



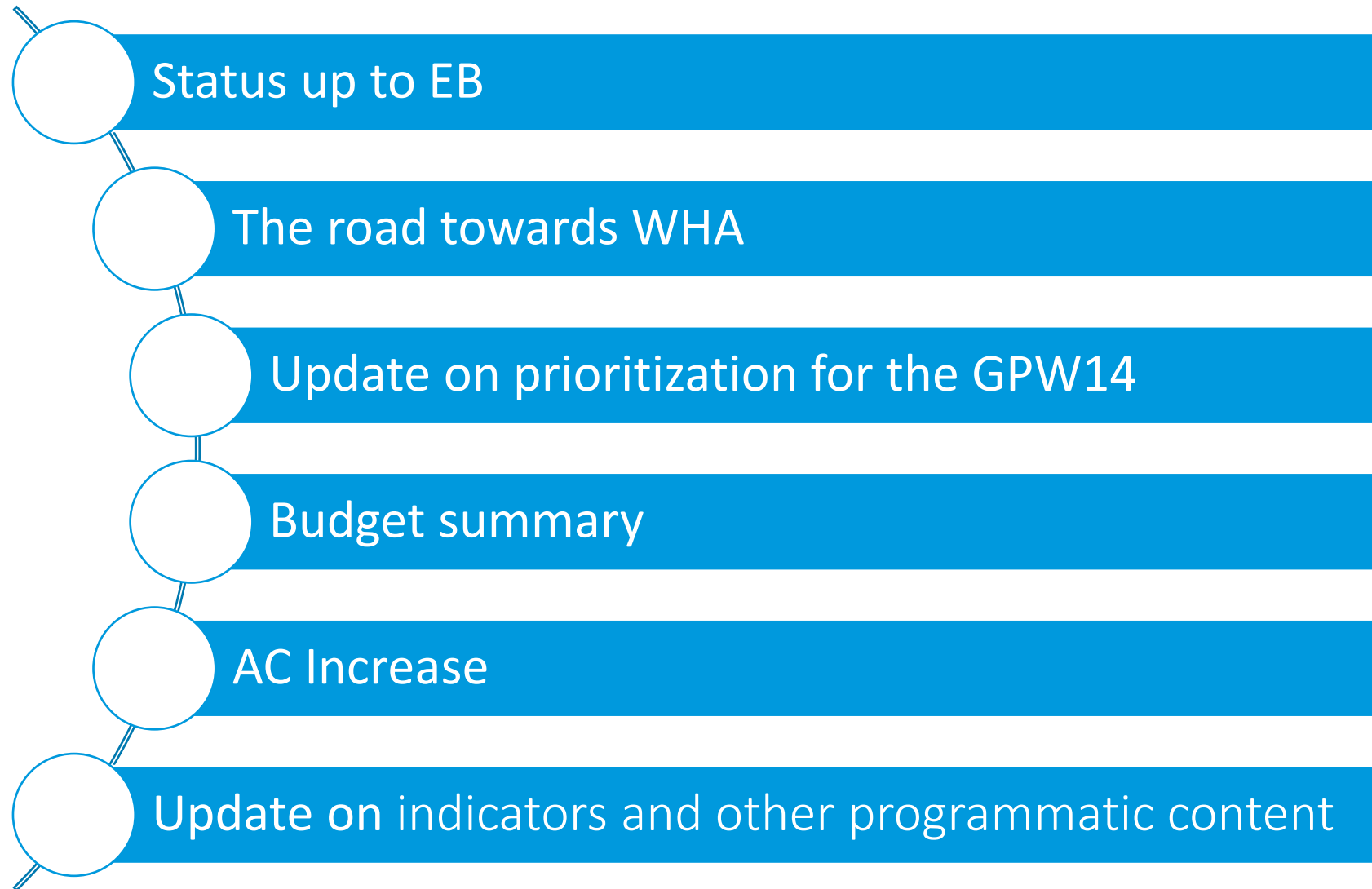
**World Health
Organization**

Proposed Programme Budget 2026-2027

Executive Board version

Geneva, January 2025

Agenda

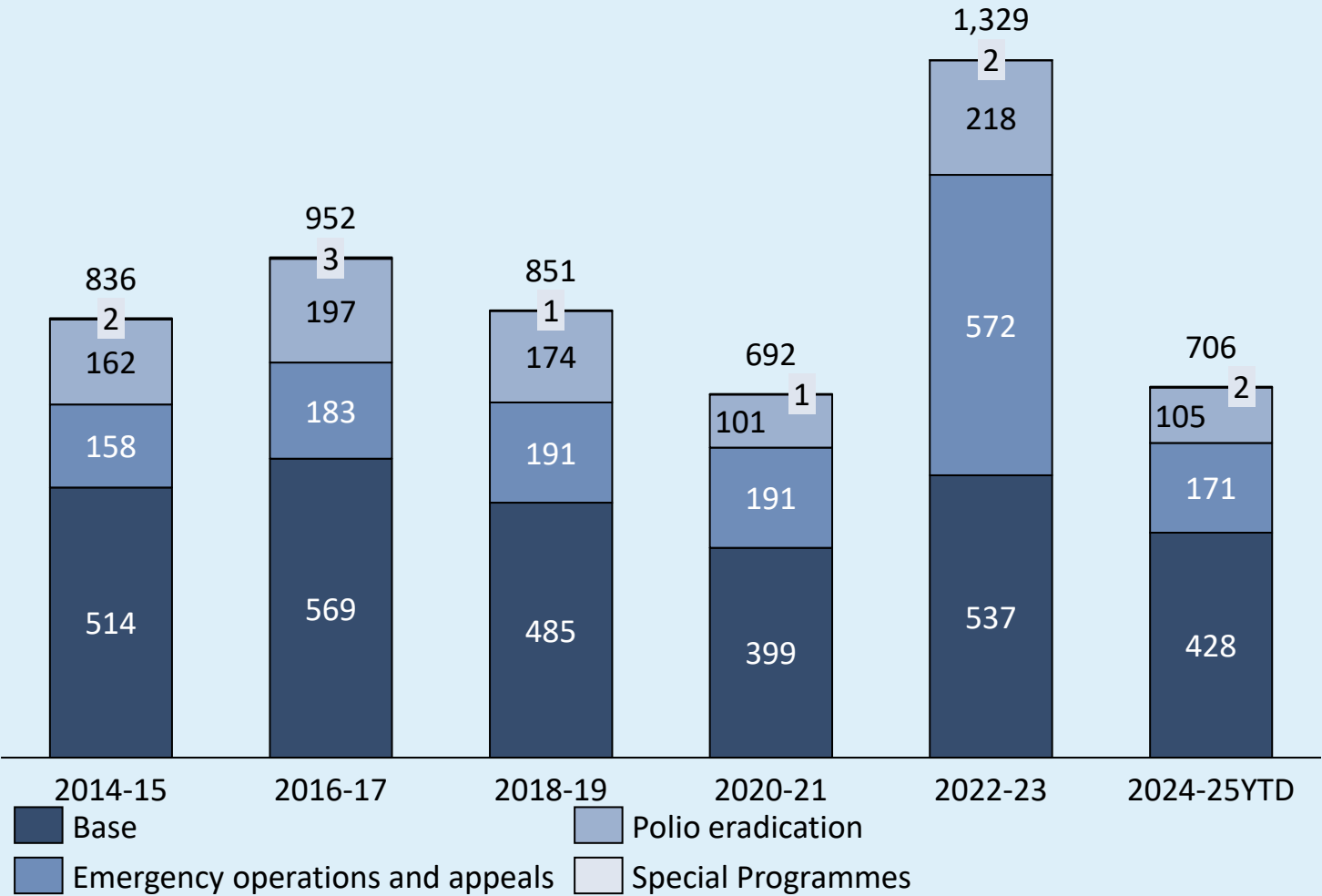


Financial relevance of USA: main facts

- ❑ USA: top contributor to WHO, considering **AC and VC** (except in 2020/2021)
- ❑ Member State with the **highest** (capped) **scale of assessment, at 22%.**
- ❑ Contributions have been **consistent across biennia**
- ❑ **WHO invoices USA for reimbursement** (for approved funds, WHO pays upfront and later invoices USA)



