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Draft Proposed programme budget 2024–2025

Contents

INTRODUCTION

1. Shaped at a turbulent time, with the world recovering from the pandemic of coronavirus disease (COVID-19) – the most devastating health crisis in living memory – the draft Proposed programme budget 2024–2025 is both unique and historic. It is unique in reflecting a new approach in response to the pandemic, together with a greater country focus than ever before, more efficient features and a new presentation format. It is also historic in benefitting from an increase in assessed contributions, after several decades without change, which marks a radical shift that paves the way towards a more sustainably financed Organization.

2. Significantly, Member States have played an increased role in shaping the budget through a greater consultative and participatory process, which has resulted in strengthening priority-setting and a country focus, as well as steps to enhance transparency, accountability and efficiency.

3. Recognizing the urgent need for countries to speed up recovery from the pandemic and build resilient health systems that protect against future health challenges and advance progress on global priorities, the draft Proposed programme budget 2024–2025 has three main overarching objectives:

- strengthen country capacity to accelerate progress towards the triple billion targets;
- continue the work defined by the recent revision of the Programme budget 2022–2023;
- further strengthen accountability and transparency, incorporating guidance from the Agile Member States Task Group on strengthening WHO's budgetary, programmatic and financing governance.

FOCUS ON THE TRIPLE BILLION TARGETS

4. Central to the draft Proposed programme budget 2024–2025 are the triple billion targets, which remain more important than ever to drive progress in health. Aligned with the Sustainable Development Goals, the targets aim to deliver:

- 1 billion more people benefiting from universal health coverage (Billion 1);
- 1 billion more people better protected from health emergencies (Billion 2);
- 1 billion more people living with better health and well-being (Billion 3).

5. The targets were anchored in the Thirteenth General Programme of Work 2019–2023, now extended for two years (GPW 13). The extension offers an opportunity to pick up the pace on the suboptimal progress made towards the triple billion targets, apply the lessons of the pandemic and intensify investments to countries, while also providing a measure of continuity and stability. Progress will be tracked with the same results and indicator framework as that of the GPW 13.

6. Given the enormity of the task ahead, heightened action is needed to galvanize progress. WHO has outlined five priority areas to provide further focus on the triple billion targets. The draft Proposed programme budget 2024–2025 is aligned with these priorities, which aim to support countries to:

- promote health and well-being and prevent disease, by addressing root causes and creating conditions for good health through multisectoral collaboration;
- provide health through a radical reorientation of health systems towards primary health care as the foundation of universal health coverage;
- protect health by strengthening the global architecture for health emergency preparedness and response, with relevant systems and tools, as well as strong governance and financing;
- power health through science, research, innovation, data, delivery, digital technologies and partnerships as critical enablers of the other priorities; and
- perform and partner for health by building a stronger WHO that delivers results and is reinforced in its role as the world's leading health authority.

7. While keeping the directions of the GPW 13 and the five priorities at its core, the draft Proposed programme budget 2024–2025 was strongly shaped by the use of both epidemiological data and evidence (delivery-for-impact approach), as well as the increased engagement of Member States, partners and stakeholders to identify country priorities and needs. While strongly anchored in bottom-up country prioritization, the draft Proposed programme budget 2024–2025 has begun to implement the delivery-for-impact approach, which establishes acceleration scenarios for the triple billion targets and related indicators, based on Member States' priorities, and identifies the resources needed for the acceleration and rigorous execution of implementation and tracking of high-impact solutions.

8. The robust prioritization process was a fundamental feature of the budget development, based on the principle that WHO should invest its limited capacities and resources in areas where it can maximize impact to progress towards the triple billion targets. A bottom-up process was employed, starting at the country level, to ensure maximum alignment with the country situation and priorities, guided by global and regional directions and the use of credible data and evidence, while recognizing where WHO provides most value. This approach serves a key aim of the draft Proposed programme budget 2024–2025 in order to strengthen country capacity to drive progress towards the triple billion targets. Accordingly, half the base budget is allocated to countries – a significant first for a programme budget.

BUILDING ON PROGRAMME REVISION AND INCORPORATING LESSONS LEARNED

9. Given that there are important lessons for WHO to learn from a crisis of the magnitude of the COVID-19 pandemic, many independent reviews were conducted, resulting in almost 300 recommendations on how WHO can support Member States more effectively and strengthen transparency and accountability. The recommendations identified several key areas for revision, such as the global health architecture and governance, and the sustainable financing of WHO. In addition, the revision also foresaw a need to intensify support for countries in order to advance universal health coverage and health promotion and well-being, with linkages to health security.

10. The severe disruptions of many essential health services triggered by the pandemic highlighted the need to build resilience, which is behind WHO's radical pivot towards strengthening primary health care on the way towards universal health coverage. Another element incorporated into the draft Proposed programme budget 2024–2025 is an intensified focus on the health workforce, given the strains and inequalities witnessed during the pandemic. The COVID-19 pandemic also revealed the need to drastically improve the global architecture for health emergencies, preparedness, resilience and response, which is being taken forward as a priority. Similarly, given the dramatic changes in the global health environment, with health playing a more central role as a precondition for development and the pandemic demonstrating the dangers of neglecting the environmental, social and economic drivers of health, there is an intentional pivot towards prevention rather than cure.

11. A special element also contained in the revision was to continue strengthening the Organization's capacity in the prevention of and response to sexual exploitation, abuse and harassment (PRSEAH) and to reinforce a culture of zero tolerance for sexual misconduct.

12. Based on the evidence and inputs from a bottom-up priority-setting process, the draft Proposed programme budget 2024–2025 has considered the revised Programme budget 2022–2023 to realign and integrate budget focusing on country needs.

SUSTAINABLE FINANCING

13. The pandemic highlighted WHO's longstanding challenge of sustainable financing. The Organization's ability to make an impact is limited by a funding model in which only 14% of WHO's funding is fully flexible and predictable (while the remaining funds are dependent on generous donors, heavily earmarked and arrive at

unpredictable times). In May 2022, Member States made a landmark decision[1] to gradually increase assessed contributions in order to eventually represent 50% of the base programme budget by 2030–2031 at the latest.

14. The draft Proposed programme budget 2024–2025 benefits from this decision – it has been developed on the expectation of a 20% increase of assessed contributions (from the approved levels of 2022–2023), marking a historic move towards a more empowered and independent WHO. This development reflects the increased trust in WHO to serve its Member States.

15. The Secretariat recognizes that this increased trust requires further strengthening accountability and transparency. It has submitted an implementation plan on reform to strengthen budgetary, programmatic and finance governance – with timelines and deliverables – for consideration by the Executive Board at its 152nd session.[2] The plan was shaped by inputs from Member States, including through the Agile Member State Task Group.

16. Also notable is that the draft Proposed programme budget 2024–2025 foresees no increase despite rising inflation, reflecting the concerted commitment of the Secretariat to ongoing improvements in efficiencies and managing within existing means.

IMPROVED AND EFFICIENT FORMAT

17. The Secretariat's commitment to greater accountability, transparency and efficiency is also reflected in other facets of the draft Proposed programme budget 2024–2025. One facet is that it is risk-informed. Consideration is given to uncertainties – that is, risks – with the prioritization of mitigation actions to maintain levels of risk to an acceptable degree.

18. Another facet is the transformed presentation format of the draft Proposed programme budget 2024–2025, which attempts to accomplish the seemingly impossible task of being more concise while providing more detailed information. This was to serve varying requests from policy-makers and is achieved by having a shortened document and consigning specific details and further information to a user-friendly web platform. Comprehensive information on past performance, past expenditures, prioritization by countries, indicators, costing of outputs and more are provided on a dynamic platform that includes interactive dashboards.

19. Lastly, it should be noted that the draft Proposed programme budget 2024–2025 will be revised by the Secretariat following discussions by the Executive Board, prior to its submission for consideration by the Seventy-sixth World Health Assembly.

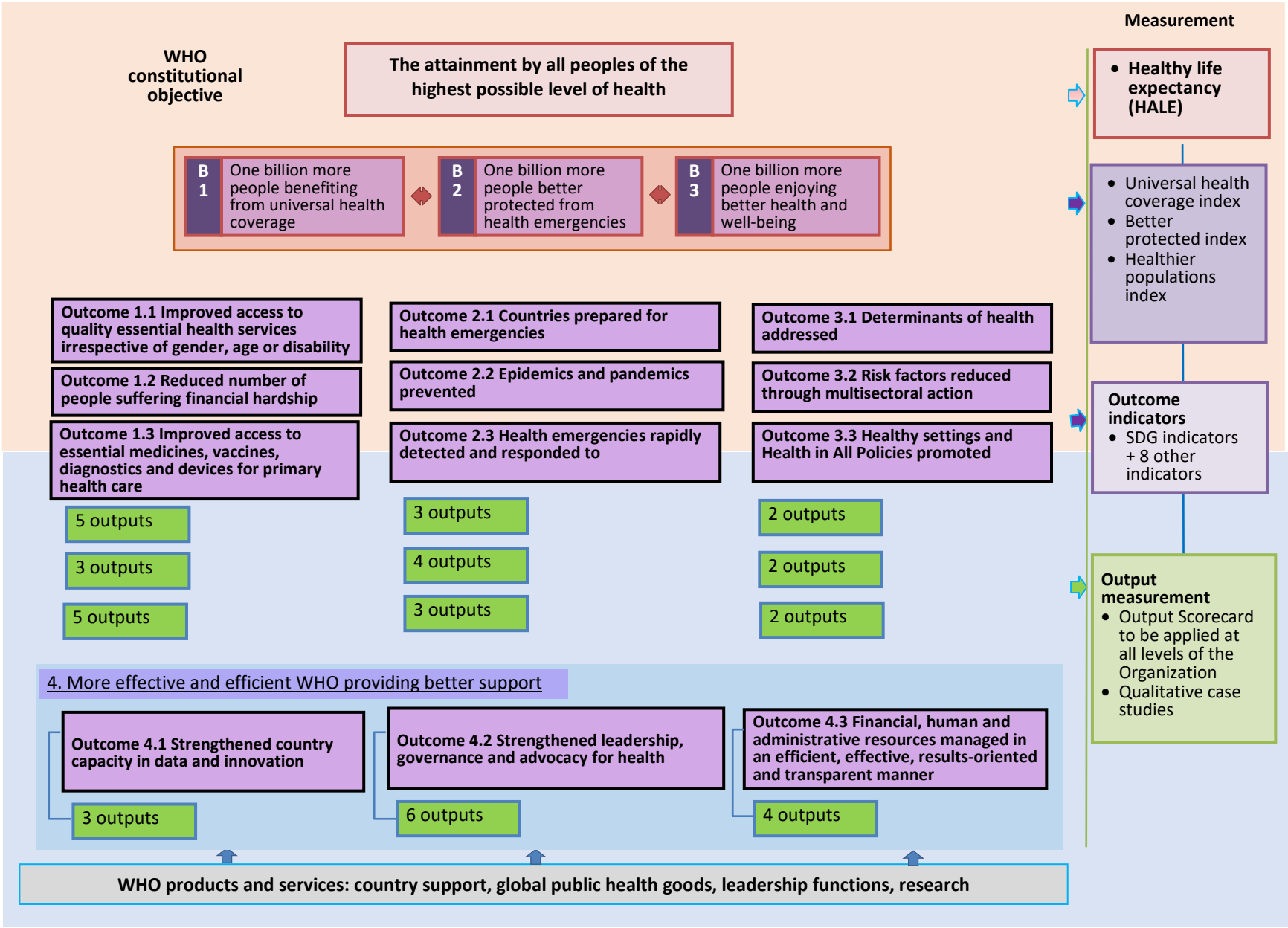
[1] Decision WHA75(8) (2022).

