The extended 12-member working group appointed by the 136th Session of the Executive Board (EB) presented its methodology to the 137th Session of EB in May 2015, based on a new set of criteria and a population smoothening method. This new methodology has identified a share of 14.1% for Segment 1 for SEAR Member States when compared to the 10.8% identified in the earlier model.

The Eighth Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM), held at the WHO Regional Office in New Delhi on 3 July 2015, reviewed the attached working paper and made the following recommendations:

**Action by Member States**

1. Actively follow up and communicate any relevant issues to be raised at the 138th Session of the Executive Board, with SEAR representatives in the Programme Budget and Administration Committee (PBAC).

**Action by WHO**

1. Facilitate formation of a working group of the Member States to communicate regularly on the discussion, progress, outcomes and recommendations of PBAC.

The working paper and SPPDM recommendations are submitted to the Sixty-eighth Session of the Regional Committee for its consideration.
Introduction

1. At the Sixty-sixth World Health Assembly in May 2013, the Director-General was requested to propose, in consultation with Member States, a new strategic budget space allocation (SBSA) methodology in WHO for consideration by the Sixty-seventh World Health Assembly, starting with the development of Proposed Programme Budget 2016–2017.

2. A working group was established at the 134th Session of the WHO Executive Board (EB) to work on SBSA and to provide guidance to the Secretariat in further developing the proposal for a new SBSA methodology. Maldives represented the Region in this working group.

3. Development of a new resource allocation methodology in WHO is quite complex and interdependent with many other WHO reform initiatives that are currently under way, such as the work on bottom-up planning, identification and costing of outputs and deliverables, roles and functions of the three levels of the Organization, and review of the financing of administrative and management costs.

4. The working group met through teleconference and face-to-face meetings and agreed on the scope, guiding principles and a set of criteria for SBSA. They also agreed on four expenditure segments as the basis of SBSA.

5. The outcome of the working group discussions was presented to the 136th Session of EB in January 2015. The EB agreed to the recommendations of the working group and the methods proposed under operational Segments 2, 3 and 4. However, it was of the view that further discussions were needed on SBSA methodology in the operational Segment 1, which is “technical cooperation at country level”.

6. The decision of the 136th Session of EB explicitly states the need for discussions in further developing the methodology for SBSA in Segment 1.

7. This segment relates to functions and activities at the country level, where the benefits are experienced directly by individual countries. Activities could include building country capacity, providing technical support, conducting policy dialogue, adapting guidelines and strengthening systems to collect, analyse and disseminate data.

8. The proportion of allocation of budget space under Segment 1 for WHO regions as submitted by the working group and tabled at the 136th Session of EB is given in Table 1. Model 5 was found to be the most appropriate of the different models proposed.
**Table 1:** Proportion of allocation of budget space under segment 1 for WHO regions as proposed by the working group in January 2015

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Planned budget 2014–2015</th>
<th>Average from 2006 validation mechanism</th>
<th>Composite model 1 (B)</th>
<th>Composite model 2 (S)</th>
<th>Composite model 3 (T)</th>
<th>Composite model 4 (U)</th>
<th>Composite model 5 (V)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>43.00</td>
<td>47.67</td>
<td>42.53</td>
<td>45.00</td>
<td>45.70</td>
<td>44.31</td>
<td>44.87</td>
</tr>
<tr>
<td>The Americas</td>
<td>8.00</td>
<td>10.24</td>
<td>11.15</td>
<td>13.35</td>
<td>12.48</td>
<td>10.78</td>
<td>10.16</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>15.00</td>
<td>10.45</td>
<td>13.96</td>
<td>10.97</td>
<td>10.22</td>
<td>11.67</td>
<td>13.69</td>
</tr>
<tr>
<td>Europe</td>
<td>5.00</td>
<td>11.86</td>
<td>10.81</td>
<td>13.61</td>
<td>14.91</td>
<td>16.67</td>
<td>12.51</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>16.00</td>
<td>10.44</td>
<td>12.74</td>
<td>7.89</td>
<td>7.74</td>
<td>8.61</td>
<td>10.84</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>14.00</td>
<td>9.34</td>
<td>8.81</td>
<td>9.91</td>
<td>8.95</td>
<td>7.96</td>
<td>7.92</td>
</tr>
</tbody>
</table>

1. Indicators considered: GDP per capita PPP$; life expectancy; births in the presence of skilled attendants; DPT3 vaccine coverage
2. Indicators considered: GDP per capita PPP$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density; Gini coefficient
3. Indicators considered: GDP per capita PPP$; births in the presence of skilled attendants; DPT3 vaccine coverage; DALYs due to communicable, maternal, perinatal and nutritional conditions; DALYs due to noncommunicable diseases and injuries; price level; population density; Gini coefficient
4. Indicators considered: GDP per capita PPP$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; price level; population density
5. Indicators considered: GDP per capita PPP$; births in the presence of skilled attendants; DPT3 vaccine coverage; total DALYs; population density

9. The criteria identified by the working group and the model thus developed were subjected to detailed discussions by Member States that resulted in the EB expanding the membership of the working group to 12 members – two from each region – and providing them more time to further discuss a robust and fair model to allocate the budget space under segment 1.