USA total contributions (AC and VC revenue) to the programme budget, for GPW12 and 13, by biennium and budget segments (US\$ millions)



USG funding to WHO Programme Budget: Key Financial figures

2022-2023 and 2024-2025 –as of Dec 2024

	2022-2023	2024-2025 (as at Dec 2024 - provisional)
Revenue from USG ¹	US\$ 1,329 M	US\$ 706 M ○ Base Programmes: US\$428 ○ AC: US \$264M (not yet received) ○ VC: US\$ 164 M ○ Polio eradication and Emergency operations and appeals : US\$278 M all VCs
Share of total PB Revenue (\$B)	18% (of US\$7.3 B)	18% (of US\$ 3.9 B)
Main Strategic priority/ budget segments funded by USG	○ 50% to Emergency operations and appeals budget segment ○ 17% to Strategic priority of health emergencies ○ 16 % to Strategic priority 1 for improved access to quality essential health services. ○ 13 % to the Global Polio Eradication Programme budget segment.	○ 33% to Emergency operations and appeals budget segment ○ 25% to Strategic priority 1 for improved access to quality essential health services. ○ 21% to Strategic priority 2 of health emergencies ○ 18 % to the Global Polio Eradication Programme budget segment.

¹ **Revenue** from voluntary contributions is recognized in accordance with IPSAS when a binding agreement is signed by WHO and a contributor. Where (a) there are “subject to” clauses in an agreement, or (b) the total amount is indicative or not mentioned in the agreement and only confirmed upon release of funds, WHO does not control the resource and does not record the revenue and amount receivable until the cash is received. Where there are no payment terms specified by the contributor or where payment terms are in the current accounting year, revenue is recognized in the current period.

Programmes most dependent on US VC funding:

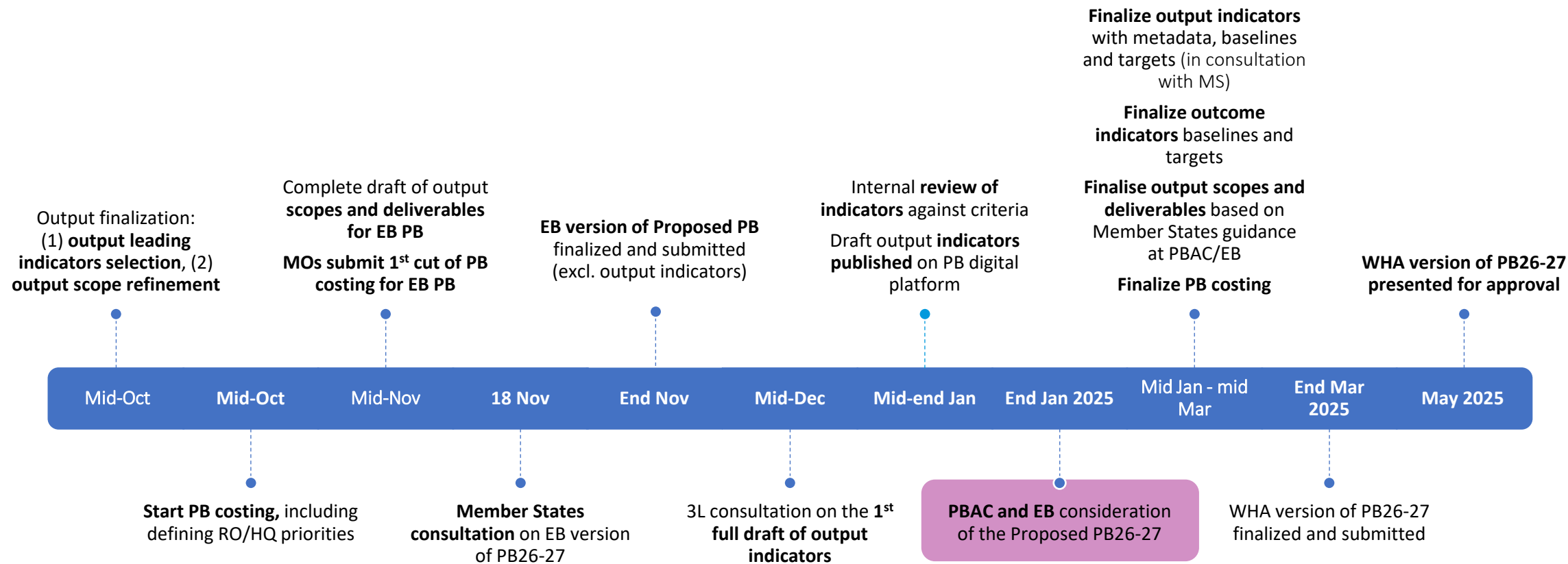


Emergency operations and appeals segment	Polio eradication segment	Health Emergencies Programme (SP2)	HIV, hepatitis, STI	Tuberculosis	Immunization (conservative)
\$235M US VCs in 2024-2025	\$133M US VCs in 2024-2025	\$154M US VCs in 2024-2025	\$41M US VCs in 2024-2025	\$29M US VCs in 2024-2025	\$16M+ US VCs in 2024-2025
15% US VCs of total VCs	13% US VCs of total VCs	29% US VCs of total VCs	70% US VCs of total VCs	61% US VCs of total VCs	9%+ US VCs of total VCs

Status up to EB

Proposed programme budget development: Milestones

PB digital platform to be used to communicate PB developments throughout the process and especially in between the governing bodies documents



Feedback from RCs:

Strong agreement

Country priority setting process and results

Joint assessment of results

Continue improving **transparent resource allocation** to country level

Continue **consulting with Member States** on overall PB development.

Differing views

Budget increase proposed (USD 550 M) could “water down” the impact of AC increase

Scenario to follow on Emergency Operations and Appeals segment

Scenario 1: keep as is at US\$1B, increase as needed

Scenario 2: Increase to US\$2.8B (size of Global Health Emergency Appeal)

AC increase: strong support from many, some asked for more gradual approach/scenarios and more budget details

Proposed programme Budget 2026-2027: Main updates since RC version

Budget segment	Approved Programme budget 2024–2025	Proposed programme budget 2026–2027 - Regional committees version	Proposed programme budget 2026–2027 - MS consultations version	Proposed programme budget 2026–2027 - Executive Board version	Variance (EB vs 24-25)	Increase (EB vs 24-25)
Base programmes	4 968.2	5 530.2	5 303.6	5 324.1	355.9	7%
Polio eradication	694.3	976.3	976.3	976.3	282.0	41%
Special programmes	171.7	162.4	166.4	172.8	1.1	1%
Emergency operations and appeals	1 000.0	1 000.0	1 000.0	1 000.0	0.0	0%
Total	6 834.2	7 668.9	7 446.3	7 473.2	639.0	9%