[2] Document EB152/34.

THE RESULTS FRAMEWORK: A TOOL FOR IMPACT AND ACCOUNTABILITY

20. The draft Proposed programme budget 2024–2025 maintains the same results framework used for reporting on GPW 13 since 2019 in order to track results on the 12 outcomes and 42 outputs (Fig. 1). More details are provided in the Annex to this document.

Fig. 1. Results framework of the GPW 13



21. The integrated results framework (Fig. 1) serves as an organizing frame for programmatic work and budgeting and also reflects the interconnected nature for the triple billion targets envisaged by the GPW 13 and reinforced by the reality of the COVID-19 pandemic.

22. The framework demonstrates the pathway through which the Secretariat's outputs will lead to eventual impacts. It clearly articulates what specific results will be measured and what measurement criteria will be used:

(1) an impact measurement system for tracking progress on the triple billion targets and 46 outcome indicators (39 of which are health-related Sustainable Development Goals);

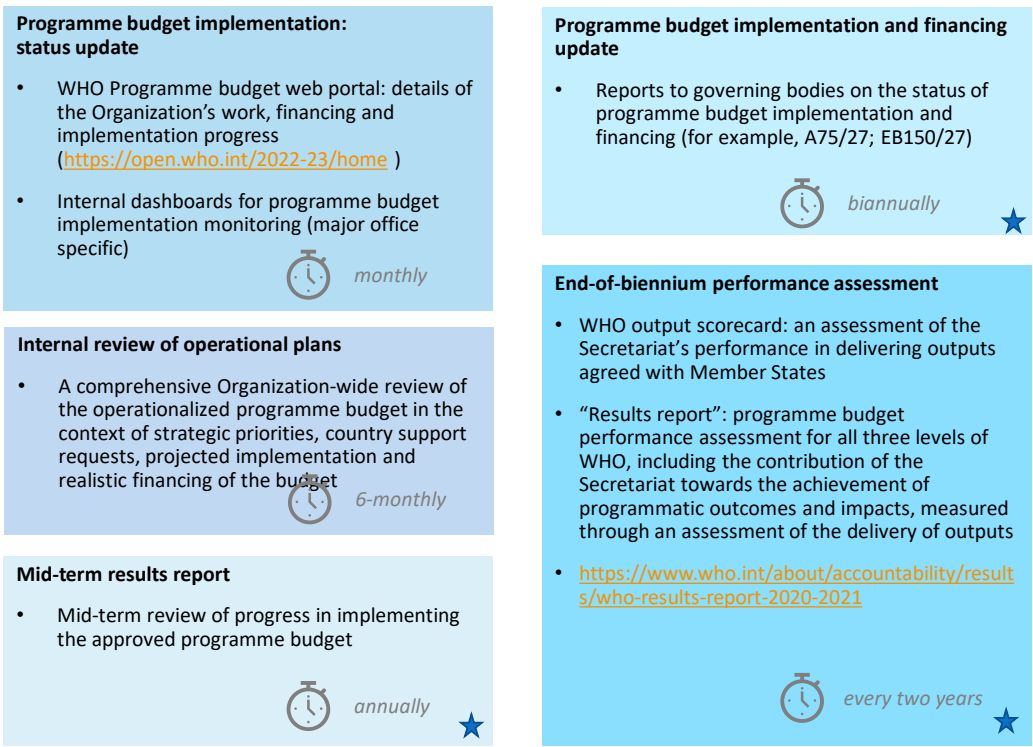
(2) an output scorecard; and

(3) qualitative country case studies.

23. Monitoring and assessment are essential for the proper management of the programme budget and to guide necessary revisions to policies and programmes. WHO will continue to monitor, assess and report on programme budget implementation, in line with the results framework described above.

24. The monitoring and assessment of programme budget implementation will be conducted through the mechanisms outlined in Figure 2 and in alignment with the Organization's results-based management approach in order to ensure transparency and accountability for results.

Fig. 2. Overview of programme budget monitoring and assessment mechanisms[1]



[1] A star indicates a governing bodies document.

PRIORITY-SETTING FOR THE DRAFT PROPOSED PROGRAMME BUDGET 2024–2025: RESULTS AND IMPLICATIONS

25. A strengthened approach to priority-setting is an integral part of the draft Proposed programme budget 2024–2025. While priority-setting has always been a feature of programme budgets, the process in this case was more systematic, refined and data driven. A more prioritized approach is essential to ensure that WHO invests its limited resources in areas of potential maximum impact and also contributes towards better governance and transparency.

26. The iterative approach applied – starting at the country level and engaging Member States and partners – maintained a focus on delivering impact in countries, thus reinforcing the GPW 13 aim to achieve measurable impact on people's health in all countries.

27. The use of credible, actionable data – including data analyses of country-level trends – together with indicators within the triple billion framework identified a number of areas of concentration on which to focus efforts to accelerate progress. This process informed priority-setting for the draft Proposed programme budget 2024–2025. The areas of concentration are presented below under each strategic priority and the fourth enabling pillar.

Strategic priority 1: One billion more people benefiting from universal health coverage

28. Considering the setbacks from the COVID-19 pandemic, the world will be 770 million short of the target of one billion more people benefiting from universal health coverage (Billion 1) by 2025. With an unaltered trajectory, the rate of progress is less than one quarter of the pace needed to reach the Sustainable Development Goal target by 2030. At a time when the world is facing multiple political, economic, social and environmental challenges, such as war, famine, the existential threat of climate change and economic recession, a more targeted approach is needed in the next two years to reverse the downward trend in progress towards Billion 1 and to move towards the equitable and resilient recovery of the health systems.

29. With limited resources and only two years ahead, moving towards the target requires a strategic approach, matched with the most effective solutions for each country guided by data and evidence, as well as a clear priority-setting. Initial estimates show that by prioritizing areas that have the largest gaps and the highest potential for impact, there is a potential to double the progress by 2025, with approximately 390 million more people likely to benefit from universal health coverage.

30. With 92 countries experiencing little change or worsened financial hardship in the past two decades and more people falling into poverty, financial protection is a critical element for achieving Billion 1. To make measurable improvements, the Secretariat will provide targeted support to countries to develop their capacity to monitor and produce actionable evidence on gaps in coverage, including by providing context-specific policy recommendations and delivering evidence-based interventions and best practices for universal health coverage. By providing intensive health financing support to 25 countries among the 92 countries whose progress has stalled or is trending negatively during this biennium, WHO can help accelerate progress towards Billion 1.

31. Evidence shows that by prioritizing high-impact service delivery interventions, such as childhood immunization, HIV treatment, tuberculosis and high blood pressure control, the gap in meeting the Billion 1 can be reduced by half. These are the essential services that have been most heavily impacted by the disruptions caused by the COVID-19 pandemic. To reverse this negative trajectory, the Secretariat will focus its efforts to help build community resilience and take multisectoral approaches to addressing the drivers of the disease burden. For instance, for childhood immunization, reducing the number of zero dose and under-immunized children will be the key priority. Similarly, for tuberculosis, focusing on the high-burden countries that account for almost 90% of the new tuberculosis cases will drive impact. To manage high blood pressure, which kills more people than all infectious diseases combined, interventions will be aimed at scaling up the high blood pressure control programme, initially implemented in 18 countries.

32. Prioritizing specific disease areas will not be sufficient without a radical reorientation of health systems towards primary health care, which will drive progress towards all of the triple billion targets. In fact, 90% of essential universal health coverage interventions can be delivered through primary health care, while 75% of the projected health gains from the Sustainable Development Goals could be achieved through primary health care, which provides the foundation upon which countries can build equitable and resilient health systems to deliver quality, affordable health services to everyone, especially the most vulnerable. Building on its Special Programme on Primary Health Care and the Universal Health Coverage Partnership, with 115 policy advisories embedded in country offices, the Secretariat will provide intensive support to low- and lower-middle income countries. In tandem, the Secretariat will step up its global leadership for impact by developing a compelling investment case for primary health care, in partnership with international institutions and investment partners. This will include strengthened advocacy for domestic investments in primary health care as a key priority, supporting countries to implement core guidance on essential universal health care interventions and developing a framework to address antimicrobial resistance through a core set of primary health care interventions.

33. The pandemic has exposed acute systemic gaps in the health workforce, which need to be urgently addressed as a cross-cutting element to make progress towards all the triple-billion targets. The insufficient availability of the health workforce was the leading cause for health service disruptions during the COVID-19 pandemic, with glaring inequalities across the WHO regions. The current density and distribution of the health workforce is not sufficient to achieve Billion 1. A 35% reduction of the shortage in the health workforce is needed by 2025 to be on track for the Sustainable Development Goal Target. To achieve this, the Secretariat will provide support to selected countries to develop a road map for action and investment plans to strengthen health and care workforce investments to improve workforce availability; improve occupational health and safety measures to protect the lives of health workers; and strengthen national workforce capacity to implement essential public health functions, emergency preparedness and response. Addressing gender gaps in the health and care workforce will be a specific area of focus. The WHO Academy will continue to play a key role in designing learning programmes to build country capacity. In addition, the Secretariat will step up its efforts to support countries to seamlessly integrate the core functions and capacities of the polio eradication programme into broader public health, so that the knowledge, skills and infrastructure set up to eradicate polio are successfully transitioned to strengthen disease detection, immunization and primary health care.

34. All actions towards the Billion 1 will require a targeted approach, driven by evidence and aligned with country priorities. As explained in detail in this document in the section entitled “Results and strategic significance of priority-setting,” the Secretariat’s interventions are guided by the bottom-up priority-setting, which is the foundation of the development of the draft Proposed programme budget 2024–2025, starting at the country level to ensure maximum alignment with country situations and priorities, supported by available credible data, evidence and trends and focusing on areas in which WHO’s added value is recognized. This will include a more proactive discussion with Member States on the development of the technical products to better align them with country priorities. For country support, scaling up innovations in areas working with the WHO Innovation Hub, such as primary health care, mental health, noncommunicable diseases, women and children’s health and reproductive health, will be prioritized. The Secretariat will also intensify efforts to foster integration across programmes, by demonstrating the benefits of integrated platforms in selected countries that are lagging furthest behind on progress towards universal health coverage, which will then be expanded to more countries in 2024–2025.

