Programme Budget matters:

Programme Budget Performance Assessment: 2012–2013

The Organization-wide report on the 2012–2013 Programme Budget Performance Assessment (PBPA) was submitted to the Sixty-seventh World Health Assembly in May 2014 (SEA/SPPDM-Meet.7/2.1 Inf. Doc. 1 – Document A67/42) after it was initially reviewed at the Twentieth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board. The PBAC, in its report to the World Health Assembly (SEA/SPPDM-Meet.7/2.1 Inf. Doc. 2 – Document A67/55) welcomed the 2012–2013 PBPA report contained in document A67/42 and highlighted the improvement in the level of fully achieved Organization-wide expected results (OWERs), which had increased from 54% during the 2010–2011 biennium to 63% during the 2012–2013 biennium. The Committee also noted the improvement in the level and alignment of financing of the Strategic Objectives (SO) in the major offices. However, it observed that full financial alignment has not yet been achieved.

The attached document provides a summary of the findings of the 2012–2013 PBPA exercise as conducted in the WHO South-East Asia Region. The summary document includes an overview of key achievements recorded during the biennium, WHO’s contributions to these achievements, and an assessment of the degree of achievement of expected results in the WHO South-East Asia Region.

The Seventh Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM), held in New Delhi, India, on 18 July 2014 reviewed the document and made the following recommendation:

Action by the WHO Regional Office

(1) To revise the working paper to include: information on the factors that facilitated mobilization of more resources than the Programme Budget in some other regions but not in the South-East Asia Region; further information on Office-specific expected results (OSERs) that were “partly achieved or not achieved”, and the reasons thereof; OWERs that were linked with 50% of the total implementation as of May 2013; and Budget Centre-wise and SO-wise financial implementation details; and submit to the Sixty-seventh Session of the Regional Committee for discussion.

The revised background document and recommendation of the SPPDM are submitted to the Sixty-seventh Session of the Regional Committee for its consideration.
Background

1. The Programme Budget 2012–2013: Performance Assessment, a self-assessment exercise, is the final assessment carried out within the framework of the Medium-term Strategic Plan 2008–2013. Achievement of the Organization-wide expected results (OWERs) was assessed on the basis of the achievement of indicators.

2. The lessons learnt and actions to be taken were documented at each level. Peer review and quality assurance elements were built into the process to ensure that progress was assessed in an objective and consistent manner.

3. Of a total of 80 OWERs for the biennium 2012–2013, 50 (63%) were globally assessed as “fully achieved” and 30 (37%) as “partly achieved”, representing an improvement in performance over 2010–2011 when 46% of the OWERs were rated as “partly achieved”.

4. Twelve out of 30 OWERs were rated as “partly achieved” because of either a more rigorous indicator measurement criteria leading to a reduction in the number of Member States reported to have achieved the target, or countries lacking the capacity to provide timely reports on the indicator. Of the 30 OWERs, 14 were rated as “partly achieved” because either one or more target Member States did not achieve the results expected, or because Member States that had previously achieved the target failed to continue to meet the achievement criteria.

5. The details as per each Strategic Objective are available in the “Programme Budget 2012–2013: Performance Assessment Summary Report” (Provisional Agenda item 20.1 of the, Sixty-Seventh World Health Assembly, document A67/42).

6. At the end of the 2012–2013 biennium, the financing available for all segments of the Budget, including both Assessed Contributions (AC) and Voluntary Contributions (VC), was US$ 4210 million. Out of the available funding, US$ 1170 million (28%) was made up of AC and other flexible funding, whereas US$ 3040 million (72%) was earmarked funding.

7. Financing was not evenly distributed across all budget segments, affecting levels of implementation by major office, Strategic Objective and budget segment. This also highlighted the problems created by the high level of earmarked funding and inadequacy of flexible funding.

8. The total implementation (including expenditure and encumbrances) was US$ 3914 million, or 99% of the approved budget, confirming the realistic nature of the Programme Budget 2012–2013.