Items	Approved Programme budget 2024–2025	Draft RC proposed Programme budget 2026–2027	Draft EB Proposed programme budget 2026–2027	Variance between RC and EB versions
Baseline	4,968.2	4,968.2	4,968.2	
Country strengthening		387.0	183.4	(203.6)
Strengthening accountability		100.0	100.0	
Strengthening data and innovation		75.0	0.0	(75.0)
Global technical centres		0.0	72.5	72.5
Total	4,968.2	5,530.2	5,324.1	(206.1)

- Update on Priority setting (154 MS)
- Implications of governing bodies' approval of mandates
- Total budget increase (from 24-25): **RC: +\$562M in base + \$282M in polio** **EB: +\$355M in base + \$282M in polio**
- Global technical centres as new budget line as agreed
- Evolution of base programme budgets over recent biennia
- Draft base programme budget by Major Office and outcome
- Update on outcome and output indicators
- Results of investment round
- Risks of no AC increase
- Update of output scopes

The road towards WHA 78

Programme budget 2026-2027: possible process towards WHA version (1)

Consider budget options based on the following principles and assumptions

- WHO's Programme Budget is grounded in the results-based principles
- Priority setting with the Member States for the duration of GPW14 is the foundation for PB development
- AC increase approved
- Assumption 1: PB 2026-2027, as presented to EB, viable, including proposed increases, despite decreased financing from US
- Assumption 2: proposed PB 2026-2027 should reflect financial/economic reality, and flat budget (Base PB 2024-2025) is a realistic way forward. However, an increase for the Global technical centres could be kept because they are fully VC funded from specific funds
- Assumption 3: Base PB 2024-2025 should be decreased by a percentage corresponding to a realistic estimate of how much US VC cannot be "replaced" with new VC, but keep Global technical centres increase

Programme budget 2026-2027: possible process towards WHA version (2)



Jan-Feb 2025

- PBAC/EB considers proposed budget and provides guidance on PB adjustment for WHA



Feb-May 2025

- Secretariat implements EB recommendations
- Informal PB consultations with Member States
- Finalize priority setting with Member States (currently 154 countries set priorities)
- Adjust and finalize budget costing
- PB26-27 proposal for WHA



May 2025-Jan 2026

- Secretariat continues resource mobilization activities and assesses level of PB26-27 financing
- Secretariat reports to PBAC (Jan 2026) as part of the PB26-27 implementation document; PBAC recommendations



May 2026

- Secretariat reports on the level of PB26-27 financing
- If projected levels are lower compared with the same time previous biennium, proposal to Member States on suspending implementation of low priority outputs



May 2027

- Secretariat reports and revisits as guided by PBAC

Update on Prioritization

Establishing country priorities for the duration of GPW 14

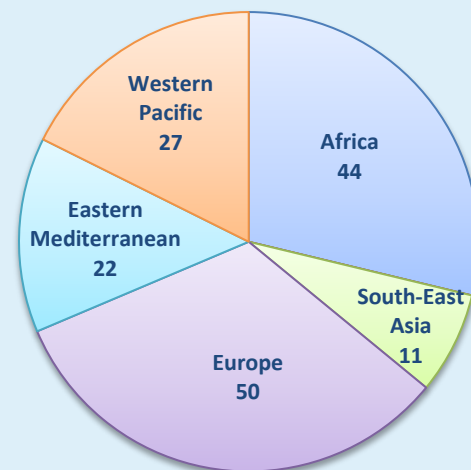
- **Prioritization:** the cornerstone of PB development
- N=154
- **Consistent:** 5 top priorities remain highest prioritized
- Informing budget **costing**, and overall WHO implementation
- Still ongoing (esp. AMRO region)
- Preliminary results are similar to 2024–2025



Prioritization results of joint outcomes from 5 Major Offices

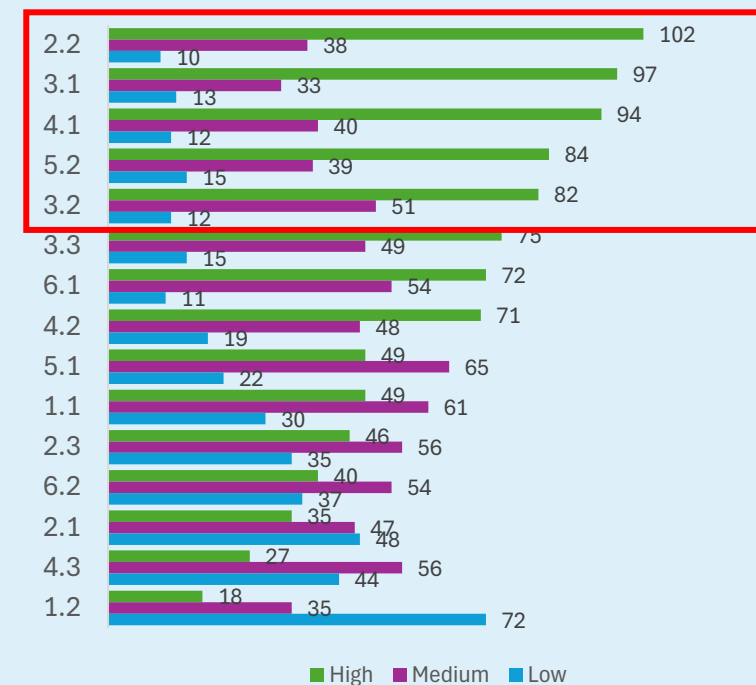
30 December 2024

N=154



Number of countries per Region that have finalized their priority-setting

Global ranking of outcomes



Main outcomes prioritized globally:

Joint outcome 2.2. Priority risk factors for NCDs and CDs, violence and injury, and poor nutrition

Joint outcome 3.1. The primary health care approach renewed and strengthened to accelerate universal health coverage

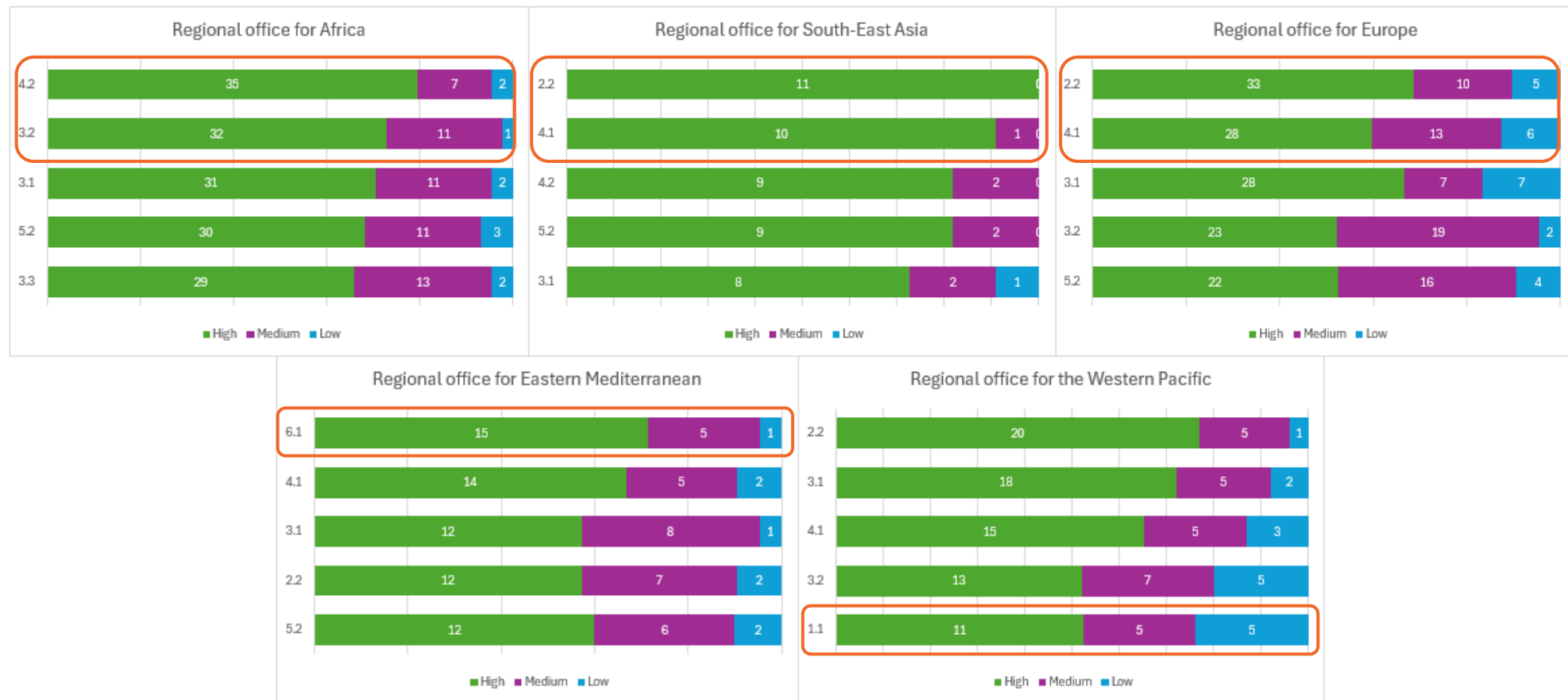
Joint outcome 4.1. Equity in access to quality services improved for NCDs, mental health conditions and CDs, and AMR