35. All the interventions towards universal health coverage will have a strong equity focus on reducing the gap both between and within countries. While pursuing the principle of leaving no one behind, the Secretariat will enhance its focus on the least-served, most marginalized populations, including migrants and refugees and internally displaced people, sexual and gender minorities and people who experience racism, ethnic minorities, and indigenous groups and people with disabilities.

36. Only by scaling up high-impact interventions and focusing on cross-cutting levers, such as primary health care and health workforce and prioritizing equity, will it be possible to reverse the downward trend towards achieving Billion 1 within the next two years and move towards the equitable and resilient recovery of the health

systems. Progress will continue to be monitored through the WHO results framework, which will include improved measurements such as proposed new indicators and an improved universal health coverage index.

Strategic priority 2: One billion more people better protected from health emergencies

37. Despite the progress made in some areas, countries will need support to accelerate actions to achieve the target of protecting one billion more people better protected from health emergencies (Billion 2) by 2025 and to address the significant gaps revealed by the COVID-19 pandemic.

38. There has been progress at the national and global levels in protecting people from health emergencies; however, urgent actions are needed to address the shortcomings exposed by the COVID-19 pandemic and to support countries in strengthening priority areas. WHO will continue to support countries to recover from the impact of COVID-19 and to accelerate progress in key areas based on the lessons learned. Targeted actions, tools and mechanisms that will enable countries to better prepare for, prevent, detect and respond to health emergencies are being strengthened and implemented with Member States and partners.

39. While health emergency preparedness has reportedly increased[1] in many countries since 2018, the need to improve assessment methods and better support countries to strengthen preparedness is paramount. Components of the International Health Regulations (2005) monitoring and evaluation framework will be updated according to the recommendations of the Review Committee regarding amendments to the International Health Regulations (2005). The establishment of more dynamic, holistic and predictive measures of preparedness, including a focus on the animal–human–environment interface, as well as the scale-up of risk and vulnerability analyses, will complement the updates to the monitoring and evaluation framework. The joint development of the Universal Health and Preparedness Review mechanism with Member States, as well as efforts to operationalize, finance and accelerate the implementation of national action plans for health security, will support countries to strengthen health emergency preparedness.

40. Activities, strategies and tools that enable countries and communities to prevent health emergencies continue to be significantly affected by the COVID-19 pandemic. There is an opportunity to build on the successes of mechanisms built in response to it, such as the Access to COVID-19 Tools Accelerator (ACT-A), in order to strengthen global systems that will catalyse the rapid development of medical countermeasures in response to emerging infectious threats and ensure their equitable and effective distribution prior to and during health emergencies. WHO will accelerate the implementation of disease-focused strategies for known high-priority pathogens, with a focus on high-risk countries in fragile, conflict-affected and vulnerable settings. This includes both implementing the existing global strategies for yellow fever, meningitis and cholera and developing a series of new global end-to-end strategies, through partnerships that build on the work carried out through the research and development blueprint for priority diseases/WHO R&D Blueprint for Epidemics. WHO will intensify support to Member States to strengthen infection prevention and control and clinical management, which are crucial for preventing and responding to health emergencies. The protection of communities from health emergencies will require the scale-up of risk communication and infodemic management capabilities and tools and increase the focus on engaging multisectoral partnerships with communities at the centre.

41. While there is evidence that countries have improved the timeliness of detection, notification and response to health emergencies,[2] the COVID-19 pandemic demonstrated weaknesses in how countries detect, monitor and manage public health threats. Some critical public health functions, such as surveillance, were strengthened; these gains and investments need to be sustained and expanded to cover an increasing number of emergencies. WHO will continue to strengthen its systems, tools and networks for early warning, alert and

[1] Average State Party Self-Assessment Annual Reporting (SPAR) scores increased in four WHO regions between 2018 and 2021.

[2] All WHO regions reported a decrease in the average number of days between event onset and response as per events reported through the Event Information Site for National International Health Regulations (2005) Focal Points, starting in 2018.

rapid response for the verification of potential threats to public health. The new Centre for Epidemic and Pandemic Intelligence will help to accelerate these developments and will support countries, regional and global actors to address future pandemic and epidemic risks by providing better access to data, better analytical capacities, and better tools and insights for decision-making. Scaling up the health emergency workforce, especially at national level and with a focus on training and coordination, as well as continuing to build the emergency global supply chain system, will be crucial for bolstering health emergency response, management and coordination at all levels. While continuing to strengthen the Organization's capacity to prepare for and respond to health emergencies, WHO will accelerate the application of its gender mainstreaming strategy to address the impact of health emergencies on gender equality, together with an active focus on PRSEAH in the context of health emergencies. WHO will prioritize working with Member States and key partners to protect and support the health needs of vulnerable populations in fragile and conflict-affected settings who are disproportionately affected by health emergencies, seeking stronger collaboration to maximize shrinking resources in the context of increasing needs.

42. There is a widespread recognition that health emergency preparedness, response and resilience (HEPR) must be drastically improved. The next two years present an unmissable opportunity to capitalize on the existing momentum and investments to collectively strengthen the global HEPR architecture. The WHO Director-General's 10 proposals[1] provide an overarching framework and vision for how to improve coherence, enhance coordination and strengthen the required capabilities. The HEPR framework is closely aligned with the priority areas for Billion 2 contained in the draft Proposed programme budget 2024–2025; resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies; the revised Programme budget 2022–2023;[2] and the priorities outlined in the report of the Director-General on extending the GPW 13.[3]

43. Many of the proposals are designed to build on, complement and strengthen the existing frameworks and capacities established in response to previous crises in order to strengthen the bonds between global health partners and bring collaboration and standardization to stronger HEPR systems. Accordingly, the proposals are grouped by the three main pillars of the global HEPR architecture: governance, systems and financing, and are based on three key principles, as follows.

- They must promote equity, with no one left behind – equity is both a principle and a goal, to protect the most vulnerable.
- They should promote an HEPR architecture that is inclusive, with the engagement and ownership of all countries, communities and stakeholders from across the One Health spectrum. Commitment to diversity, equity and inclusivity is key to effective HEPR at all levels, including equal participation in leadership and decision-making, regardless of gender.
- They must promote coherence, reducing fragmentation, competition and duplication; be totally aligned with existing international instruments, such as the International Health Regulations (2005) and the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits; ensure synergy between institutional capabilities for systems strengthening and financing; and promote the integration of HEPR capacities into national health and social systems based on universal health coverage and primary health care.

44. Strengthening the global HEPR architecture and WHO's role within it will be a part of the broader effort towards the health-related Sustainable Development Goals. A renewed global architecture for HEPR must be built on a foundation of strong national health systems that are deeply connected with and accountable to the communities they serve and that advance gender equity and human rights.

[1] 10 proposals to build a safer world together – Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience: draft for consultation. Available at: https://www.who.int/publications/m/item/10-proposals-to-build-a-safer-world-together---strengthening-the-global-architecture-for-health-emergency-preparedness--response-andresilience--white-paper-for-consultation--june-2022

[2] See resolution WHA75.5 (2022).

[3] Document EB150/29.

Strategic priority 3: One billion more people enjoying better health and well-being

45. The target of one billion more people enjoying better health and well-being (Billion 3) is likely to be reached by 2025, but current progress is about one quarter of what will be required to reach the health-related Sustainable Development Goals by 2030. Many indicators used to track Billion 3 show that progress is either lagging behind or is being reversed. Widening inequities within and among countries need urgent attention. Many of the interventions needed to accelerate progress towards Billion 3 and the health-related Sustainable Development Goals require dedicated attention, strong advocacy and multisectoral collaboration. All these factors require an urgent paradigm shift towards promoting health and well-being and preventing disease by addressing its root causes.

46. By focusing on the leading risk factors or causes of premature mortality and morbidity, an estimated 2 billion more people can lead healthier lives by 2025. This will not only accelerate progress towards the Sustainable Development Goals, but also make measurable impacts on people's health. Therefore, tackling the key root causes, such as tobacco use, obesity, road traffic injuries, air pollution and climate change, together with the environmental, social and commercial determinants of health, will be the priority in the next two years.

47. Despite much progress over the last decade, tobacco use remains the world's leading cause of death, illness and impoverishment, killing 8 million people every year. Some 80% of the world's tobacco users live in low- and middle-income countries. Evidence shows that thanks to WHO's leadership, a clear prioritization and an evidence-based technical package, tobacco prevalence may steadily decrease. Two thirds of the trajectory needed to close the gap in achieving Billion 3 can be achieved by providing targeted support to the countries with the highest prevalence. The Secretariat will focus its support on areas in which control measures could change the overall trajectory.

48. Unless urgent action is taken to reduce the prevalence of overweight and obesity, about 167 million people are expected to be less healthy by 2025. Through the implementation of the Obesity Accelerated Action Plan, the Secretariat will intensify its technical, delivery and political support for high-burden countries to stop the rise in obesity rates by 2025. Examples of this work include empowering countries to implement taxes on sugar-sweetened beverages, regulate front-of-pack warning labels, eliminate artificial trans-fats and integrate mitigating obesity into primary health care services. In addition to this package of proven interventions, the Secretariat will assist countries to scale up innovations, such as through remote coaching or health insurance incentives to drive behavioural changes that can help accelerate progress. In parallel, to improve diet and nutrition and ensure food safety, the Secretariat will advocate for a profound transformation of the production and consumption of food in order to improve people's health and minimize negative impacts, while reducing the impact of antimicrobial resistance and preventing environmental impacts and the spread of food and vector-borne and zoonotic diseases.

49. The world is not on track to achieve the Decade of Action for Road Safety target to reduce road traffic deaths and injuries by 50% by 2030, with more than 1.3 million deaths attributed every year to road traffic accidents, which are the leading cause of death for children and young adults. The Secretariat will prioritize interventions that can reverse this trajectory by 2025 by supporting countries to reach their voluntary targets on road safety in the five core action areas: developing national strategies; drafting and implementing relevant legislation and policies; strengthening data systems; strengthening post-crash response and emergency care; and mobilizing resources, including through intersectoral coordination.