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1 The use of the indicator values as the primary method of assessing achievement of expected results at the end of the biennium is in accordance with the recommendations of the External Auditor. It also reflects the Organization-wide efforts to strengthen the culture of evaluation, as well as the specific capacity to assess results through the definition of, and reporting under, robust indicators.

9. Implementation was 90% of the approved Programme Budget for base programmes, 140% for special programmes and collaborative arrangements, and 73% for outbreak and crisis response.

10. The table below provides the details of the financial implementation by major offices:

11. Financial implementation by major office for all segments (figures in US$ million as on 31 December 2013)

<table>
<thead>
<tr>
<th>Location</th>
<th>Approved budget 2013–2013</th>
<th>Assessed Contributions</th>
<th>Voluntary contributions</th>
<th>Total</th>
<th>Funds available as % of approved budget</th>
<th>Implementation as % of approved budget</th>
<th>Implementation as % of funds available</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Region</td>
<td>1093</td>
<td>204</td>
<td>1025</td>
<td>1229</td>
<td>112</td>
<td>1149</td>
<td>105</td>
</tr>
<tr>
<td>Region of the Americas</td>
<td>173</td>
<td>80</td>
<td>53</td>
<td>133</td>
<td>77</td>
<td>129</td>
<td>75</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>384</td>
<td>99</td>
<td>242</td>
<td>341</td>
<td>89</td>
<td>317</td>
<td>82</td>
</tr>
<tr>
<td>European Region</td>
<td>213</td>
<td>60</td>
<td>153</td>
<td>213</td>
<td>100</td>
<td>204</td>
<td>95</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>554</td>
<td>88</td>
<td>631</td>
<td>719</td>
<td>130</td>
<td>650</td>
<td>117</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>246</td>
<td>76</td>
<td>191</td>
<td>267</td>
<td>109</td>
<td>251</td>
<td>102</td>
</tr>
<tr>
<td>Headquarters</td>
<td>1296</td>
<td>309</td>
<td>999</td>
<td>1308</td>
<td>101</td>
<td>1214</td>
<td>94</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3959</strong></td>
<td><strong>916</strong></td>
<td><strong>3294</strong></td>
<td><strong>4210</strong></td>
<td><strong>106</strong></td>
<td><strong>3914</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

Source: WHA67 background document A67/42

12. The table shows that some regions especially the African and Eastern Mediterranean Regions during the whole biennium were able to implement budgets that exceeded the initially approved budgets for the 2012-2013 biennium. Classified by office, the funds available against the approved budget ranged between 77% for the Regional Office for the Americas and 130% for the Regional Office for the Eastern Mediterranean. There are a number of reasons for the enhanced mobilization of resources. The higher availability of funds is partly attributable to the high proportion of funds for the special programmes and collaborative arrangements segment, including polio eradication and partly due to enhanced funding to address health issues in conflict emergency situations.
Programme assessment review of the South-East Asia Region

13. For the WHO South-East Asia Region, the approved budget for the biennium 2012–2013 as on 1 January 2012 was of the order of US$ 384 million. The budget at the end of the biennium 2012–2013 was US$ 430 million. This includes US$ 99 million as Assessed Contributions.

14. The implementation against Strategic Objectives varied from 91% to 98% against the funds available, whereas the implementation by Budget Centre varied from 88% to 99%. The details are provided under Annex 1.

15. The analysis highlights several issues:

- confirmation of the overall, more realistic budget for 2012–2013, which closely matched both funding available and expenditure projections;
- acceleration in the overall implementation of activities during the second year of the biennium; and
- slight under-implementation against the Programme Budget 2012–2013 available funding, which can be explained by:
  - continuation of the cost-saving measures introduced in 2010–2011 into the current biennium that resulted in a further reduction in salary expenditures;
  - further savings generated by other efficiency measures, especially in WHO headquarters; and
  - conservative spending by managers in the current financial climate.