Joint outcome 5.2. Preparedness, readiness and resilience for health emergencies enhanced

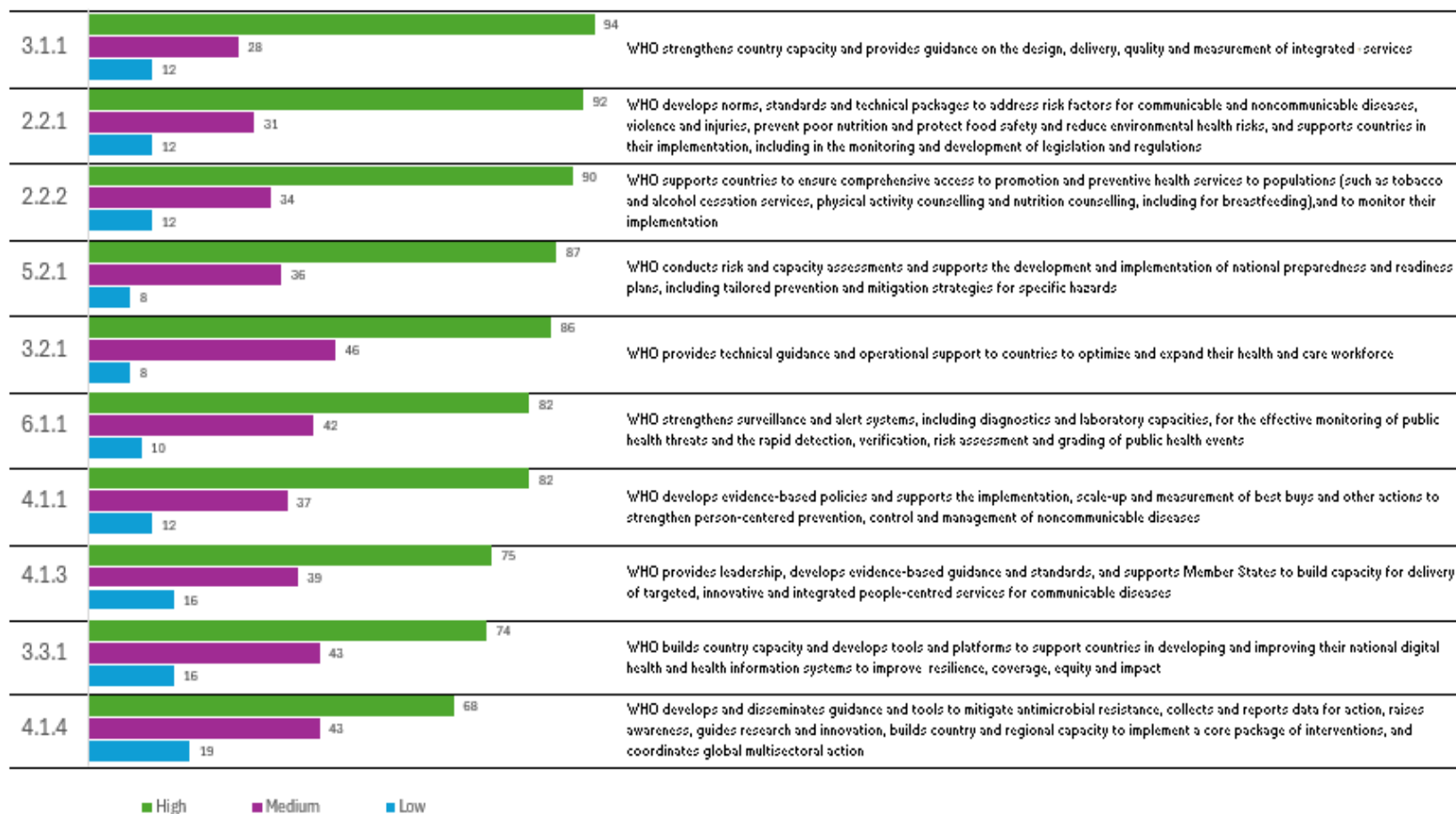
Joint outcome 3.2. Health and care workforce, health financing and access to quality-assured health products substantially improved

Country prioritization: a global process with regional flavour

While there is consistency on outcomes that have been prioritized globally, each region has focused on some that are most relevant to them



