority-setting. It is worth noting that, given that the floor component in the proposed policy has been enhanced to ensure a minimum standard of country presence, the variable portion in the proposed policy will be available for more strategic uses in the countries, rather than for compensating countries where budget reductions due to the current policy have gone beyond their ability to sustain minimum operations.

19. Table 1 illustrates the Country Budget Allocation conceptual model. The following paragraphs provide an explanation of the various elements of the model.

Results of the Modeling

20. The two elements of the model that substantially affect the degree of redistribution of resources among the countries of the Region are the statistical methods used (i.e., population handling and progressivity) and the standard for minimum country presence. The criteria for selecting these methods in the proposed model is to meet two principal objectives:

(a) that equity is present in providing and assigning a greater weight percentage to countries in the greatest need, and

(b) that solidarity is observed in ensuring standards for minimum country presence for all countries where a physical PAHO presence is needed.

21. The progressivity method used—centroids—has a more gentle distribution effect from one quintile of greater need to the next, as compared to the current model. The aggressiveness of the weighting scale in the current model is one of the main factors contributing to the severe and unsustainable budget reductions suffered by several countries over the past six years. The centroids method offers a progressivity that is proportional to the distance among the groups' HNI*e*-weighted means. This progressivity scale generates a more balanced redistribution of resources, while still exerting a positive impact on the neediest groups of countries.

22. The proposed model uses the adjusted log population squared (ALPS) method for statistically handling the countries' population sizes. This method of smoothing has a higher compression factor, thus reducing the range of the populations more than does the method that the current model uses (i.e., square root of the population). This method tends to benefit smaller and medium-sized countries, since the size of the population has less influence on the distributive power of the model.

23. The core portion of the allocation is shown in proportional terms. Column J of Table 3 shows the floor component of the core portion, which represents the country

presence factor. Column K represents the needs-based component as calculated using the logic contained in the model. Column L illustrates a tentative distribution of the results-based component. The total of these three components of the core portion is presented at 95% of the total country budget allocation. The remainder of 5% will be assigned as the variable portion (Column N), based on the criteria mentioned earlier for this component.

24. In this model and to compute the Health Needs Index, the statistical data used (life expectancy at birth, purchasing power parity [PPP], income per capita, Gini coefficient, and population) comes from the official PAHO Core Health Data System. The most recent data available from PAHO's Core Health Data System will be used in every reiteration of the budget cycle whenever formulating the allocation of country resources.

25. The proposed model serves to indicate the proportional share of resources that will be allocated among countries. The actual amount of budgetary resources allocated to any given country will be guided by these percentages. However, it will depend on the budget levels approved by the Directing Council or Pan American Sanitary Conference in future years.

26. The following three tables illustrate the proposed modifications to the Country Budget Allocation model:

(a) Table 1 is a diagram of the conceptual model;

(b) Table 2 contains the calculation of the Health Needs Index *expanded,* with all of its elements; and

(c) Table 3 illustrates the detailed model and the relative percentages of its components.

Table 1: The Country Budget Allocation Conceptual Model

Country		Quantile	Core Funding			Variable Funding
			Floor	*Needs-Based*	*Results-Based**	
Country A	(+) Needs-Based Parameter (-)	Group1 (least needy)	$	$	%	
Country B			$		%	
Country C			$		%	
Country J		Group 2	$	$$	%	
Country K			$		%	
Country L			$		%	
Country X		Group3 (most needy)	$	$$$	%	
Country Y			$		%	
Country Z			$		%	
			90%		**5%**	**5%**

* The percentage per country may vary from one budget period to another, depending on the specific programmatic targets that require support during a given biennium.