Key regional achievements

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

- By the end of 2013, the South-East Asia Region had remained polio-free for nearly three years, and was thus on track to be certified polio-free by the end of March 2014. Technical support was provided to Member States to assist them in the intensification of routine immunization and also in increasing the number of countries with a DTP3 coverage of 90% by the end of 2013 from seven to nine.
- The Region has established a goal to eliminate measles and control rubella and congenital rubella syndrome by 2020.
- Elimination of lymphatic filariasis (LF) as a public health problem is on track in the Region. Two Member States maintained elimination status and three are in the process of certification of LF elimination.
Substantial progress has been made in the implementation of the Jaipur Declaration on Antimicrobial Resistance and the same was reported to the Health Ministers of the Region at their Thirtieth Meeting at Yogyakarta, Indonesia (September 2012), and Thirty-first Meeting in New Delhi, India (September 2013).

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

- The HIV/AIDS epidemic in four of five Member States in the Region has been halted and reversed. The epidemic continues only in Indonesia.

- The number of new infections of HIV/AIDS has been reduced to less than 230,000 per year. This is a reduction of almost 34% over the last decade. There has been an exponential increase in the number of people living with HIV who are receiving antiretroviral treatment (ART) in the Region to almost 1 million, which is 55% of all those who are in need of it.

- The figures for tuberculosis case detection and treatment, as well as the reduction in TB mortality in the Region, is in consonance with the Millennium Development Goals (MDGs) targets. Enhanced support for prevention and containment of drug resistance in TB through technical and programmatic support has been provided to Member States.

- Elimination of malaria has been targeted in five countries of the Region and Maldives has remained malaria-free.

- A sustained reduction in the number of malaria cases and associated deaths has been achieved.

- The artemisinin resistance programme in the Greater Mekong Subregion, which encompasses Thailand, has been strengthened.

- WHO has continuously supported all Member States in mobilization of resources from development partners, especially the Global Fund, as well as in their implementation.

- Cumulative funding has been approved for the Region from the Global Fund for diseases covered within Strategic Objective 2. This is approximately US$ 4 billion, of which about US$ 3 billion has been disbursed.

Strategic Objective 3: To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries

- High-level advocacy has been carried out for the prevention and control of noncommunicable diseases (NCDs) through various forums, including the Health Ministers’ Meeting and the Regional Committee sessions.
• The regional action plan for NCDs and regional targets were developed through a consultative process with Member States as well as technical experts. It was endorsed at the Sixty-sixth session of the Regional Committee. Continued progress is being made towards strengthening NCD surveillance and monitoring systems.

• At least one national or subnational survey (WHO STEPS, or equivalent) has been completed in 10 of the 11 Member States of the Region to assess prevalence of behavioural and metabolic risk factors. Global Adult Tobacco Surveys (GATS) have been conducted in four countries and Global Youth Tobacco Surveys (GYTS) in 10. One round of school-based multirisk-factor surveys have been conducted in seven countries. Thus, data on NCD risk factors are increasingly available in the Region.

• Two countries have national child motorcycle helmet standards in place and are now manufacturing and exporting standardized child motorcycle helmets. Drowning prevention programmes are progressing in two Member States and a few more are initiating the process.

• In the areas of mental health and substance abuse, the Regional Office has been working closely with experts in Member States to address the most common and disabling mental and neurological disorders. Successful pilot projects have been implemented in Bangladesh, Bhutan, Myanmar and Timor-Leste. Impact evaluation of these programmes has also been conducted, which revealed that the treatment gap for mental and neurological disorders can be substantially reduced by adopting this strategy.

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

• Good progress has been made in the new area of prevention of birth defects through advocacy and capacity development in surveillance for birth defects.

• Pre-conception care and healthy transitions for adolescents has been introduced in the Region. Data and information on adolescent health and adolescent pregnancy in the Region has been collated in the form of factsheets for 11 Member States.

• Preventing unsafe abortion to reduce maternal mortality was advocated and updated guidelines were shared with countries and partners. This was followed up with country workshops to refine the plans and address specific issues.