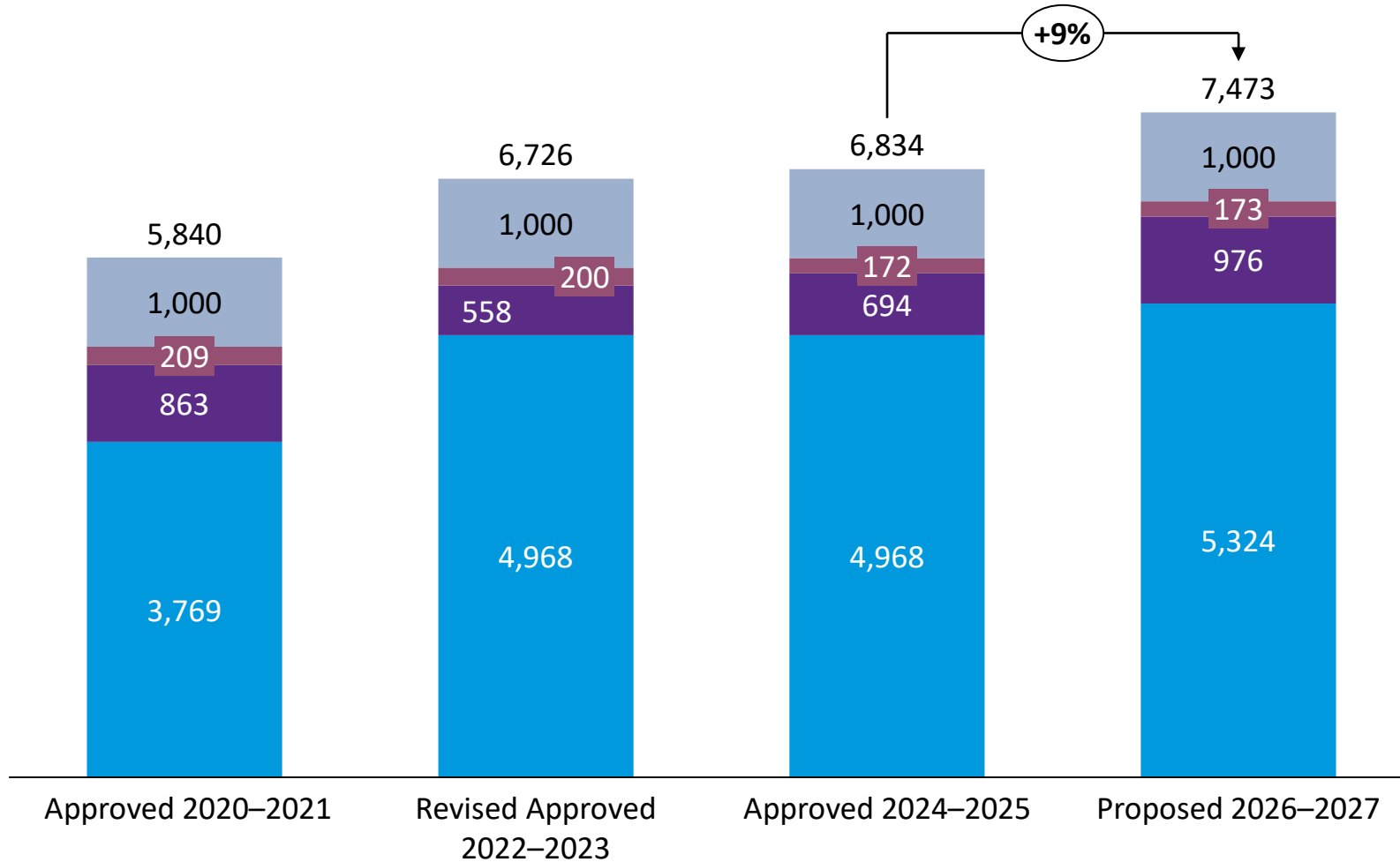
Output prioritization



- An overall direction on where countries think that WHO adds the most value
- Guided by outcome prioritization and country discussions
- Commitment to show budgetary trend
- Commitment to finance high priority outputs: align budget and resources with priorities
- Limited by quality of funding to be received to finance the Programme Budget

Budget Summary

Total Proposed Programme Budget 2026-2027



\$7.4 B

For the four PB segments

9%

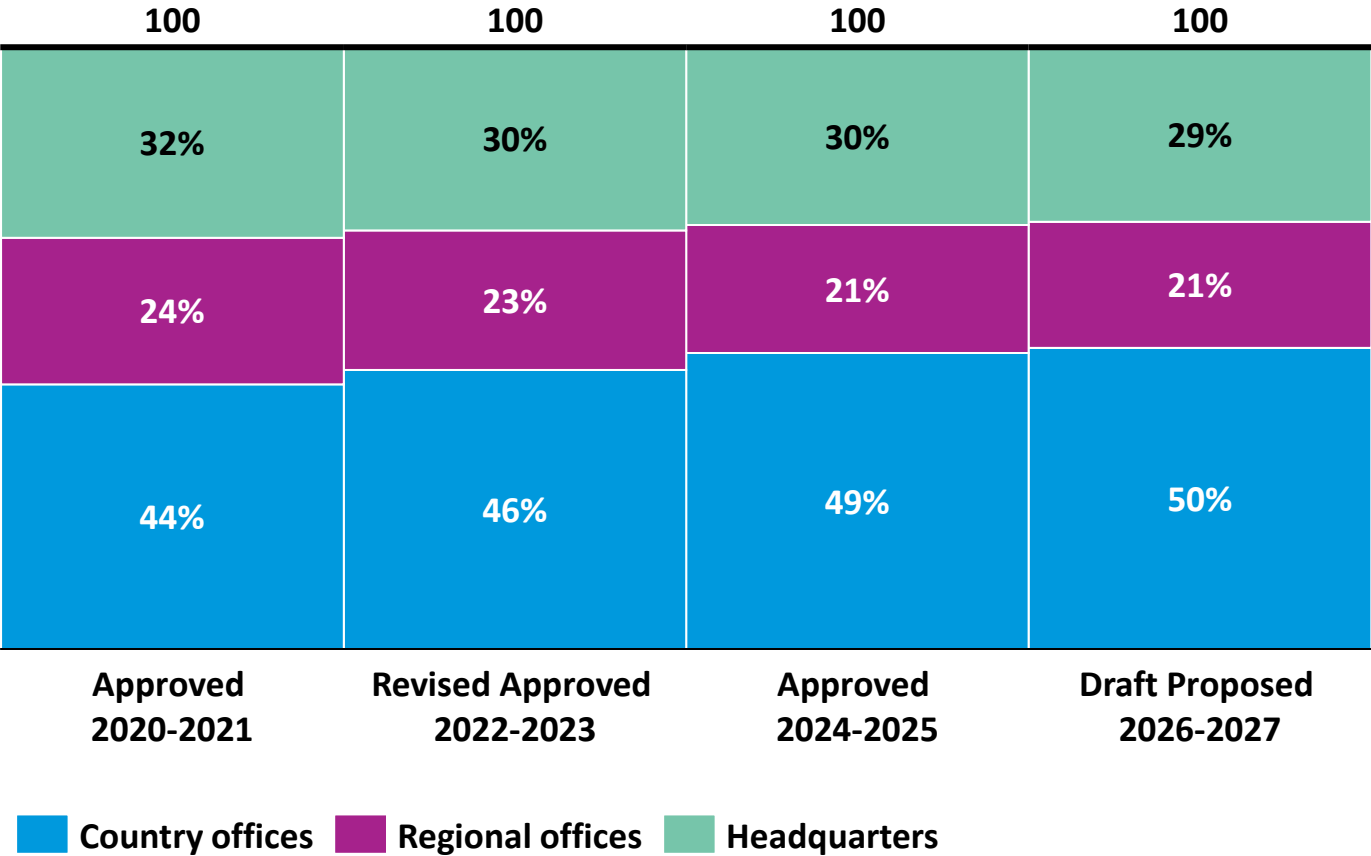
From 24-25 level

\$639 M

Increase, mostly in base and Polio eradication segments

Base Programmes: Evolution by organizational Level

- Base: largest budget segment, covers core work of WHO
- Country level share has slowly but steadily increased since 2020-2021
- Increases without going in detriment of functions at other levels, by assigning most budget increases to country level
- Resources need to follow budget for budget increase to be impactful: sustainable financing is key.



Base Programmes: By Major Office and investment item

Major office	Approved 2024–2025	INVESTMENT			Total draft Proposed 2026-2027	Increase
		Country strengthening	Strengthening accountability	Global technical centres		
Africa	1 326.6	61.9	28.5		1 417.0	7%
The Americas	295.6	20.2	6		321.8	9%
South-East Asia	487.3	15.9	10.5		513.7	5%
Europe	363.6	20	7.5		391.1	8%
Eastern Mediterranean	618.4	46.7	13.5		678.6	10%
Western Pacific	408.1	18.7	9		435.8	7%
Headquarters	1 384.6*		25		1 409.6	2%
Global technical centres	84*			72.5	156.5	86%
Total	4 968.2	183.4	100	72.5	5 324.1	7%

* Existing global technical centres were part of Headquarters budget in 2024-2025, but have been separated in the table for comparison purposes only.