50. A dedicated and multisectoral approach is needed to reduce air pollution, enhance safe drinking water, sanitation and hygiene practices, and accelerate the use of clean fuels to attain healthy environments and mitigate the negative impact of climate change. The Secretariat will strengthen its advocacy to build the public health case to reduce the 7 million deaths per year from cancer, cardiovascular and respiratory diseases that are currently caused by indoor and outdoor air pollution, and will support the necessary global shift towards clean energy to protect health and develop a health argument for action on climate change. To that end, the Secretariat will promote WHO air quality standards, produce guidance on assessing interventions to improve air quality, and raise awareness and increase capacity to improve air quality and other environmental factors in targeted countries by 2025. To stabilize and reduce carbon emissions from the global health care sector on a

path to halve emissions by 2030, the Secretariat will accelerate work through the Healthy Energy Platform of Action, to scale up investments in renewable energy for households and health care facilities.

51. The pandemic has underscored the need to tackle the environmental, social and commercial determinants of health across sectors, highlighting the role of health for peace and security. By taking clear positions linked to the priorities of communities, WHO will promote and champion the compelling narrative for a promotion of health and well-being agenda, with a focus on prevention and Health in All Policies. Country capacity will be strengthened to make measurable impact on the determinants of health. WHO platforms that focus on municipalities, workplaces and schools will be strengthened to shift the focus from treating diseases to championing health and well-being at all levels. To specifically tackle commercial determinants, WHO will engage with industry and civil society in order to reduce health-harming products and increase and promote healthy products and services and the well-being of employees. A key approach will be to build the case for investment in health; step up engagement with institutional investors, companies, regulators and other relevant actors; and support country-level capacity for effective private-sector engagement. In tandem, the Secretariat is developing a new global health for peace initiative, in consultation with Member States.[1]

52. Accelerating progress towards Billion 3 and the health-related Sustainable Development Goals will require a specific focus on targeted geographies. Only 2 % of the 430 million people who have become healthier in the last few years reside in low-income countries and significant progress can be driven by a small selection of countries. Countries with smaller populations that might be disproportionately affected by specific issues – such as the health effects of climate change on small island States – will require preferential support. To address the glaring inequities both across and within countries, the Secretariat's interventions will have a sharp equity focus.

53. As explained in detail in this document in the section entitled "Results and strategic significance of priority-setting," these focus areas are aligned with and guided by a strengthened approach to priority-setting, starting at the country level, to ensure maximum alignment with country situations and priorities, supported by available credible data, evidence and trends and focusing on areas in which WHO's added value is recognized. Technical products will be developed through a more institutionalized and agile process in order to better address emerging health situations and drive country impact. Scaling mature innovations in the management of risk factors, working with the WHO Innovation Hub, will be prioritized for country support, together with the application of behavioural insights. The Secretariat will also intensify efforts to promote integration and reduce fragmentation by demonstrating the benefits of integrated platforms in selected countries, which will then be expanded to more countries in 2024–2025. Progress towards this goal will continue to be measured by the healthy populations index, through the WHO Results Framework, with a particular focus on improving the measurement of equity.

Enabling pillar: More effective and efficient WHO providing better support to countries

54. In order to accelerate the achievement of its public health goals in an agile, efficient and effective manner, it is necessary that WHO strive for a supporting system that is modern, transparent, dynamic, visionary and also able to hold and demonstrate accountability. At the same time, the efforts of technical teams and the time spent must be oriented more towards achieving and demonstrating results at the global, regional and country levels and less towards the managerial and administrative processes that are inevitably required for achieving them.

55. The target of a more effective and efficient WHO providing better support to countries (pillar 4) has two main streams. The first, outward-looking and future-oriented stream will continue to seek to position WHO as a key player in shaping the global health architecture. WHO also serves as the custodian for the health-related Sustainable Development Goals. It needs to keep up with the latest research and also to anticipate developments, innovate, and provide rapid and robust advice on all public health issues. WHO norms and

[1] See document EB152/17.

standards are founded on cutting-edge scientific research, the collection of rigorous data and statistics and the maintenance of a strong evidence base, and are pivotal to the Organization's work to accelerate the achievement of the GPW 13 triple billion targets. At the same time, WHO aims to provide countries and regions with the most reliable advice, science and evidence that is currently available for decision-making in the area of public health. Given that countries have matured and developed their own systems, WHO needs to act as the global convener who facilitates the exchange of knowledge across its constituencies in real time.

56. But science and evidence need to be supported by strong and reliable national health information systems that are also capable of adapting to the latest technologies available. Member States continue calling for WHO to more proactively address data gaps by strengthening health information systems and setting global data governance and standards; reducing data fragmentation and making health data accessible; and building the capacity to deliver impact in countries. Digital health technologies have the potential to accelerate progress towards healthier societies and close inequality gaps. WHO will take advantage of the transformative, accelerating power of digital health technologies to accelerate the achievements of its impact goals.

57. The second, more inward-looking stream of pillar 4 aims to have a WHO that is fit for purpose to support WHO's efforts to achieve its ambitious public health agenda. All technical work that is delivered by the Organization would not be possible without enabling areas that support the work that is being done. Enabling functions also keep the Organization accountable, transparent, efficient and results-oriented.

58. In this inward-looking stream of the draft Proposed programme budget 2024–2025, the WHO Secretariat will continue investing in strengthening leadership, accountability, compliance and risk management, with a special focus on the Organization's capacity in PRSEAH, in line with the revised Programme budget 2022–2023. Investments of the approved budget revision for 2022–2023 (US$ 50 million) will continue enabling the Secretariat to deliver towards meeting WHO's goals of ensuring zero tolerance of sexual exploitation and abuse of the communities we serve, and of sexual harassment within our workforce, as well as zero tolerance of inaction against both. Concretely, investments will support:

- making the shift within the Organization towards a victim- and survivor-centred approach to addressing sexual exploitation, abuse and harassment;
- ensuring that all WHO personnel and implementing partners are aware of the imperative of practicing zero tolerance, are provided with the capacity to make zero tolerance a reality, and are accountable for the prevention of sexual exploitation, abuse and harassment and the response to any cases that might occur; and
- reforming the Organization's culture, overhauling its accountability functions and structures, revising its policy, and ensuring best practice for sexual exploitation, abuse and harassment.

59. The Secretariat will continue to enhance its capacity for conducting investigations into sexual exploitation and abuse, sexual harassment and abusive conduct, including its capacity for response to observations at the country level, particularly in austere operating environments. It will continuously strengthen a proactive investigative posture that takes a risk-based and data-driven approach to conducting investigative reviews involving all three levels of the Organization. Finally, in the context of the investigation of suspected misconduct involving allegations of offenses against people, it will (through the Office of Internal Oversight Services) revise policies and procedures and strengthen resources to improve the timeliness of the processing of cases in order to ensure prompt justice for those involved.

60. Further investments will be allocated to ensuring the sustainable impact of PRSEAH work across all accountability functions. The request of Member States is to ensure that the work on PRSEAH, in particular the PRSEAH management response plan, permeates all functions of the Organization in the future. The Organization will continue its focus on building a more respectful, inclusive and equitable workplace culture that everyone can be proud of by involving a diverse and representative group of the workforce and ensuring WHO's alignment with global initiatives on diversity, equity and inclusion, PRSEAH and the prevention of abusive conduct.

61. True to its commitment to finding, promoting and reporting on efficiencies, the Secretariat submitted its first report on operational efficiencies to the Seventy-fifth World Health Assembly,[1] including data collected using the methodology for efficiency reporting developed by the United Nations Sustainable Development Group, to which WHO fully aligned in 2021 and that will be used to report to the United Nations on a yearly basis. Looking ahead, the Secretariat is learning and improving the way it documents its cost savings and efficiency gains, while seeking to minimize the potential additional administrative burden this could create due to the manual tracking and reporting involved. The emphasis in the biennium 2024–2025 will be on reporting on a more exhaustive list of efficiency initiatives across the three levels of the Organization, while incorporating reporting needs in the new Business Management System, which will improve the automatization of reporting in the coming years.

62. Actions related to progress towards implementing budgetary, programmatic, finance, governance and accountability reforms within the remit of the Secretariat, as presented in the Secretariat's implementation plan on reform, will also be coordinated, delivered and monitored through pillar 4.[2] To arrive at the final version of the implementation plan, the Secretariat considered recent discussions with Member States in the context of the Sustainable Financing Working Group and governing bodies' meetings, as well as verbal and written comments submitted by Member States through the Agile Member State Task Group meetings[3] and offline consultations held during 2022. The Secretariat is mandated to report on the plan regularly to the governing bodies.

63. Consistent with the request of Member States for the identification of a clear set of deliverables for the biennium 2024–2025, the deliverables in the implementation plan have been grouped by the broad themes of accountability, compliance, efficiency and transparency. Each deliverable is subdivided into one or more activities and includes the more specific objective or need being addressed, the estimated costs and expected completion deadlines, and a brief update by the Secretariat on the progress achieved to date. All actions are aimed at having a better, fit-for-purpose, transparent Organization, which is trusted by its Member States and transforms its way of work to provide better support and value-for-money to its constituencies.

Results and strategic significance of priority-setting

64. The final list of areas of concentration, including integrated solutions for areas in which WHO has particular added value in supporting implementation in Member States, is informed by country and regional processes in order to prioritize the support needed from the WHO Secretariat.

65. A strengthened approach to priority-setting was an integral part of the development of the draft Proposed programme budget 2024–2025. An iterative approach was applied, starting at the country office level, in order to ensure maximum alignment with country situations and priorities. It was guided by both global and regional strategic directions, as well as available credible data, evidence and trends, especially at the country level, and it focused on those areas in which WHO's added value is recognized.

66. Leadership in WHO country offices was responsible for convening prioritization consultations at country level, engaging key government counterparts and relevant partners. Each region applied an approach appropriate to that region, but used a common set of minimum criteria for prioritization of their needs for WHO's support (see Box 1).

[1] Document A75/7.

[2] See document EB152/34.

[3] See document EB152/33.

Box 1: Minimum criteria for priority-setting

(a) The extent of contribution to:

(i) health outcomes that need priority attention, informed by credible data sources at global, regional or country levels; and

(ii) accelerating progress in meeting the triple billion targets and indicators relevant to the country, defined by data and evidence.

(b) The extent of alignment with:

(i) up-to-date national health strategic plans and other relevant national prioritization and planning instruments;

(ii) up-to-date instruments that define the cooperation between WHO and the country (WHO country cooperation strategies or other cooperation agreements); and

(iii) available United Nations common planning instruments (such as the United Nations Sustainable Development Cooperation Framework).

(c) Adherence to relevant mandates and binding commitments made by the governing bodies of WHO.

(d) The degree of WHO's comparative advantage:

(i) WHO is best placed, compared with other partners, to achieve specific results, clear bottlenecks and provide support to countries in implementing their priorities or addressing crises; or

(ii) WHO plays a critical or niche role for specific deliverables in countries.