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Table 2

Health Needs-based Index - Expanded (proposed model with expanded HNI formula)

Country[1]	Code	Population 2012	Life expectancy (e_0)		Income per capita (i$)		Gini index	Arithmetic averages		log income	Standardized values			HNI expanded	HNI groups	
			2010	2011	2009	2010	lay*	e_0	income		e_0	income	Gini		2012	2004
United Kingdom territories	UKT	207,854	80.1	80.0	35,640	36,410	28.9	80.0	36,025	4.557	1.043	0.932	0.941	0.972	0	0
French territories	FRT	1,116,756	79.3	79.4	33,870	34,440	28.9	79.3	34,155	4.533	1.000	0.917	0.941	0.953	0	0
Canada	CAN	34,674,708	80.9	81.1	37,260	38,310	36.5	81.0	37,785	4.577	1.098	0.944	0.704	0.915	0	0
Netherlands territories	NET	313,125	76.1	76.2	39,720	41,900	28.9	76.1	40,810	4.611	0.816	0.965	0.941	0.907	0	0
United States	USA	315,899,874	78.5	78.6	45,400	47,360	46.4	78.5	46,380	4.666	0.955	1.000	0.397	0.784	0	0
Puerto Rico	PUR	3,743,380	79.1	79.2	13,019	13,019	52.9	79.1	13,019	4.115	0.990	0.656	0.197	0.614	0	0
Barbados	BAR	274,530	76.8	76.9	17,960	19,000	28.9	76.9	18,480	4.267	0.858	0.751	0.941	0.850	1	1
Antigua and Barbuda	ANI	90,510	75.0	75.0	21,080	20,240	28.9	75.0	20,660	4.315	0.751	0.781	0.941	0.824	1	2
Cuba	CUB	11,249,266	79.0	79.2	6,117	6,330	27.0	79.1	6,224	3.794	0.987	0.455	1.000	0.814	1	4
Dominica	DOM	67,665	76.0	76.0	11,820	11,990	28.9	76.0	11,905	4.076	0.809	0.631	0.941	0.794	1	3
St. Kitts and Nevis	SCN	53,697	74.0	75.0	16,740	15,850	28.9	74.5	16,295	4.212	0.722	0.716	0.941	0.793	1	1
Grenada	GRE	105,303	75.9	76.0	9,640	9,890	28.9	75.9	9,765	3.990	0.805	0.578	0.941	0.774	1	4
St. Lucia	SAL	177,794	74.5	74.7	10,080	10,520	28.9	74.6	10,300	4.013	0.727	0.592	0.941	0.753	1	3
St. Vincent and Grenadines	SAV	109,367	72.2	72.4	10,850	10,830	28.9	72.3	10,840	4.035	0.592	0.606	0.941	0.713	2	3
Bahamas	BAH	351,275	75.5	75.7	26,120	24,800	43.0	75.6	25,460	4.406	0.783	0.837	0.503	0.708	2	1
Uruguay	URU	3,391,428	76.9	77.1	12,920	13,990	45.3	77.0	13,455	4.129	0.866	0.664	0.431	0.654	2	1
Trinidad and Tobago	TRT	1,350,999	70.0	70.2	24,300	24,040	40.2	70.1	24,170	4.383	0.468	0.823	0.590	0.627	2	2