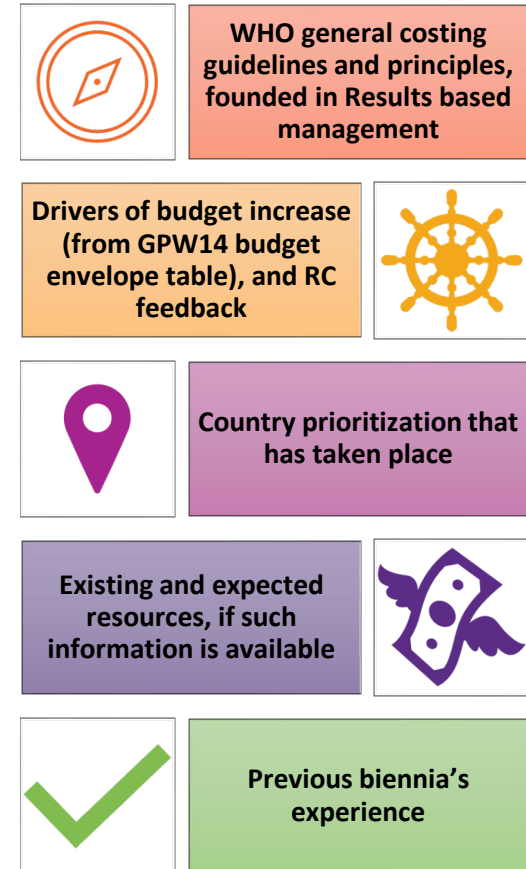
- 7% increase explained mostly by specific investments in Core capacities at country level and accountability functions
- New budget line: Global technical centres (deducted from Headquarters) – follow AMSTG T2¹ recommendation

¹ decision EB152(15) OP1(a)

Budget by outcome (ongoing)

- Preliminary results of budget costing included in EB version
- Budget costing still ongoing across all Major offices, and will affect final budget levels by outcome
- Factors that define/influence costing:
 - Prioritization to be completed (i.e. AMRO)
 - RBM principle: while the total budget envelope may be defined, each Major office prioritizes their budget levels according to own defined priorities
 - RC recommendations (reduction) incorporated across all Major office envelopes for the EB version
- Final costing by outcome to be presented in WHA version

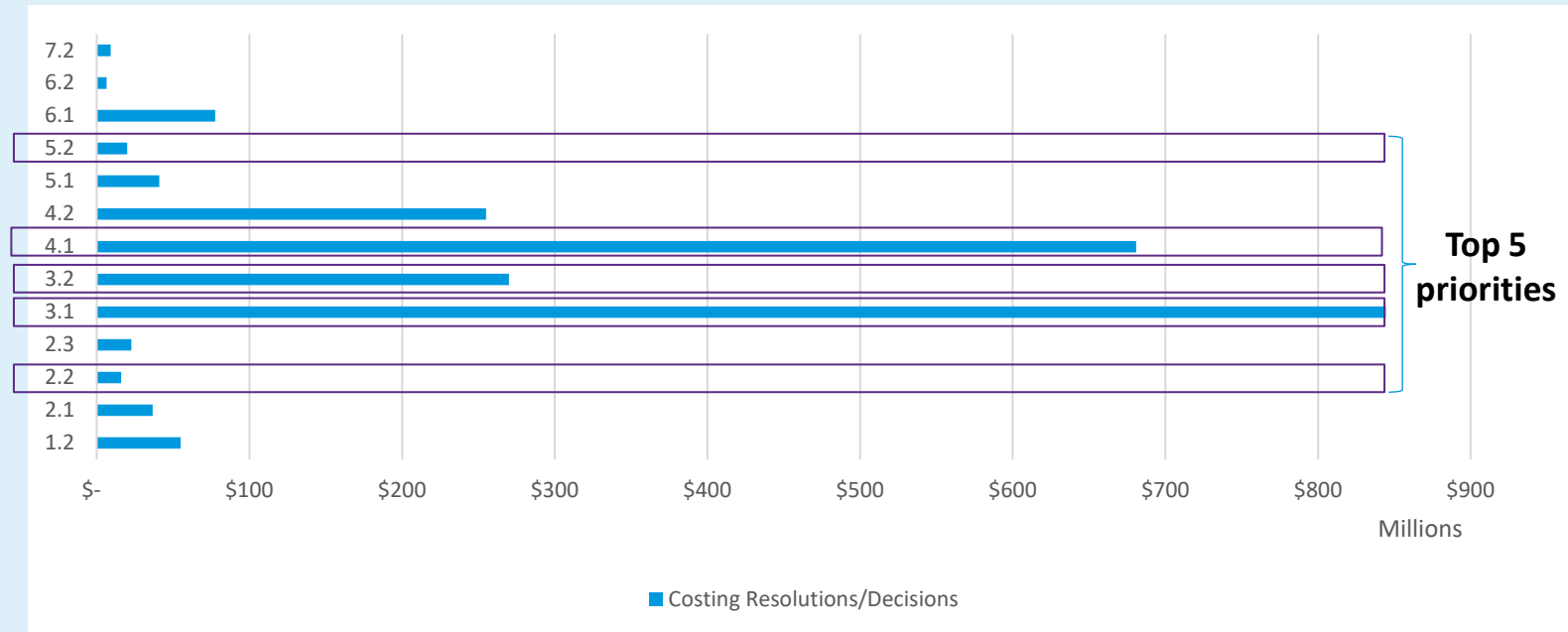
Overall Guiding principles



Costing of resolutions and decisions, and Programme Budget

- Consistency between mandates and priority-setting
- Costings amount to US\$ 2.3B for 2026-2027
- In 2022-2023, financing of related outcomes was not sufficient to fully finance the deliverables for that outcome, which also indicates insufficient funding for mandates

Resolutions and decisions with budgetary implications for 2026–2027, by GPW 14 outcome



Financing of PB26-27 and AC increase

Why AC increase matters?

...While Member States support making financing of WHO more sustainable, and there is wide support to the Investment Round, **the road to achieve WHA75 (8)** and increasing the AC by the end of the decade to reach 50% of the 2022-2023 base budget **is not certain**.

Any scenario of **less than 20%** for 2026-2027 would make further increases less realistic

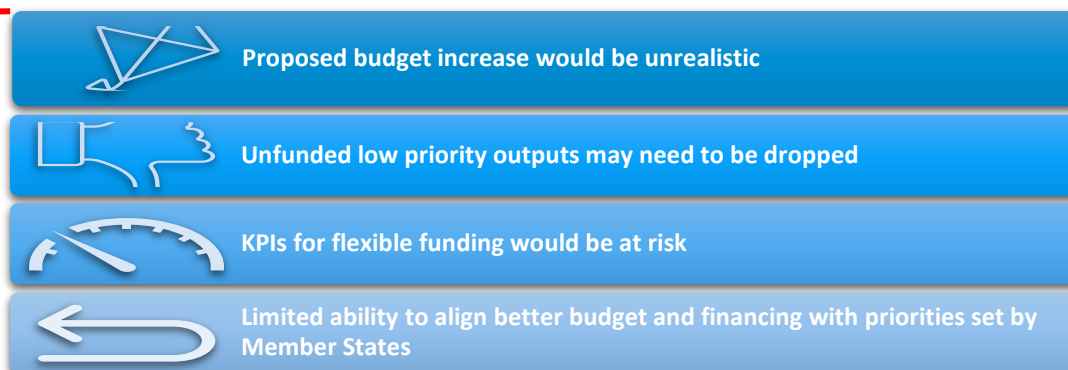
Assessed contributions increase between 2022 and 2031 (incl. USA)