• Roadmaps have also been developed to follow up on the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health, and are being implemented and followed up in five countries.
• Closer partnerships with collaborating centres in the area of maternal and reproductive health was also facilitated with the establishment of a network. A regional meeting to review cervical cancer in Member States of the Region, including the readiness levels of countries to introduce the human papilloma virus (HPV) vaccine, was organized. The Regional Strategic Framework for Comprehensive Cervical Cancer Control (CCCC) was developed as a consequence.

• A regional consultation on the post-2015 development agenda reiterated the importance of focusing on the unfinished agenda of the Millennium Development Goals and highlighted the crucial element of securing reproductive health through universal health coverage.

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

• Benchmark assessments for disaster risk management capacities have been completed for Bangladesh, Bhutan, DPR Korea, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. India and Maldives are finalizing the planning process to undertake such assessment in 2014.

• The Regional Meeting on Disaster Risk Management in the Health Sector was organized in Bangkok in June 2012 and outlined the strategic directions. Trainings and drills on WHO’s levels of readiness in responding to emergencies and disasters were conducted at the WHO country offices in Bangladesh, Nepal and Sri Lanka. Thailand conducted a simulation to update their country office plan on this issue. The second SEARHEF Working Group Meeting and meetings of the focal points of the South-East Asia Region EHA were conducted at the Regional Office in New Delhi.

• The Nursing unit in the Regional Office provided support for the Fifth Asia-Pacific Nursing in Emergencies Network Conference organized in Kuala Lumpur, Malaysia, in 2012, and the Asia-Pacific Emergency and Disaster Nursing Network (APEDNN) in Bangkok, Thailand, in December 2013.

Technical and operational support has also been provided:

– The Regional Office has also collaborated with the WHO Kobe Centre to conduct the WHO consultation in Bangkok on “Strategic directions for urban health emergency management”.

– EHA in the Regional Office has provided technical inputs and feedback towards developing the Emergency Risk Management Framework (ERMF) document, which will provide Organization-wide standards for responding to a wide range of emergencies.
Strategic Objective 6: To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex

- High-level advocacy was carried out for the prevention and control of risk factors for noncommunicable diseases (NCDs) – such as unhealthy diet, physical inactivity, and use of tobacco and alcohol – through the regional conference for parliamentarians as well as at the Health Ministers’ Meetings and the Sixty-fifth and Sixty-sixth sessions of the Regional Committee for South-East Asia.

- The Regional Office has facilitated the exchange of best practices in multisectoral actions for the prevention and control of risk factors for NCDs at regional meetings. Furthermore, country-level technical assistance was provided in identifying multisectoral actions for addressing childhood obesity in Indonesia.

- Most of the countries in the Region are implementing provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC), and some have gone beyond the Framework Convention. The Regional Office supported Bangladesh, Indonesia and Timor-Leste to draft, promulgate or improve their current or new tobacco control policies/legislation.

- The tobacco surveillance system in the Region is on track and findings from surveys have been utilized to improve tobacco control in Member States, especially Bangladesh, India, Indonesia, Nepal and Thailand. Standard tobacco questions for surveys (TQS) have been used in ongoing national surveys in five Member States.

- During this biennium, health promotion work in the South-East Asia Region has been strongly emphasized through intersectoral actions at the policy level. The Regional Framework for Health in All Policies was developed. The Regional Office provided technical support for the development of the National Health Promotion Strategic Plan with multisectoral agencies in Bhutan, the National School Health Programme in Timor-Leste, and the National Health Promotion Communication for NCDs in Bangladesh.

- Country-specific strategies have been developed to implement the Global Strategy to Reduce the Harmful Use of Alcohol.

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

- Mainstreaming of the social determinants of health across sectors in urban areas had been achieved through intersectoral action and advocacy for healthy urban planning during 2012. UNICEF, UNESCO, UN HABITAT, IOM, DFID and USAID became active
partners in addressing urban health, migration and pro-poor strategies, particularly in India. Member States were sensitized on gender-based and human rights-based programmes and activities in health.