Costa Rica	COR	4,793,725	79.2	79.4	10,830	11,270	50.7	79.3	11,050	4.043	1.000	0.611	0.263	0.625	2	1
Argentina	ARG	41,118,986	75.8	76.0	14,230	15,570	48.3	75.9	14,900	4.173	0.802	0.692	0.339	0.611	2	1
Chile	CHI	17,423,214	79.1	79.2	13,270	14,590	54.6	79.1	13,930	4.144	0.989	0.674	0.144	0.602	3	1
Mexico	MEX	116,146,768	76.8	77.0	13,570	14,290	51.1	76.9	13,930	4.144	0.862	0.674	0.252	0.596	3	2
Venezuela	VEN	29,890,694	74.3	74.5	12,410	12,150	47.6	74.4	12,280	4.089	0.716	0.640	0.360	0.572	3	2
Panama	PAN	3,624,991	76.0	76.2	12,210	12,770	54.8	76.1	12,490	4.097	0.816	0.644	0.136	0.532	3	2
Peru	PER	29,733,829	73.8	74.1	8,270	8,930	48.1	73.9	8,600	3.934	0.689	0.543	0.344	0.525	3	4
Jamaica	JAM	2,761,331	73.0	73.2	7,280	7,310	45.5	73.1	7,295	3.863	0.639	0.499	0.425	0.521	3	3
Ecuador	ECU	14,864,987	75.6	75.7	7,590	7,880	53.4	75.6	7,735	3.888	0.787	0.514	0.179	0.494	3	5
Belize	BLZ	324,292	75.9	76.1	6,080	6,210	53.1	76.0	6,145	3.789	0.811	0.452	0.189	0.484	4	3
Dominican Republic	DOR	10,183,339	73.3	73.5	8,390	9,030	51.9	73.4	8,710	3.940	0.658	0.547	0.228	0.477	4	4
Brazil	BRA	198,360,943	73.3	73.7	10,230	11,000	54.7	73.5	10,615	4.026	0.662	0.600	0.140	0.468	4	3
El Salvador	ELS	6,264,129	72.1	72.3	6,380	6,550	48.4	72.2	6,465	3.811	0.588	0.466	0.336	0.463	4	4
Colombia	COL	47,550,708	73.6	73.8	8,760	9,060	56.2	73.7	8,910	3.950	0.674	0.553	0.092	0.440	4	2
Guyana	GUY	757,623	69.7	70.0	3,270	3,450	44.2	69.8	3,360	3.526	0.450	0.288	0.466	0.402	4	5
Suriname	SUR	534,175	70.4	70.7	7,420	7,680	52.9	70.5	7,550	3.878	0.491	0.508	0.197	0.399	5	4
Paraguay	PAR	6,682,943	72.4	72.6	4,460	5,050	53.9	72.5	4,755	3.677	0.604	0.382	0.165	0.384	5	4
Nicaragua	NIC	5,954,898	73.8	74.1	2,610	2,790	52.3	74.0	2,700	3.431	0.691	0.229	0.215	0.378	5	5
Honduras	HON	7,912,032	73.0	73.3	3,720	3,770	57.0	73.1	3,745	3.573	0.642	0.318	0.070	0.343	5	5
Guatemala	GUT	15,137,569	71.0	71.3	4,600	4,650	55.9	71.2	4,625	3.665	0.528	0.375	0.103	0.335	5	5
Bolivia	BOL	10,248,042	66.5	66.8	4,510	4,640	56.3	66.6	4,575	3.660	0.265	0.372	0.091	0.243	5	5
Haiti	HAI	10,255,644	61.9	62.2	1,140	1,180	59.2	62.0	1,160	3.064	0.000	0.000	0.000	0.000	5	5