Biennium	Total assessed contributions (US\$ million)	Increase over current level of assessment (%)	Increase per biennium, (US\$ million)	% of base budget 2022–2023
2022–2023	956.9	–	–	22
2024–2025	1 148.3	20	191.4	26
2026–2027	1 377.9	20	229.6	32
2028–2029	1 722.4	25	344.5	39
2030–2031	2 182.0	27	459.6	50

Assessed contributions increase between 2022 and 2031 (excl. USA)

Biennium	Total assessed contributions (US\$ million)	Increase over current level of assessment (%)	Increase per biennium, (US\$ million)	% of base budget 2022–2023
2022–2023	956.9	–	–	22
2024–2025	1 148.3	20	191.4	26
2026–2027	1 060.0	20	-88.3	24
2028–2029	1 355.0	25	265.0	30
2030–2031	1 628.8	27	357.8	39

At risk if increase is not approved

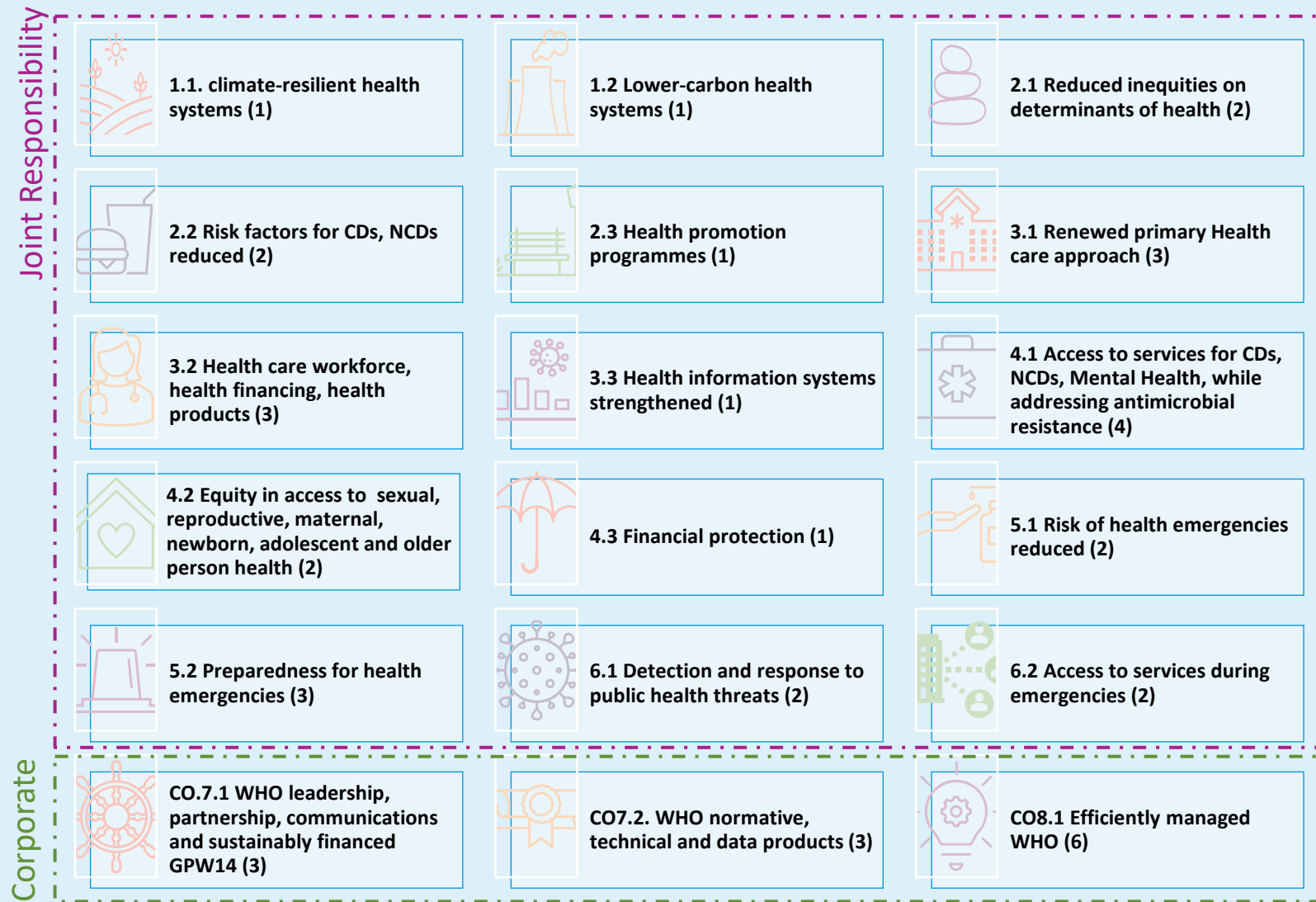


Update on indicators and other programmatic content

Results Framework of PB 2026-2027

- Builds on GPW 14 Outcomes and organization of results
 - 15 Joint outcomes
 - 30 outputs
 - 3 Corporate outcomes
 - 12 outputs
- Output development addresses identified gaps and seeks for more transparent alignment between outcomes and outputs
- Output scopes standardized, presented by WHO core function
- Work on indicators ongoing in preparation for WHA78

PB 2026-2027: Outcomes with number of draft outputs in (#)*



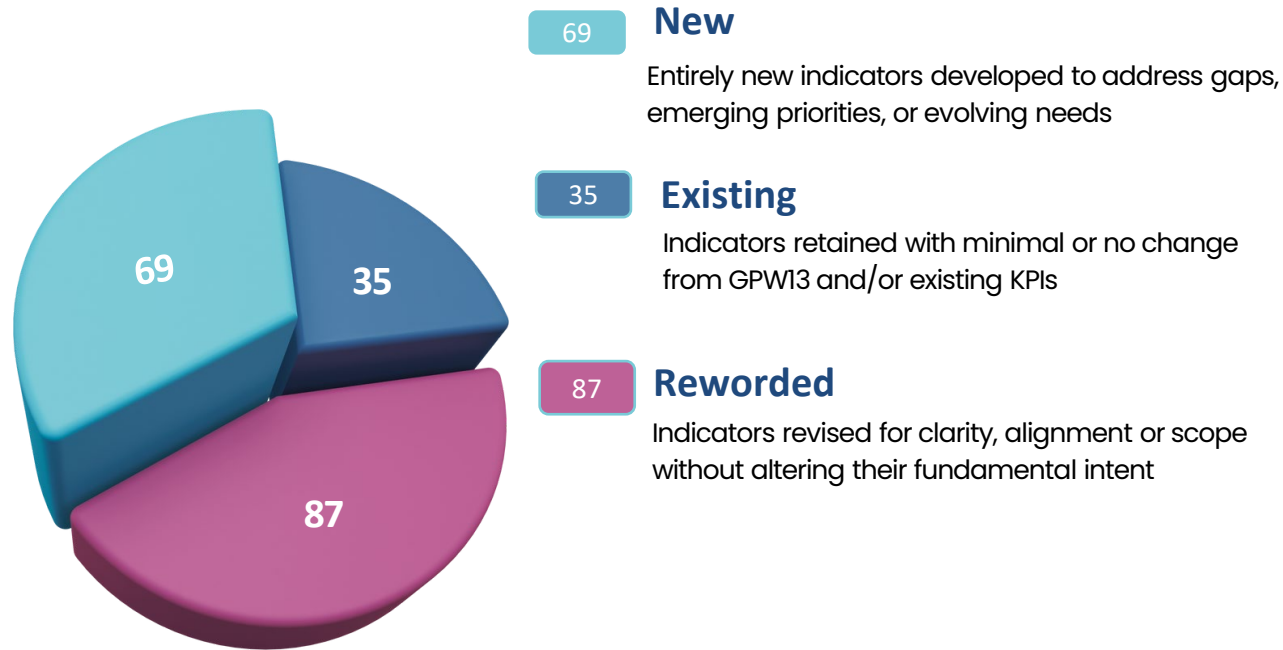
*Names abbreviated for illustration purposes