67. For country-level consultations, countries received more structured and specific data and evidence on health issues that informed their priorities. The regional committees in the six regional offices, at their meetings this year, provided directions on the priority-setting relevant to their regions. Several regional offices also held subsequent meetings or briefings to further discuss the priority-setting of their respective region. All these efforts resulted in a set of prioritized programme budget outputs and outcomes for countries in three priority tiers (high, medium or low). The country priorities were then consolidated into regional and global results to identify the areas in which the Organization's efforts are needed most and to which WHO's technical cooperation adds the most value.

68. The consolidated country prioritization results are key to implementing the GPW 13, attaining the triple billion goals and informing budget costing, allocation of resources and resource mobilization efforts. Individual country results are the main inputs to the planning and implementation of the biennial operational plans of country offices.

69. The priority ranking (high, medium or low) does not indicate the importance of a specific result but rather the level of technical cooperation that Member States can expect from WHO, which has a mandate from Member States to work towards the achievement of all outcomes and outputs. Nonetheless, the outcomes that are ranked of high and medium priority are recognized as the greatest challenges and their outputs indicate where the Secretariat's technical support is most needed during the biennium.

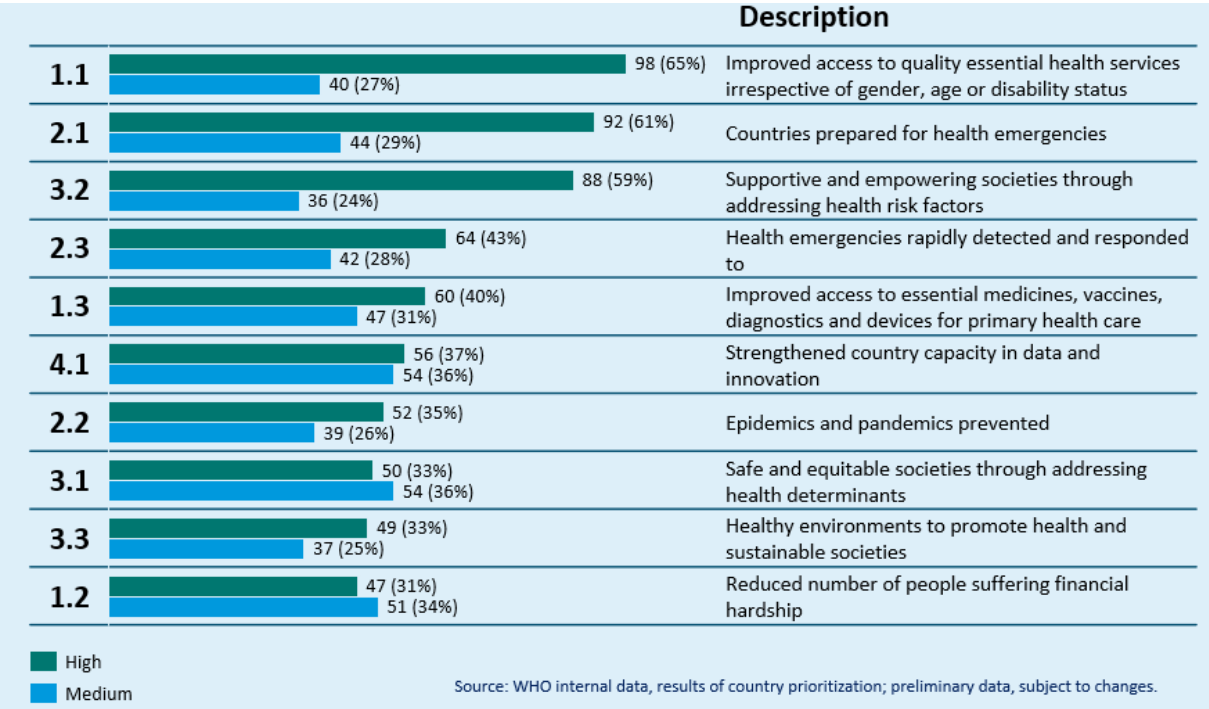
Fig. 3. Number of countries that completed the priority-setting exercise, by region

70. At the time of preparation of this document, 150 Member States had discussed and identified their priority needs for the support of WHO Secretariat, as expressed in prioritizing programme budget outcomes and outputs (Fig. 3), as well as in many cases identifying strategic deliverables for the Secretariat's support.

71. The priority-setting exercise is still ongoing in a number of countries, with consultations taking place based on the country specific situations. The final results of the prioritization will be included in the Proposed programme budget 2024–2025 that will be submitted to the Health Assembly for consideration in May 2023.

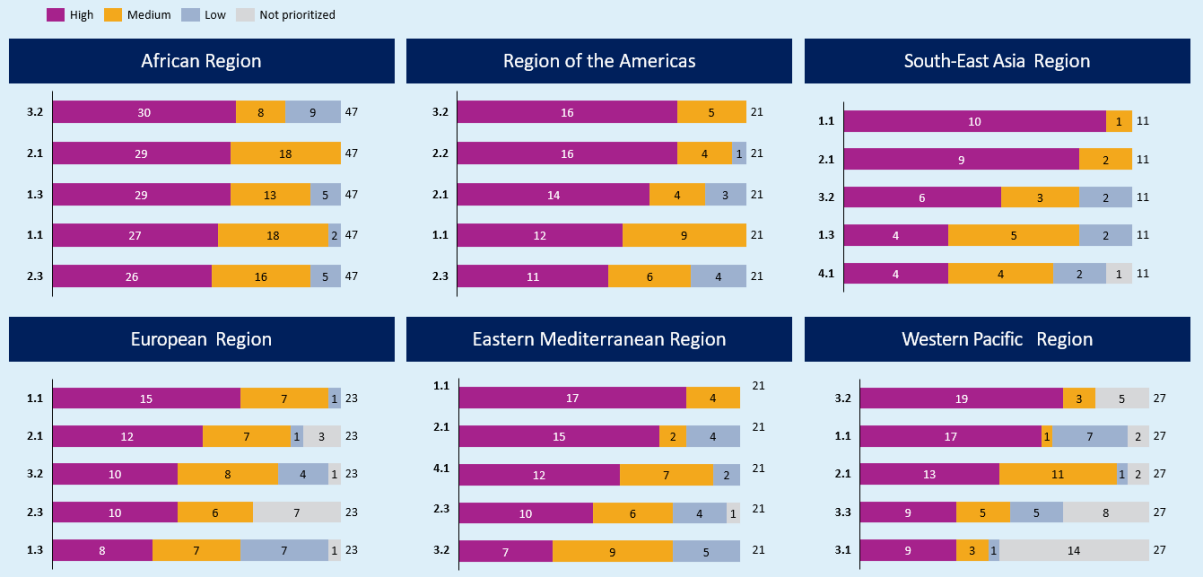
72. The consolidated preliminary results of country prioritization show that countries collectively continue to prioritize WHO's technical cooperation largely in areas that are oriented to outcomes 1.1 (*Improved access to quality essential health services irrespective of gender, age or disability status*); 2.1 (*Countries prepared for health emergencies*); and 3.2 (*Supportive and empowering societies through addressing health risk factors*), which were ranked of high and medium priority by a significant number of countries (Fig. 4).

Fig. 4. Outcomes identified as a high or medium priority, by number of countries and percentage of all countries with priority-setting results



73. The regional consolidation of country priorities shows a more nuanced priority-setting that is tailored to the specific regional context (Fig. 5). It is notable that in the light of the ongoing impact of the COVID-19 pandemic, all regional offices prioritized outcome 2.1 *(Countries prepared for health emergencies)* among their top three priorities.

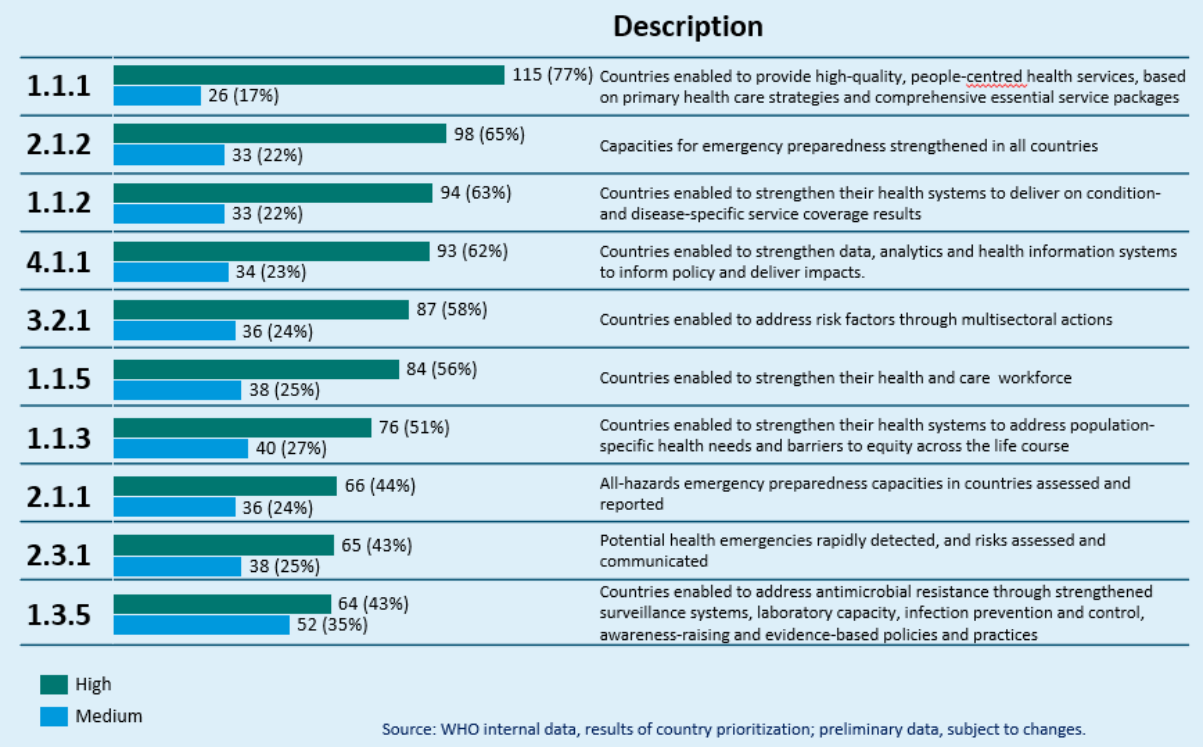
Fig. 5. Top five budget outcomes prioritized by region (number of countries)



74. While ranking the priority of the programme budget outputs that will require the most technical support, the Secretariat and the Member States based their prioritization on region-specific data and evidence and were guided by a common set of minimum criteria (see Box 1), such as overall contribution to health outcomes, alignment with existing strategies/instruments and WHO's comparative advantage. Consequently, priority outputs that are ranked the highest overall are closely aligned with the highest priority outcomes (six of the top seven outputs with high or medium rankings are under outcomes 1.1, 2.1 and 3.2). The only notable exception is output 4.1.1 (*Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts*), which is among the top seven (Fig. 6) and highlights the importance of quality data as a cross-cutting area for the rest of the programmatic outputs.