- The Regional Framework on Health in All Policies was finalized and adopted at the Regional Consultation in April 2013, and the Regional Office Statement on Health in All Policies (HiAP) was shared at the 8th Global Conference on Health Promotion in Helsinki in June 2013. The Regional Office has shared intersectoral experiences from in-depth case studies from Bhutan, Nepal, India, Sri Lanka, Thailand and Timor-Leste at the conference website under the WHO Action for Social Determinants of Health (SDH) (http://www.actionsdh.org/Contents/Action/Governance.aspx).

- SDH drew considerable attention during the Regional Consultation on the Post-2015 Development Agenda in March 2013, where multisectoral partners in the Region were consulted and the Joint Statement of the UN Platform on SDH was shared.

- During the biennium the capacity and understanding of Member States of the Region on intellectual property rights, international trade agreements and laws, and treaties for public health and access to medical products was enhanced. Significant progress was made in building capacity and knowhow in Bangladesh, India, Indonesia, Myanmar, Thailand and Timor-Leste through engagement with the ministries of health, commerce and trade, and academic circles.

- Member States of the South-East Asia Region played an active role on programme activities related to the Report of the Consultative Expert Working Group (CEWG) on Research and Development: Financing and coordination for promoting access to health products.

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

- Bangladesh, DPR Korea, Indonesia, Myanmar, Sri Lanka and Thailand developed their multisectoral climate change strategies and action plans, either as a separate document or as part of their national environmental health action plans.

- More than 280 water and sanitation professionals were trained on water safety plans through training of trainers organized at the regional level and national-level trainings. A regionally focused training manual on urban water safety plans was prepared. Bangladesh has incorporated water safety plan training in a university curriculum.

- A Regional Strategy for Protecting Health from Climate Change has been developed.

- Support was extended to studies on a health vulnerability index, prevalence and incidence of diarrhoea, acute respiratory tract infection, malaria and livelihood and health conditions after sea storms.
A number of countries in the Region were supported to establish their national programmes to address priority occupational risks and diseases.

A guideline for total sanitation was developed and piloted in 10 village development committees in Nepal. Amarpuri village development committee was declared the first “total sanitation” in Nepal.

Water, sanitation and handwashing facilities have been improved in 40 primary health centres in coastal areas of Bangladesh.

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

- National nutrition activities are in close alignment with the regional nutrition strategy.
- Regional food safety strategy formulated and shared with Member States and partner agencies.
- Overview of national Codex committees and INFOSAN activities prepared and technical support provided to strengthen the national Codex committees and INFOSAN focal points.
- Timor-Leste has been assisted in its membership to the Codex Alimentarius Commission.

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

- Health systems strengthening in the South-East Asia Region has been supported, based on the principles of revitalization of primary health care (PHC). Member States were supported to integrate their health systems and to assess country health system performances ensuring good quality and providing safe health care.
- Efficient coordination in HSD programme management operations and implementation of Strategic Objectives has been achieved through well-executed managerial and administrative support that has been provided.
- Country capacity in operational research on community empowerment for sustainable development was strengthened. Information and knowledge management capacity of Member States has improved.
- The management of and access to health information by countries has been strengthened, along with regional health workforce networks and partnerships.
Strategic Objective 11: To ensure improved access, quality and use of medical products and technologies

- Situational analysis of the pharmaceutical sector was undertaken in all 11 Member States of the South-East Asia Region (including in two states [provinces] of India) during 2010–2013. In 2013, a regional consultation was held on the effective management of medicines that was attended by participants from all 11 Member States.

- The Better Medicines for Children project was completed in 2012, having undertaken training programmes for doctors and pharmacists on the new essential medicines lists for children in two states of India. All country essential medicines lists were technically reviewed.

- With greater advocacy and commitment on the part of Member States, almost all countries in the Region are implementing the Global Strategy for Safe Blood, and have also nationally coordinated blood transfusion services (BTS) as well as a national blood policy. There has been a gradual increase in total blood collection: about 12 million units of blood are annually collected in the Region. The number and proportion of voluntary non-remunerated blood donations have gradually increased each year. All (100%) blood donated in the Region is screened for HIV, hepatitis B and hepatitis C.