Update on indicators

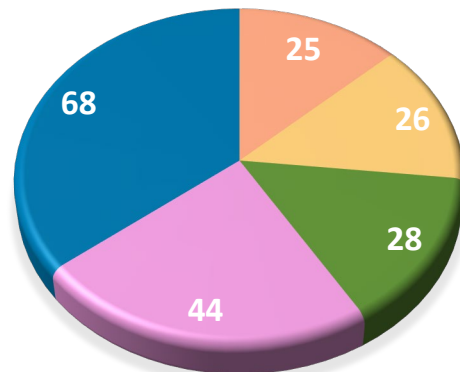
Proposed programmatic / outcome indicators

	PROMOTE (HPOP)	PROVIDE (UHC)	PROTECT (HEP)
GPW 13 46 indicators	20	22	4
GPW 14 96 indicators	29	58	9

Status to date on output indicators



- Perform
- Power
- Promote
- Protect
- Provide



- Output indicators demonstrate how the WHO Secretariat contributes to health outcomes and impact.
- After review/refinement of over 1000 indicators based on specific criteria (data availability, link to outcome, WHO's added value), followed by 3-L consultations, there are **191** proposed output indicators.
- **This is still a long list.** The objective is to have **1-3 indicators per output** (with some flexibility).
- Dedicated consultations with all WCOs to assess country relevance.
- Some of the output indicators will gather the data needed to report on **WHO Investment Case commitments**.
- **MS / WCO feedback so far:**
 - **Concerns about the high number** – need to focus on what is most relevant, and where WHO adds most value.
 - Concerns about **duplication, measurability, scope**.
 - **MS welcome strengthening the results chain, by linking output and outcome indicators.**

Linking Output Indicators to Outcome Indicators



Enhanced accountability: demonstrate Secretariat's contribution to support health outcomes

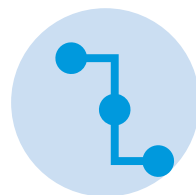


Improve outcome measurements: establish structure to track progress

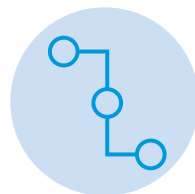


Optimize resource allocation: effective use of limited resources by prioritizing and identifying interventions with the most direct impact to improve health outcomes

Mapping outcome and output indicators to determine links



Direct link: A clear relationship where the output **directly influences** the outcome. It is expected to lead to measurable change either in the **short term** (during the timeframe of GPW14) or over a **longer** period.



Indirect link: A supportive relationship where the output contributes to **enabling conditions** that, combined with other factors, support the outcome over time.

Mapping output/outcome indicators

Mapping status	Number of output indicators
Mapped to an outcome indicator	139
Not applicable (Power and Perform)	51
Not mapped	1

Breakdown of mapped output indicators (by type of link)

Type of link	Number of output indicators
Direct and Indirect	27
Only direct	77
Only indirect	35

Challenges and limitations



Complexity of attribution: health outcomes are often influenced by factors beyond WHO's control



Contextual variability: linkages vary across health systems, populations, and settings, limit universal applicability



Time lag: many health outcomes, such as chronic conditions, may take years to manifest.



Definitions: distinguishing 'direct' and 'indirect' often requires judgment, introducing potential bias and variability

Next steps for the EB and the WHA

At the Executive Board

- Proposed outcome indicators, with available baselines and targets,
- Proposed output indicators (long list)
- will be available on the [Programme Budget 2026–2027 Digital Platform](#) website by 24 January 2025

At the World Health Assembly

- Final list of outcome and output indicators, with baselines and targets, will be presented to the WHA in May 2025, as a part of PB 2026-27

The “long list” of output indicators to be presented to the EB will include:

- **“Recommended” following three rounds of review + consultations**
- **“TBD” to be further discussed / refined between the EB/WHA.**

We request feedback from MS on:

- **Which proposed indicators are the most relevant?**
- **Are there any gaps?**

Questions for Member States

- Is proposed budget agreeable, including areas to be strengthened?
- Have Member States identified any programmatic issue (i.e. duplication, inconsistency, gap) that the Secretariat must deal with between now and WHA?
- Any initial feedback on proposed simplified reporting focusing on indicators, and outcome/output indicator linkages?
- Is the proposed AC increased supported?
- Is impact of non-approval of AC increase clearly explained? What else should be de-prioritized by the Secretariat?

Thank you!



World Health
Organization



GPW14 outcomes and number of draft outputs within

Outcome text	# Out puts
Joint outcome 1.1. More climate-resilient health systems are addressing health risks and impacts	1
Joint outcome 1.2. Lower-carbon health systems and societies are contributing to health and well-being	1
Joint outcome 2.1. Health inequities reduced by acting on social, economic, environmental and other determinants of health	2
Joint outcome 2.2. Priority risk factors for noncommunicable and communicable diseases, violence and injury, and poor nutrition reduced through multisectoral approaches	2
Joint outcome 2.3. Populations empowered to control their health through health promotion programmes and community involvement in decision-making	1
Joint outcome 3.1. The primary health care approach renewed and strengthened to accelerate universal health coverage	3
Joint outcome 3.2. Health and care workforce, health financing and access to quality-assured health products substantially improved	3
Joint outcome 3.3. Health information systems strengthened, and digital transformation implemented	1
Joint outcome 4.1. Equity in access to quality services improved for noncommunicable diseases, mental health conditions and communicable diseases, while addressing antimicrobial resistance	4
Joint outcome 4.2. Equity in access to sexual, reproductive, maternal, newborn, child, adolescent and older person health and nutrition services and immunization coverage improved	2
Joint outcome 4.3. Financial protection improved by reducing financial barriers and out-of-pocket health expenditures, especially for the most vulnerable	1
Joint outcome 5.1. Risks of health emergencies from all hazards reduced and impact mitigated	2
Joint outcome 5.2. Preparedness, readiness and resilience for health emergencies enhanced	3
Joint outcome 6.1. Detection of and response to acute public health threats is rapid and effective	2
Joint outcome 6.2. Access to essential health services during emergencies is sustained and equitable	2
Corporate outcome 1: Effective WHO health leadership through convening, agenda-setting, partnerships and communications advances the draft GPW 14 outcomes and the goal of leaving no one behind	2
Corporate outcome 2: Timely delivery, expanded access and uptake of high-quality WHO normative, technical and data products enable health impact at country level	3
Corporate outcome 3 : A sustainably financed and efficiently managed WHO with strong oversight and accountability and strengthened country capacities better enables its workforce, partners and Member States to deliver the draft GPW 14 outcomes	7

Overview of US funding

Top 10 contributors to the programme budget

2016-2017

2018-2019

2020-2021

2022-2023

2024-2025 YTD