75. The global consolidation of priority outputs (Fig. 6) shows that the outputs prioritized across all countries are closely aligned with the programmatic priorities to reach the triple billion targets and accelerate progress towards the Sustainable Development Goals. For instance, for Billion 1, the prioritization of output 1.1.1 aligns with the need for a radical reorientation towards primary health care. Similarly, output 1.1.3 reflects the urgent need for an equitable and resilient recovery of health systems, for which polio assets that have now been integrated into broader health functions, will play a role in a large number of countries. Outputs 1.1.2, 1.1.5 and 1.3.5 comprise areas that have the largest gaps and highest potential for impact, such as health workforce, antimicrobial resistance and high-priority condition and disease-specific interventions. For Billion 2, the top three priority outputs (2.1.1, 2.1.2 and 2.3.1) fully reflect the move towards assisting countries to better prepare for and promptly detect health emergencies. For Billion 3, the prioritization of 3.2.1 is fully aligned with the urgency of focusing on the leading risk factors or causes of premature mortality and morbidity.

Fig. 6. Top ten outputs identified as a high or medium priority across all countries, by number of countries and percentage of all countries



76. The regional consolidation of the prioritization results demonstrates that Secretariat support in each region will need to be tailored to the regional context, based on the country and regional public health priorities driven by multiple factors (demographics, disease burden, economic and social drivers), together with country-specific health challenges and opportunities. However, despite the differences, all regional offices rank output 1.1.1 (*Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages*) as the highest priority, with the exception of the Regional Offices for the Americas and for South-East Asia (Fig. 7) and for the top five outputs there is overall alignment with the global consolidated ranking.

77. Similarly, the preliminary results of the consolidated country prioritization show a great degree of alignment with the priorities identified under the triple billion targets, as outlined in the dedicated sections for each strategic priority (Fig. 8). Under Billion 1, cross-cutting priorities such as primary health care, essential health services and the health workforce come out very strongly in country prioritization. Under Billion 2, the global momentum to strengthen the global architecture for health emergency preparedness, response and resilience is well reflected in the desire of countries to focus on increasing capacities for emergency preparedness. Under Billion 3, many countries want to prioritize risk factors, which are those identified as the root causes of premature mortality and morbidity, such as tobacco use and obesity, together with existential risks, such as climate change and air pollution, which require multisectoral action.

Fig. 7. Top five budget outputs prioritized by region (number of countries)

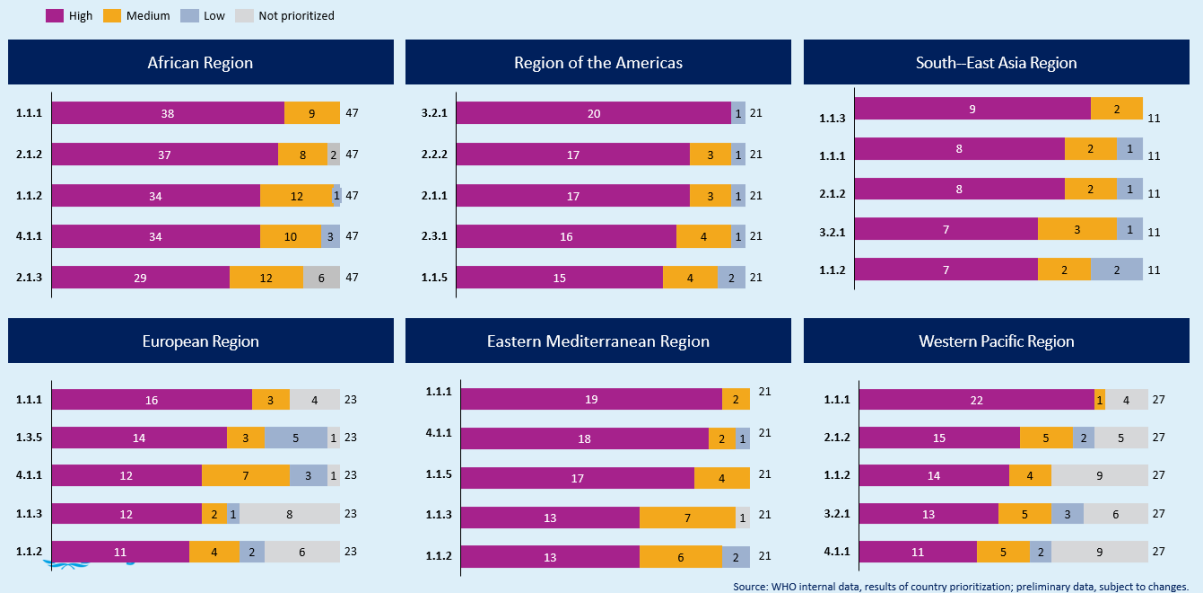


Fig. 8. Proposed global areas of concentration, based on data and aligned with triple billion targets and preliminary country prioritization results

GPW 13	Global areas of concentration	Preliminary country priorities: outcomes	Preliminary country priorities: outputs
Healthier populations	Tobacco, alcohol, obesity, dietary risk, air pollution and climate change	3.2 Supportive and empowering societies through addressing health risk factors	3.2.1 Countries enabled to address risk factors through multisectoral actions
Universal health coverage	Health financing and financial protection, health workforce and access to essential services	1.1 Improved access to quality essential health services irrespective of gender, age or disability status	1.1.1. Countries enabled to provide high -quality, people -centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition - and disease-specific service coverage results 1.1.3. Countries enabled to strengthen their health systems to address population -specific health needs and barriers to equity across the life course 1.1.5. Countries enabled to strengthen their health and care workforce
Health emergency protection	Preparedness (International Health Regulations (2005)) and timeliness of detection, notification and response	2.1 Countries prepared for health emergencies	2.1.2 Capacities for emergency preparedness strengthened in all countries
Leadership functions	Local production of health products, data and delivery, World Health Data Hub	4.1 Strengthened country capacity in data and innovation	4.1.1 Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts

Governing bodies resolutions and decisions guiding regional and headquarters priority-setting for the biennium 2024–2025

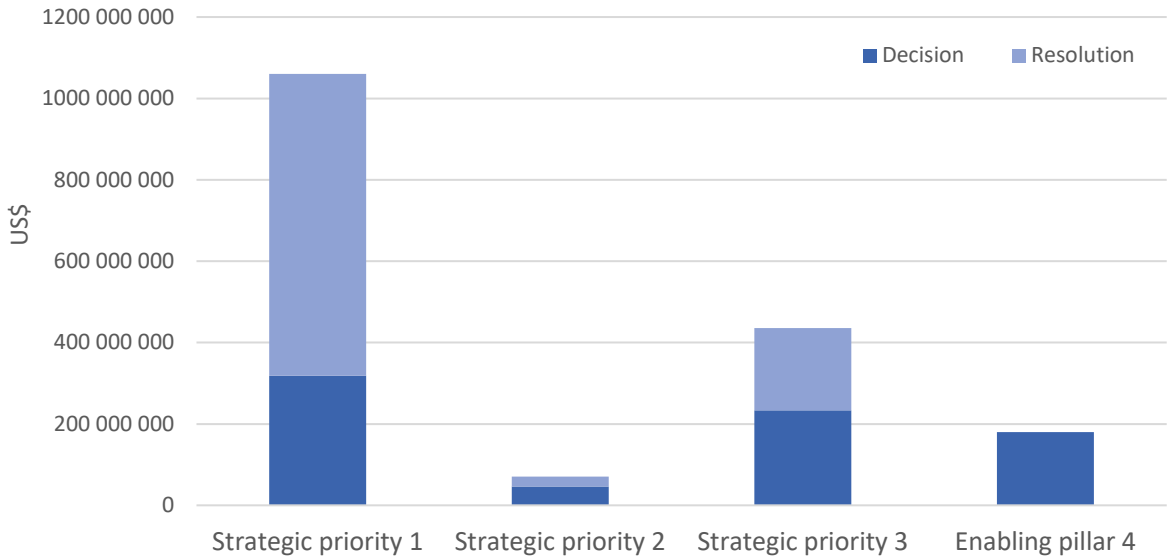
78. Between 2017 and 2022, the Health Assembly and the Executive Board approved nine resolutions and 21 decisions with implications for both implementation and costing in the biennium 2024–2025 under the base segment of the programme budget, mainly under results related to strategic priority 1 (total value of US$ 1.75 billion; Fig. 9).

79. The most intensive investment in terms of cost (US$ 1.12 billion) will result from seven resolutions and decisions that endorsed various global strategies, notably in partnership with the United Nations. These mainly concerned noncommunicable diseases, the global digital health strategy, human resources for health, and communicable disease strategies. In terms of planning, they identified the expected results from the respective

approved programme budgets at the time of approval and costed them according to the resource requirements needed for the Secretariat to deliver the objectives defined in each resolution or decision.

80. The technical results emanating from these resolutions and decisions form the backbone of the priority-setting at the headquarters and regional office levels, in addition to the country priorities that require the Secretariat's support, which will be provided by the three levels of the Organization.

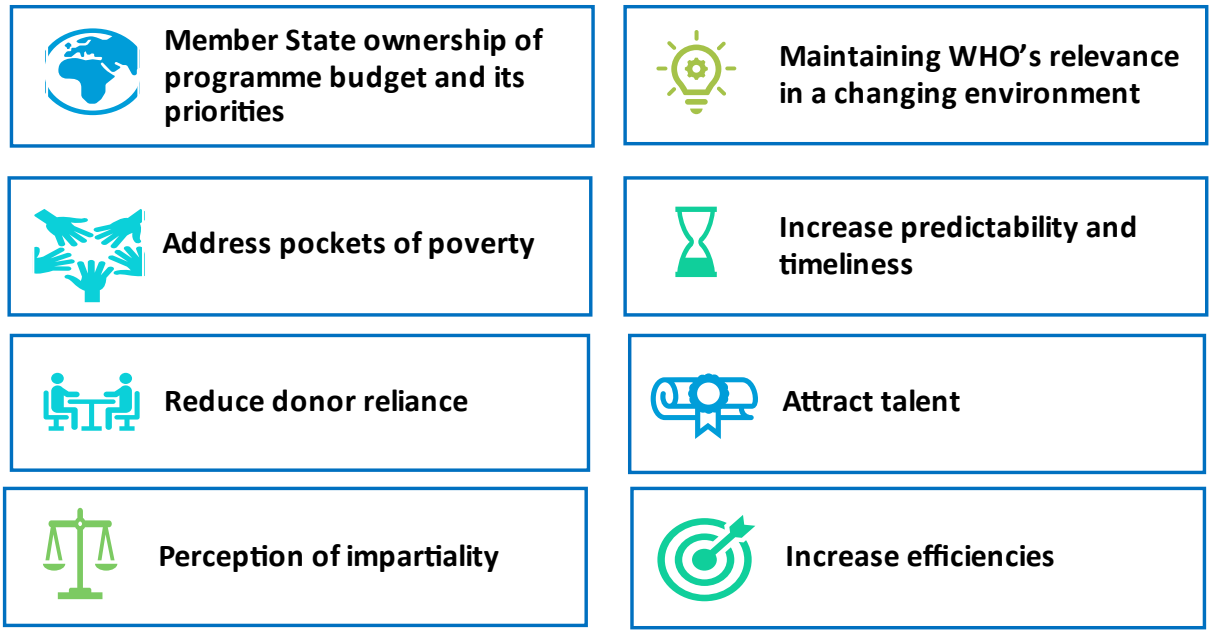
Fig. 9. Costing of governing bodies' resolutions and decisions, with implications for the base segment of the draft Proposed programme budget 2024–2025



Budgetary and resource allocations implications of the prioritization

81. At the core of the Working Group on Sustainable Financing deliberations were eight key challenges showing why the financing model of WHO was not viable and the status quo was no longer acceptable. These challenges are summarized in Figure 10 and described in detail in background document EB/WGSF/7/INF./1.