[1] Netherlands territories include Aruba, Netherlands Antilles; French territories include French Guiana, Guadeloupe, Martinique; United Kingdom territories include Anguilla, British Virgin Islands, Montserrat, Bermuda, Cayman Islands, Turks and Caicos Islands

$e0$ = life expectancy at birth; income = power-purchasing parity-adjusted gross national income per capita (international dollars, i$); * lay = latest available year

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Proposed Country Budget Allocation Model (HNI*e* with Floor, Needs-based, and Results-based Components)

Table 3

			a	b	c	d	e	f	g	h	i	j	k	l	m	n	o
Country	Code	Health needs index	Needs-based grouping	Needs-based weighting		Population 2012		Adjusted log population squared		Share of needs-based allocation		Core allocation (proportional share)				Variable allocation	Total Allocation
				Factor	%	(1,000)	%	(1,000)	%	(b x f)	%	Floor Comp.	Needs-Based Comp.	Results-Based Comp.	Total (j+k+l)		
United Kingdom territories	UKT	0.972	0									0.37		0.02	0.39		
French territories	FRT	0.953	0									0.27		0.01	0.28		
Canada	CAN	0.915	0									0.40		0.02	0.42		
Netherlands territories	NET	0.907	0									0.27		0.01	0.28		
United States	USA	0.784	0									0.27		0.01	0.28		
Puerto Rico	PUR	0.614	0									0.13		0.01	0.14		
Barbados	BAR	0.850	1	1.00	2.3	275	0.0	31.6	1.0	31.6	0.8	0.00	0.36	0.02	0.38		
Antigua and Barbuda	ANI	0.824	1	1.00	2.3	91	0.0	20.3	0.7	20.3	0.5	0.10	0.23	0.02	0.35		
Cuba	CUB	0.814	1	1.00	2.3	11,249	1.9	96.8	3.2	96.8	2.3	1.40	1.12	0.14	2.66		
Dominica	DOM	0.794	1	1.00	2.3	68	0.0	17.8	0.6	17.8	0.4	0.10	0.20	0.02	0.32		
St. Kitts and Nevis	SCN	0.793	1	1.00	2.3	54	0.0	15.9	0.5	15.9	0.4	0.10	0.18	0.02	0.30		
Grenada	GRE	0.774	1	1.00	2.3	105	0.0	21.7	0.7	21.7	0.5	0.09	0.25	0.02	0.36		
St. Lucia	SAL	0.753	1	1.00	2.3	178	0.0	26.9	0.9	26.9	0.6	0.10	0.31	0.02	0.43		
St. Vincent and Grenadines	SAV	0.713	2	1.24	2.8	109	0.0	22.1	0.7	27.4	0.7	0.10	0.32	0.02	0.44		
Bahamas	BAH	0.708	2	1.24	2.8	351	0.1	34.5	1.1	42.8	1.0	1.53	0.49	0.11	2.13		
Uruguay	URU	0.654	2	1.24	2.8	3,391	0.6	68.3	2.3	84.8	2.0	1.43	0.98	0.13	2.54		
Trinidad and Tobago	TRT	0.627	2	1.24	2.8	1,351	0.2	52.6	1.7	65.4	1.6	1.38	0.75	0.12	2.25		
Costa Rica	COR	0.625	2	1.24	2.8	4,794	0.8	75.3	2.5	93.5	2.2	1.34	1.08	0.13	2.56		
Argentina	ARG	0.611	2	1.24	2.8	41,119	6.9	159.6	5.3	198.3	4.8	1.47	2.28	0.21	3.96		
Chile	CHI	0.602	3	1.29	3.0	17,423	2.9	112.1	3.7	145.1	3.5	1.59	1.67	0.18	3.44		
Mexico	MEX	0.596	3	1.29	3.0	116,147	19.4	295.3	9.8	382.2	9.2	1.70	4.40	0.34	6.44		
Venezuela	VEN	0.572	3	1.29	3.0	29,891	5.0	138.2	4.6	178.8	4.3	1.92	2.06	0.22	4.20		
Panama	PAN	0.532	3	1.29	3.0	3,625	0.6	69.6	2.3	90.1	2.2	1.44	1.04	0.14	2.62		
Peru	PER	0.525	3	1.29	3.0	29,734	5.0	137.8	4.6	178.4	4.3	1.87	2.06	0.22	4.14		
Jamaica	JAM	0.521	3	1.29	3.0	2,761	0.5	64.5	2.1	83.5	2.0	1.38	0.96	0.13	2.47		
Ecuador	ECU	0.494	3	1.29	3.0	14,865	2.5	106.1	3.5	137.3	3.3	1.43	1.58	0.17	3.18		
Belize	BLZ	0.484	4	1.43	3.3	324	0.1	33.5	1.1	48.0	1.2	1.26	0.55	0.10	1.92		
Dominican Republic	DOR	0.477	4	1.43	3.3	10,183	1.7	93.9	3.1	134.4	3.2	1.45	1.55	0.17	3.17		
Brazil	BRA	0.468	4	1.43	3.3	198,361	33.2	446.4	14.8	638.9	15.4	2.14	7.36	0.53	10.03		
El Salvador	ELS	0.463	4	1.43	3.3	6,264	1.0	81.2	2.7	116.3	2.8	1.42	1.34	0.15	2.92		
Colombia	COL	0.440	4	1.43	3.3	47,551	8.0	171.5	5.7	245.5	5.9	1.83	2.83	0.26	4.92		
Guyana	GUY	0.402	4	1.43	3.3	758	0.1	44.3	1.5	63.4	1.5	1.28	0.73	0.11	2.12		
Suriname	SUR	0.399	5	1.67	3.8	534	0.1	39.6	1.3	66.1	1.6	1.30	0.76	0.11	2.18		
Paraguay	PAR	0.384	5	1.67	3.8	6,683	1.1	82.8	2.7	138.1	3.3	1.49	1.59	0.17	3.25		
Nicaragua	NIC	0.378	5	1.67	3.8	5,955	1.0	80.0	2.6	133.5	3.2	1.35	1.54	0.16	3.05		
Honduras	HON	0.343	5	1.67	3.8	7,912	1.3	87.0	2.9	145.1	3.5	1.52	1.67	0.18	3.37		
Guatemala	GUT	0.335	5	1.67	3.8	15,138	2.5	106.7	3.5	178.1	4.3	1.62	2.05	0.20	3.88		
Bolivia	BOL	0.243	5	1.67	3.8	10,248	1.7	94.1	3.1	156.9	3.8	1.50	1.81	0.18	3.49		
Haiti	HAI	0.000	5	1.67	3.8	10,256	1.7	94.1	3.1	156.9	3.8	1.74	1.81	0.20	3.75		
TOTAL				43.78	100.0	597,747	100.0	3,022	100.0	4,159.5	100.0	42.09	47.91	5.00	95.00	5.00	100.00