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

- Strengthening governance and engagement with Member States: The Sixty-fifth and Sixty-sixth sessions of the WHO Regional Committee for South-East Asia, the Thirtieth and Thirty-first Health Ministers’ Meetings that are preceded by the meeting of their Senior Advisers, and other high-level meetings have been held with the participation of all Member States. These meetings featured key regional priorities including country focus, and development and alignment of national and regional priorities.

- Implementation of WHO reform: In the area of governance, the link between global and regional governing bodies is being strengthened. In the area of management, internal review and technical assessment (IRTA) missions to two country offices were conducted during the second half of 2012 and 2013.

- Monitoring and evaluation: Technical and administrative support was provided at regional and country levels to monitoring and evaluation, including reporting templates at the workplan level, Top-Task level, OSER level and Strategic Objective-level.

- Resource mobilization: Resource mobilization has been facilitated through coordination support, database development and continued partnership building.
• The communication network functioned as a communications channel, with support provided for high-level meetings. A communications strategy plan was prepared for the Region, and a new Regional Office website was launched with support from WHO headquarters.

• **Information portals and institutional repositories**: Support for sustainable development of information management (for example, information portals), was provided. The development of institutional repositories and public health libraries (especially in schools of public health) has been supported.

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

• The South-East Asia Region oriented its administrative services delivery to support not only the administrative expected results but also the WHO reform process. Across administrative areas, processes and systems spanning all three levels of the Organization have been harmonized leading to reduced operational costs and greater efficiency.

• Human resource processes have been significantly streamlined and harmonized, resulting in best-in-class performance on recruitment turnaround times within the Organization. Staff development and learning activities have been further aligned to support PMDS and technical workplan outcomes. Global, common information and communications technology (ICT) projects have been implemented resulting in more common systems, reduced costs of ownership and better administrative performance.

• Strategic and operational planning and subsequent implementation monitoring processes have been oriented to better reflect country needs and to optimize resource management during the biennium. Country office capacities in programme planning and results-based management have been strengthened.

• Significant work has been done to strengthen the control environment. The region has instituted compliance and risk management activities resulting in improved audit performance and, importantly, also resulting in greater staff awareness of this key and ongoing activity.

• Work continues to improve the infrastructure and working environments to ensure staff safety and security though promulgation of MOSS compliance and better equipped facilities.

**Analysis of reporting of OSERs in the South-East Asia Region**

16. End-of-the-biennium assessment carried out in the South-East Asia Region reflected that out of 834 Office-specific expected results (OSERs) reported upon, 783 (93.88%) OSERs were “fully achieved”, 35 OSERs were “partially achieved” and 16 were “in trouble”.
17. The following were the main reasons for partial or non-achievement of the OSERs:

- some planned activities became “not feasible” due to the changes in the “environment”. Planned progress could also not be achieved owing to multiple stakeholders not under the direct organizational reach of WHO or the Ministry of Health as well as insufficient advocacy and partnership mechanisms.
- funding constraints as well as changing priorities at the end of first year of the biennium.
- non-availability of technical staff resulted in a delay in processes and procedures leading to low implementation.
- restricted donor support, administrative delays, and non-availability of timely technical assistance, and time delays due to collaborative nature of work were also cited as reasons.

Lessons learned

18. Many important lessons which will inform future plans and programmes have been learned during the conduct of the PBPA exercise. These include the following salient ones:

- Multisectoral actions require cooperation, collaboration and coordination which were not easily established in an atmosphere where government bodies and partners are more comfortable to work within their own jurisdiction and responsibility.
- Some Member States that have a strong foundation of experience in working together multisectorally could achieve the process with some technical guidance, while others needed more capacity-building.
- Leadership from the health sector is often limited. The health sector has limited technical inputs or evidences to convince other sectors to support the health of the population by having other sectors doing their work effectively, which links to good governance.
- Health impact assessment is often not being considered a tool for healthy public policies; thus greater promotion and understanding of the same is needed.
- Strengthening of surveillance in Member States that are yet to do so, such as with areas like malaria, is required.
- Tremendous demands are placed on the Organization while supporting countries that continue to look to WHO for guidance in responding to the rise in incidence of noncommunicable diseases. The “One WHO” approach has helped meet such demands.
• In matters related to technical monitoring in the South-East Asia Region, implementation was linked to 79 Organization-wide expected results for the biennium 2012–2013. As of May 2013, five out of 79 OWERs accounted for half of the total funds implemented and nine out of 79 OWERs accounted for 67% of total funds implemented. Details of the five major OWERs reflecting 50% of implementation as of May 2013 are shown in Annex 2.

• The main reasons provided for “partially achieved” or “in trouble” OSER progress ratings were:
  – lack of funding for certain areas, especially owing to over-reliance on specified funding;
  – lack of dedicated staff in certain areas;
  – delay in implementation due to the collaborative nature of the work;
  – involvement of many sectors at the national level;
  – insufficient advocacy and partnership mechanisms; and
  – administrative delays.
### Annex 1

**Table 1: Budget implementation by Strategic Objective for the South-East Asia Region**  
(figures in US$ million as on 31 December 2013)

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Approved Budget as on 1 January 2012</th>
<th>Approved Budget as on 31 Dec. 2013</th>
<th>Funds available as on 31 Dec. 2013</th>
<th>Funds available (% of approved budget on 1 Jan. 2012)</th>
<th>Utilization (expenditure plus encumbrances)</th>
<th>Utilization (% of approved budget on 1 Jan. 2012)</th>
<th>Utilization (% of funds available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To reduce the health, social and economic burden of communicable diseases</td>
<td>129.1</td>
<td>175.7</td>
<td>169.9</td>
<td>132%</td>
<td>154.4</td>
<td>120%</td>
<td>91%</td>
</tr>
<tr>
<td>2. To combat HIV/AIDS, tuberculosis and malaria</td>
<td>76.3</td>
<td>70.9</td>
<td>58.4</td>
<td>77%</td>
<td>53.0</td>
<td>69%</td>
<td>91%</td>
</tr>
<tr>
<td>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence, injuries and visual impairments</td>
<td>11.5</td>
<td>10.9</td>
<td>10.7</td>
<td>93%</td>
<td>9.9</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>4. To reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth and neonatal period, childhood and adolescence and improve sexual and reproductive health and promote active and healthy ageing for all individuals</td>
<td>13.6</td>
<td>16.6</td>
<td>15.5</td>
<td>114%</td>
<td>14.2</td>
<td>104%</td>
<td>91%</td>
</tr>
<tr>
<td>5. To reduce the health consequences of emergencies, disasters, crises in conflicts, and minimize their social and economic impact</td>
<td>38.4</td>
<td>27.3</td>
<td>17.1</td>
<td>45%</td>
<td>15.9</td>
<td>41%</td>
<td>93%</td>
</tr>
<tr>
<td>6. To promote health and development, and prevent or reduced risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex</td>
<td>13.0</td>
<td>9.7</td>
<td>6.8</td>
<td>52%</td>
<td>6.3</td>
<td>48%</td>
<td>92%</td>
</tr>
<tr>
<td>Strategic Objective</td>
<td>Approved Budget as on 1 January 2012</td>
<td>Approved Budget as on 31 Dec. 2013</td>
<td>Funds available as on 31 Dec. 2013</td>
<td>Funds available (% of approved budget on 1 Jan. 2012)</td>
<td>Utilization (expenditure plus encumbrances)</td>
<td>Utilization (% of approved budget on 1 Jan. 2012)</td>
<td>Utilization (% of funds available)</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</td>
<td>2.5</td>
<td>3.1</td>
<td>3.1</td>
<td>123%</td>
<td>3.0</td>
<td>121%</td>
<td>98%</td>
</tr>
<tr>
<td>8. To promote a healthier environment, intensified primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health</td>
<td>9.4</td>
<td>9.5</td>
<td>8.9</td>
<td>95%</td>
<td>8.4</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development</td>
<td>4.1</td>
<td>4.1</td>
<td>3.7</td>
<td>90%</td>
<td>3.5</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research</td>
<td>36.4</td>
<td>43.9</td>
<td>39.5</td>
<td>109%</td>
<td>38.4</td>
<td>105%</td>
<td>97%</td>
</tr>
<tr>
<td>11. To ensure improved access, quality and use of medical products and technologies</td>
<td>6.2</td>
<td>6.9</td>
<td>6.1</td>
<td>99%</td>
<td>6.0</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nation System and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work</td>
<td>13.0</td>
<td>13.0</td>
<td>12.7</td>
<td>97%</td>
<td>12.4</td>
<td>96%</td>
<td>98%</td>
</tr>
</tbody>
</table>
### Strategic Objective