Fig. 10. Key challenges emanating from the lack of sustainable financing



82. The lack of sustainable financing poses a challenge to the critical prerequisites that make country prioritization impactful at the country level, which in turn results in all of the above challenges:

- **Financial resources** need to be fully flexible and fully interchangeable across priorities and areas of work in order to match the priorities set. Still, public health priorities in any country may not necessarily be well aligned with donor funding preferences. Similarly, some countries may benefit more from voluntary contributions than others. As long as the base programmes of the WHO programme budget are primarily funded by specified voluntary contributions, any misalignment between the size of budget and the priorities will remain a challenge.
- The main asset of the Organization lies in the skills and expertise of its **human resources**, which at the same time constitute the single largest financial liability of the Organization. To be able to deliver on the priorities set out in the programme budget, the Organization needs to have its workforce plan aligned with the priorities. Given the financing model of WHO, full alignment is currently not possible.

83. One of the most significant implications of the prioritization process will therefore be the proposed new approach to the allocation of flexible resources,[1] especially assessed contributions, which will be strategically directed towards high-priority outputs, as needed. The aim of this approach is twofold:

(a) to ensure that high-priority outputs – and therefore the Secretariat's contribution to the achievement of outcomes – are delivered without delays and impediments related to earmarking of voluntary contributions and their potential unpredictability in terms of timing and amounts; and

(b) to provide information to Member States on how an increase in assessed contributions will be deployed for the delivery of results of the programme budget across the three levels of the Organization.

84. In the past several bienniums, flexible funds have been made available before the start of the biennium through biennial envelopes by major office, as approved by the Director-General in consultation with the Global Policy Group.[2] The Regional Directors have the delegated authority for strategic allocation/reallocation of

[1] Flexible resources (or funds – used interchangeably) refer to assessed contributions, programme support costs and core voluntary contributions.

[2] The internal group comprises the Director-General, the Deputy Director-General and the six Regional Directors.

flexible funds in their regions, particularly when it comes to strategically addressing funding gaps. In allocating resources, among the factors that the Regional Directors consider are country prioritizations, historical patterns (mainly set by existing human resources), existing specified voluntary contributions and resource projections. Based on the most recent full biennial utilization of 2020–2021, 62% of all flexible resources were utilized at the regional and country levels and 38% at headquarters.

85. The revised approach to the allocation of flexible resources would retain most of the above-mentioned elements, while adding three important principles:

(i) The allocation of the increase in assessed contributions will be directly related to high-priority outputs, with particular emphasis on the country level and those prioritized outputs that traditionally present large financial gaps. It is proposed that the Organization focus its efforts on funding high-priority outputs up to 80% of their budget through a combination of voluntary contributions and flexible funds.

(ii) The commitment to funding the high-priority outputs up to 80% of their budget will enable the strengthening of technical capacity at the country level, including the ability for country offices to increase their workforce resources. This will be done in line with the three-level workforce planning.

(iii) Any increase in the cost of enabling functions must be minimal and focused on the prioritized areas of transparency, accountability and risk management, with a specific focus on PRSEAH. The financing of enabling functions must be partially covered by an increase in efficiencies to offset the higher costs in this area.

86. To estimate the flexible funds requirement to raise the funding of high-priority outputs to 80%, the analysis of funding needs was made by high-priority output by budget centre (i.e., by every country office and regional/headquarters cost centre) to ensure that the aggregation of needs does not mask pockets of poverty (i.e., to ensure that a well-funded output in one budget centre does not mask an underfunded similar output in another budget centre). This high-level analysis also assumes that specified voluntary contributions will continue funding a large share of the draft Proposed programme budget 2024–2025 and that the flow of voluntary contributions in 2024–2025 will be to the same areas as in the biennium 2022–2023.

87. Table 1 presents the preliminary high-level estimate for flexible funds to arrive at 80% funding of high-priority outputs and to ensure that the Secretariat delivers on its commitments, while continuing its efforts to strengthen enabling functions and deliver on all programme budget outputs, including those that were considered less urgent but nevertheless require the Secretariat's support. Given the above-mentioned assumption concerning the amounts and distribution of voluntary contributions, with a 20% increase in assessed contributions (estimated total of assessed contributions for 2024–2025: US$ 1.148 billion) and assuming the same level of programme support costs as in 2022–2023 (US$ 450 million), the Organization will be close to fund the estimated flexible funds requirement if it is provided with the same level of voluntary contributions.

Table 1. Estimated flexible funds requirement (US$ millions)

	Estimated flexible funds requirement	Comments
High-priority outputs 80% financed with flexible funds and voluntary contributions	619	of which estimated 62% to country office level, excluding enabling functions
Medium- and low-priority outputs	302	maintaining the same level of flexible funds financing as in the 2024–2025 biennium
Enabling functions	877	financing 90% of the proposed budgets for outcomes 4.2 and 4.3 with flexible funds
Estimated total requirement	**1798**	

88. Making these proposed changes to the allocation of the most predictable and sustainable resources of the Organization, including the increase in assessed contribution, the Secretariat will be able to get closer to addressing the eight key challenges emanating from the lack of sustainable financing (Fig. 10):

(1) **Pockets of poverty** and **lack of funding predictability:** though the flexible funding for 2024–2025 will not be sufficient to sustainably fund the entire base budget, focusing on high-priority outputs by budget

centre offers a good start in aligning the budget, its size and resources and this is therefore a first step in greening the "heatmap". Flexible resources have a greater predictability time frame, which will allow country offices and technical programmes to start programme budget implementation in a more predictable manner.

(2) **Increased ownership by Member States of programme budget priorities:** by committing to fund 80% of the high-priority outputs, we ensure that those outputs for which Member States stressed the most urgent need to receive the Secretariat's support will be implemented through aligning priorities and resources. At the same time, the level of flexible resources available in the Organization does not guarantee that high-level outputs can be sustainably financed, as their financing will still depend on voluntary contributions.

(3) **Donor reliance:** additional flexible resources will ensure a healthier mix of resources for high-priority outputs, while also decreasing the pressure on country offices and technical programmes to mobilize additional resources, which in turn will lead to **greater efficiency** and decreased potential **perception of impartiality**.

(4) **Attracting talent:** principle 2 identified in paragraph 66 above is focused on strengthening country capacity at the country level. Thanks to the increase in flexible resources, country offices will be provided with the necessary predictable funding to ensure that the best qualified experts are recruited to deliver on high-priority outputs.

89. The draft Proposed programme budget 2024–2025 will be updated following the 152nd session of the Executive Board to take into consideration all the comments made, incorporating refinements to further clarify priorities and accelerate impacts towards the Sustainable Development Goal-based triple billion targets. These refinements will reflect in greater detail the implications of the strategy for the GPW 13 and the country-level roll-out of the delivery-for-impact approach that streamlines the priorities of WHO.

90. This approach will culminate in the finalization of the Proposed programme budget 2024–2025 for submission to the Seventy-sixth World Health Assembly, when the country priority-setting and costing of outputs will be finalized. For that final draft, the Secretariat will propose several managerial indicators to track how the improvement in sustainable financing helps to address the eight key challenges emanating from the lack of sustainable financing, in addition to output indicator 4.2.4 IND1 (*Proportion of priority outcomes at the country level with at least 75% funding by the end of the second quarter of the biennium*). The Secretariat will report on the implementation of this approach, if agreed with the Member States, in its biannual reports to the governing bodies on the implementation of the programme budget.

RISK-MANAGEMENT APPROACH TOWARDS ACHIEVING THE TRIPLE BILLION TARGETS BY 2025

91. The Secretariat recognizes that the global environment in which WHO delivers its mission is becoming increasingly complex and is filled with uncertainty. In recognition of this uncertainty, WHO will have to take calculated risks to successfully achieve its ambitious mission and the GPW 13.

92. WHO therefore needs to define appropriate approaches and strategies that will allow it to take calculated risks. However, WHO will not be able to achieve the results it has targeted through the GPW 13 and Sustainable Development Goals if the Organization is "risk blind" or "risk averse". WHO therefore needs to define effective ways to "manage" risks for optimized results.

93. The Secretariat has therefore started to implement an ambitious enterprise risk management strategy, building on international leading practices[1] and the recommendations of the Joint Inspection Unit's review of enterprise risk management practices in United Nations system organizations,[2] which proposes a framework (aligned to leading practice[3]) to ensure that risk management is fit for purpose in order to enable the achievement of organizational objectives.

94. The draft Proposed programme budget 2024–2025 has been prepared to highlight areas in which WHO has lower risk acceptability and in which as a result funds are needed to build and capacitate the necessary systems (people, processes, technology, etc.) to keep risks within acceptable levels (e.g., for high-priority risks, such as PRSEAH and other prioritized principal risks), while recognizing the critical role of the output delivery teams in identifying risks and ensuring that the funds needed for mitigation are prioritized.

95. In the context of constrained funding within WHO, it may not be possible to tackle all risks at the same time. The principle of risk-based prioritization will be applied when investing the efforts needed to implement the programme for change. For that reason, the Secretariat will prioritize resources to manage risks that are recognized to critically affect WHO's work at the country level. By prioritizing these risks, we can achieve maximum impact at country level, while prioritizing scarce resources.

96. The Global Risk Management Committee of WHO prioritized the following principal risks for the next period:

- vulnerable supply chain operations;
- inability to measure impact;
- business service disruptions/security incidents;
- fraud and corruption;
- sexual exploitation, abuse and harassment;
- cybersecurity breach;
- quality and excellence of WHO's normative work compromised.