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

28th PAN AMERICAN SANITARY CONFERENCE
64th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 17-21 September 2012

CSP28/7 (Eng.)
Annex C
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

PAHO BUDGET POLICY

THE 28th PAN AMERICAN SANITARY CONFERENCE,

Having reviewed the proposed *PAHO Budget Policy* (Document CSP28/7), which presents a revised Regional Budget Policy that defines a new way of allocating resources within the Pan American Health Organization;

Noting the recommendations contained in the evaluation of the existing policy made by the PAHO Office of Internal Oversight and Evaluation Services;

Recognizing that, although countries in the greatest need have received an influx of resources during the period of the existing policy, other countries have suffered budget reductions to levels that are unable to sustain a minimum country presence—yet notwithstanding, in the spirit of solidarity, have agreed to a distribution of resources that is workable within realistic and practical settings;

Mindful of the need to be aligned with the reform process now underway in the World Health Organization, and its possible implications for the Pan American Health Organization;

Considering the comments made by the Executive Committee,

RESOLVES:

1. To thank the Consultative Group on the PAHO Budget Policy and the Pan American Sanitary Bureau (PASB) for their efforts to recommend modifications and introduce new criteria for the allocation of Regular Budget funds and Voluntary Contributions, both across PAHO's functional levels and among its country offices.

2. To take note of the proposed country budget allocation model for allocating resources among countries.

3. To approve the new PAHO Budget Policy with the following emphasis:

(a) the Regular Budget allocation among the four functional levels of the Organization (i.e., Country, Inter-country, Subregional, and Regional) will be such that, with the aim of strengthening cooperation in countries, PASB will continuously strive to maintain optimal functional and organizational structures through internal and external assessments aimed at delivering the greatest level of impact in the countries, while still effectively responding to collective regional and subregional mandates;

(b) the minimum Regular Budget share for the country level is initially set at 40% of the total Regular Budget, which is equal to the current share. The distribution among functional and organizational levels remains dynamic, allowing for budget ceiling adjustments throughout the planning process if necessary, always with the objective of improving results in countries;