--- | --- | --- | --- | --- | --- | ---
13. To develop and sustain WHO is a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively | 30.7 | 38.9 | 38.1 | 124% | 37.2 | 122% | 98%
**Grand total** | **384.2** | **430.4** | **390.6** | **102%** | **362.5** | **94%** | **93%**

### Table 2: Budget implementation by Budget Centres of the WHO country offices
(figures in US$ million as on 31 December 2013)

<table>
<thead>
<tr>
<th>Budget Centre</th>
<th>Approved Budget as on 1 January 2012</th>
<th>Funds available</th>
<th>Funds available (% of approved budget)</th>
<th>Utilization (expenditure plus encumbrances)</th>
<th>Utilization (% of approved budget)</th>
<th>Utilization (% of funds available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>29.9</td>
<td>24.4</td>
<td>82%</td>
<td>23.0</td>
<td>77%</td>
<td>94%</td>
</tr>
<tr>
<td>Bhutan</td>
<td>3.6</td>
<td>4.9</td>
<td>138%</td>
<td>4.7</td>
<td>132%</td>
<td>96%</td>
</tr>
<tr>
<td>India</td>
<td>88.1</td>
<td>123.0</td>
<td>140%</td>
<td>115.6</td>
<td>131%</td>
<td>94%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>32.8</td>
<td>31.9</td>
<td>97%</td>
<td>28.1</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>27.2</td>
<td>18.8</td>
<td>69%</td>
<td>17.8</td>
<td>65%</td>
<td>95%</td>
</tr>
<tr>
<td>Maldives</td>
<td>3.0</td>
<td>3.6</td>
<td>121%</td>
<td>3.5</td>
<td>118%</td>
<td>98%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>37.4</td>
<td>38.5</td>
<td>103%</td>
<td>35.8</td>
<td>96%</td>
<td>93%</td>
</tr>
<tr>
<td>Nepal</td>
<td>20.3</td>
<td>25.4</td>
<td>125%</td>
<td>23.9</td>
<td>117%</td>
<td>94%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>9.6</td>
<td>6.8</td>
<td>71%</td>
<td>6.7</td>
<td>70%</td>
<td>99%</td>
</tr>
<tr>
<td>Thailand</td>
<td>10.7</td>
<td>10.0</td>
<td>94%</td>
<td>9.5</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>4.9</td>
<td>5.2</td>
<td>106%</td>
<td>5.0</td>
<td>102%</td>
<td>97%</td>
</tr>
<tr>
<td><strong>Country total</strong></td>
<td><strong>267.4</strong></td>
<td><strong>292.5</strong></td>
<td><strong>109%</strong></td>
<td><strong>273.8</strong></td>
<td><strong>102%</strong></td>
<td><strong>94%</strong></td>
</tr>
</tbody>
</table>
Annex 2

Major Organization-wide expected results (OWERs) reflecting 50% of implementation as of May 2013

- **OWERs 1.002 – POLIO M:** Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.

- **OWERs 1.003 – TROPZO:** Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.

- **OWER 2.001 – PTCHTM:** Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

- **OWER 2.002 – SERHTM:** Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.

- **OWER 13.005 – MADSUP:** Managerial and administrative support services necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.