10. The expanded working group met in Geneva in April 2015 at a face-to-face meeting and made a number of suggestions to the Secretariat on new models relating to Segment 1 that they would like them to run.

11. The working group had extensive discussions on classification of countries and population scaling methodologies. It also agreed that further work would be required to explore and compare various population scaling methods that are used by global institutions such as the African Development Bank and UN Economic and Social Council. The members discussed extensively the population-smoothing approaches and a few were proposed for consideration.

12. The working group also discussed extensively the different indicators and proportion of missing values for each of them. They agreed that the key criteria for selecting indicators should include source of information and availability, quality and relevance of the data. Certain
indicators such as total disability-adjusted life years (DALY) per capita, the proportion of deliveries in the presence of skilled birth attendants and population density were excluded from the earlier methodology.

13. The working group requested the Secretariat to run different calculations using the best available indicators and data as agreed, with different population scaling. It met in Geneva on 21 May 2015 at the margin of the Sixty-eighth World Health Assembly and reviewed the different options provided by the Secretariat.

14. After further discussions, and taking into account the needs and concerns of different regions, the 12-member working group recommended model C (ALPS_min) as a scientific, evidence-based model. Table 2 shows the allocations based on model C. The last column depicts the results of the 2014–2015 planned budget allocations to allow a comparison.

<table>
<thead>
<tr>
<th>Region</th>
<th>Log(pop)</th>
<th>SQRT</th>
<th>ALPS</th>
<th>ADB</th>
<th>ALPS_min</th>
<th>Planned Budget for 2014–2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFR</td>
<td>47.4</td>
<td>41.2</td>
<td>44.5</td>
<td>38.3</td>
<td>43.4</td>
<td>43.0</td>
</tr>
<tr>
<td>AMR</td>
<td>11.7</td>
<td>9.9</td>
<td>11.1</td>
<td>9.2</td>
<td>11.3</td>
<td>8.0</td>
</tr>
<tr>
<td>EMR</td>
<td>15.3</td>
<td>15.7</td>
<td>14.7</td>
<td>15.4</td>
<td>14.2</td>
<td>15.0</td>
</tr>
<tr>
<td>EUR</td>
<td>6.8</td>
<td>5.9</td>
<td>6.4</td>
<td>5.5</td>
<td>6.4</td>
<td>5.0</td>
</tr>
<tr>
<td>SEAR</td>
<td>10.9</td>
<td>18.7</td>
<td>14.5</td>
<td>22.3</td>
<td>14.1</td>
<td>16.0</td>
</tr>
<tr>
<td>WPR</td>
<td>7.8</td>
<td>8.6</td>
<td>8.8</td>
<td>9.3</td>
<td>10.6</td>
<td>14.0</td>
</tr>
</tbody>
</table>

15. The working group recognized the need for gradual implementation towards the allocation of model C to avoid any drastic reduction for any Region, and requested the WHO Director-General to implement the recommended model over a period of three biennia, in consultation with the regional directors, using the current allocation for technical cooperation at country level as the starting point.

16. The working group also accepted the need for regular monitoring and reporting of the implementation of the new model of SBSA through the Programme Budget and Administration Committee of the Executive Board (PBAC).

17. The working group further acknowledged that the needs of the countries may change over time, and consequently impact the estimated regional envelopes based on the model. It therefore, recommended the model to be reviewed periodically, at least every six years.

18. The proposal of the working group was submitted to the 137th Session of the Executive Board in May 2015 to consider the draft decision set out in line with the recommendations proposed.
19. While appreciating the output of the working group, the 137th Session of EB discussed the need to implement the recommended model over a period of three to four bienniums and a decision EB137(7) was made to recommend it to the Sixty-ninth World Health Assembly in 2016 to adopt it.

Regional perspective

20. The Member States of WHO SEA Region had been very proactive in discussions related to SBSA. Maldives had represented the Region in the six-member working group. Since January 2015, India and Thailand have represented the Region in the working group discussions.

21. The intersessional meeting organized by the Regional Office with Member States during 25–27 August 2014 discussed the subject in detail, followed by further discussions at the Sixty-seventh Regional Committee in September 2014. The discussion clearly reflected the view of the SEAR Member States.

22. The regional discussions led by India and Thailand were clear that being a region with high disease burden on one hand, and being vulnerable to natural disasters, epidemics and pandemics on the other, the SEA Region has a rightful claim for a bigger share of WHO’s Programme Budget when compared to many other regions.