(c) in the reallocation of Regular Budget resources among countries, no country's core allocation shall be reduced by more than 50% of its proportional allocation among countries as approved in the Program and Budget 2012-2013. Furthermore, in no instance may the resulting Regular Budget allocation be less than the computed floor component (designed to provide a minimum country presence, as defined in the Policy) of the core portion;

(d) with regard to key countries (as originally identified in the Strategic Plan 2003-2007 for the Pan American Sanitary Bureau: Bolivia, Guyana, Haiti, Honduras, and Nicaragua), PASB will make every possible effort to mobilize additional resources for any of the key countries so that the net allocation of total resources will not be less than the total amount of resources for the 2012-2013 biennium;

(e) the objectives for the use of the variable allocation among countries will be, as mentioned in Document CSP28/7, any future refinement for the use of variable funds will be presented to the Subcommittee on Program, Budget, and

Administration at the time of presentation of a proposed biennial program and budget.

4. To ensure that the country allocations in future PAHO programs and budgets are guided by the model approved in operative paragraph 3 above, to be phased in over two biennia in consultation with the Member States, so as to ensure the smoothest possible transition for technical cooperation programs.

5. To promote a prioritization in the allocation of resources among programmatic categories that is consistent with the collective and individual mandates of Member States, as expressed in PAHO's strategic planning documents.

6. To request the Director to:

(a) apply the new PAHO Budget Policy when formulating future proposed programs and budgets for the consideration of the Directing Council or the Pan American Sanitary Conference;

(b) present to the Directing Council or to the Pan American Sanitary Conference a thorough evaluation of the PAHO Budget Policy following two biennia of its implementation, to ensure that it continues to respond to changing health needs and that it consistently allocates resources in an equitable manner;

(c) collaborate with Member States to promote more effective modes of cooperation, as well as to:

(i) strengthen the capacity of those countries that will be receiving more Regular Budget resources, to ensure their effective and efficient use;

(ii) provide support to those countries that will be receiving less Regular Budget resources through targeted resource mobilization efforts aimed at both internal and external sources.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CSP28/7 (Eng.)
Annex D

Report on the Financial and Administrative Implications for the Secretariat of the Proposed Resolution

1. Agenda item: Item 4.2 PAHO Budget Policy

2. Linkage to Program and Budget

(a) Area of work: Planning, Budget, and Resource Coordination (PBR)

(b) Expected result: 16. 1 and 16.2

3. Financial implications

(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$10,000, including staff and activities)

The financial implication is the approved budget itself.

(b) Estimated cost for the biennium 2012-2013 (estimated to the nearest US$ 10,000, including staff and activities)

US$ 160,000

(c) Of the estimated cost noted in *(b),* what can be subsumed under existing programmed activities?

All

4. Administrative implications

(a) Indicate the functional levels at which the work will be undertaken

Working group consisting of six representatives from PAHO Member States, plus a team of five Regional-Level PAHO staff

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

None

(c) Time frames (indicate broad time frames for the implementation and evaluation):

To be implemented over two biennia (four years); evaluation to be conducted after the four years

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.2 PAHO Budget Policy
2. **Responsible unit:** Planning, Budget and Resource Coordination (PBR)
3. **Preparing officer:** Roman Sotela
4. **List of collaborating centers and national institutions linked to this agenda item**

   All Ministries of Health

5. **Link between Agenda item and Health Agenda for the Americas 2008-2017**

   The Budget Policy is the instrument that distributes PAHO's internal resources that fund the technical cooperation guided by the Health Agenda

6. **Link between Agenda item and Strategic Plan 2008-2012:**

   The Budget Policy specifically adheres to the programmatic guidance provided in the Strategic Plan; in this case, the proposed Budget Policy will be based on input from the next Strategic Plan 2014-2019

7. **Best practices in this area and examples from countries within the Region of the Americas**

   N/A

8. **Financial implications of this agenda item**

   There are no added financial requirements

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