97. It is important to note that risk assessment is dynamic and these risks will change over time. Therefore, the risks listed above represent a snapshot of the current assessment and are subject to change.

[1] The UN Reference Maturity Model for Risk Management is an ERM framework aligned with leading practices, including the Committee of Sponsoring Organizations of the Treadway Commission (COSO) ERM framework and ISO 31000.

[2] See document JIU/REP/2020/5.

[3] The UN Reference Maturity Model for Risk Management is an ERM framework aligned with leading practices, including the COSO ERM framework and ISO 31000.

98. Through the draft Proposed programme budget 2024–2025, the Secretariat will prioritize resources to build the necessary systems to keep these risks within acceptability levels, as defined in WHO's risk appetite framework. In particular, greater investments are needed to manage risks effectively where risk acceptability levels are minimal (i.e., for risks affecting technical excellence, people health, safety and well-being, compliance and integrity, as defined in the risk appetite framework).

BUDGET SUMMARY

99. The draft Proposed programme budget 2024–2025 is the third and the last of the GPW 13 cycle and carries the ambitious task of getting WHO back on track to achieve the triple billion targets, while providing continuity and stability for the final phase of GPW 13 implementation. At the same time, it considers the extensive revision of the Programme budget 2022–2023, which provided the Secretariat with an opportunity to reflect the lessons learned from the COVID-19 pandemic and the findings and reviews of various independent panels.

100. With these elements under consideration and as in approved programme budgets from previous bienniums, the draft Proposed programme budget 2024–2025 is presented in four segments (Table 2). Together, the four budget segments amount to a total draft Proposed programme budget 2024–2025 of US$ 6.86 billion. The total amount represents a 17% increase with respect to the 2020–2021 biennium but only a 2% increase with respect to the revised Programme budget 2022–2023, driven by the **increase in planned actions related to the polio eradication segment**. All other budget segments, including the largest segment of base programmes, remain unchanged with respect to the revised Programme budget 2022–2023.

101. Table 3 displays the distribution of the draft Proposed programme budget 2024–2025 by major office and budget segment. The mechanism for arriving at the totals for each budget segment and major office, where applicable, is described below.

Programme budget segments

Budget segment of base programmes

102. This segment is the core mandate of WHO and constitutes the largest part of the draft Proposed programme budget 2024–2025 in terms of strategic priority-setting, detail and budget figures. This segment reflects the overall health priorities and shows the budget distribution by outcome across the major offices. In May 2022, the Seventy-fifth World Health Assembly approved an increase for the revised Programme budget 2022–2023 of US$ 604.4 million in the base budget segment (an increase of 14% over the levels originally approved for the biennium 2022–2023).[1] Given this recent budget revision, it is proposed to keep the base budget segment of the draft Proposed programme budget 2024–2025 at the same level as that of the revised Programme budget 2022–2023 (US$ 4968.4 million).

103. For the biennium 2024–2025, emphasis has been placed on improving budget allocation across the three levels of the Organization – and to the extent possible on improving financing levels as well. As the very first step in the budget's development, the Secretariat agreed on a high-level distribution of the budget envelope for base programmes by major office (last column of Table 4) and proposed an increase of about 1.6% in the share of country-level budget. Within a zero-budget increase, the initial proposal to achieve this 1.6% increase in the share of the country-level budget was to shift 3% of the budgets of the headquarters and regional offices to the country office level. For headquarters, this means a net decrease in the budget; for the regions, this represents a budget shift between levels and an overall budget increase resulting from the budgetary shift from headquarters.

104. Using this information as their starting point and based on the priority-setting for the outputs, the major offices proceeded with their respective bottom-up costing process, arriving at the allocation by organizational level presented on the right side of Table 4. The budget distribution for base programmes proposed as the result of the bottom-up costing process allocated the budget more ambitiously to the country levels than originally proposed, so that it now reaches 50% of the share of base programmes (Fig. 11). As the budget is in principle unfunded, the challenge will remain for WHO to obtain the right type of financing to be able to match the priorities and their costing across the three levels of the Organization, as planned.

[1] See resolution WHA75.5 (2022).

Table 2. Total draft Proposed programme budget 2024–2025, by budget segment, relative to the approved Programme budget 2020–2021 (US$ millions)

Budget segment	2020–2021 Approved Programme budget	2022–2023 Revised approved Programme budget	2024–2025 Draft proposed programme budget	Change (relative to 2020–2021)
Base programmes	3 768.7	4 968.4	4 968.4	32%
Polio eradication	863.0	558.3	694.3	-20%
Special programmes	208.7	199.7	199.7	-4%
Emergency operations and appeals	1 000.0	1 000.0	1 000.0	0%
Grand total	**5 840.4**	**6 726.4**	**6 862.4**	**17%**

Table 3. Total draft Proposed programme budget 2024–2025, by major office and budget segment (US$ millions)

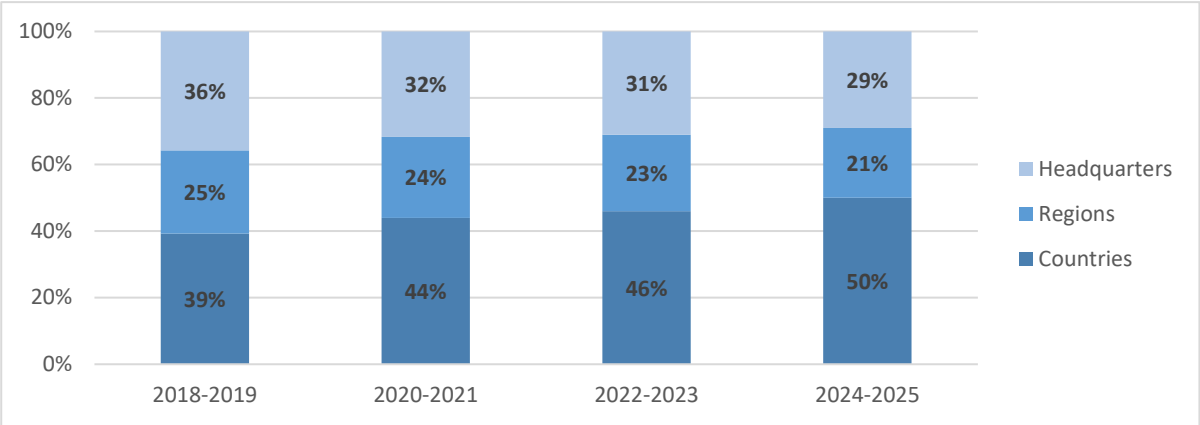
Budget segment	Africa	Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Headquarters	Grand total
Base	1 326.6	295.6	487.4	363.7	618.4	408.1	1 468.6	4 968.4
Polio eradication	20.2	–	–	–	342.8	–	331.2	694.3
Special programmes	3.6	4.3	3.9	4.1	3.8	3.4	176.7	199.7
Emergency operations and appeals	274.0	13.0	46.0	105.0	334.0	18.0	210.0	1 000.0
Grand total	**1 624.4**	**312.9**	**537.3**	**472.8**	**1 299.0**	**429.5**	**2 186.5**	**6 862.4**

Table 4. Base segment of the draft Proposed programme budget 2024–2025 across the three levels of the Organization, relative to the revised Programme budget 2022–2023 (US$ millions)[a]

Major offices	Revised Programme budget 2022–2023				Draft proposed programme budget 2024–2025			
	Country offices	Regional offices	Headquarters	Total	Country offices	Regional offices	Headquarters	Total
Africa	946.4	361.5	–	1 307.9	1 056.5	270.1	–	1 326.6
The Americas	178.1	114.0	–	292.1	185.0	110.6	–	295.6
South-East Asia	354.4	125.9	–	480.3	365.3	122.1	–	487.4
Europe	145.5	215.2	–	360.7	155.1	208.6	–	363.7
Eastern Mediterranean	434.1	175.7	–	609.8	447.9	170.5	–	618.4
Western Pacific	243.4	159.9	–	403.2	253.0	155.1	–	408.1
Headquarters	–	–	1 514.3	1 514.3	–	–	1 468.6	1 468.6
Grand total	2 301.8	1 152.3	1 514.3	4 968.4	2 462.8	1 037.0	1 468.6	4 968.4
Allocation by level (% of total)	46.3%	23.2%	30.5%	–	49.6%	20.9%	29.6%	–

[a] Row and column totals may not always add up, due to rounding.

Fig. 11. Share of the base segment across the three levels of the Organization and the GPW 13: approved Programme budgets 2018–2019 to 2022–2023 (revised) and draft Proposed programme budget 2024–2025[a]

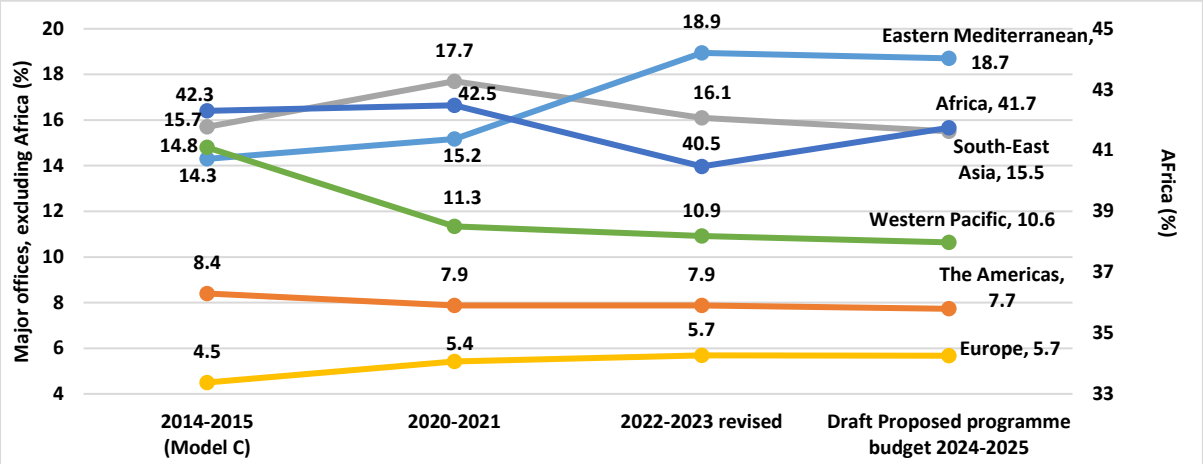


[a] Decimals may not always add up, due to rounding.

105. The evolution of the country-level budget proposed for 2024–2025 is also consistent with the model of strategic budget space allocation for segment 1, which involves technical cooperation at the country level. Despite the fact that the model adopted in decision WHA69(16) (2016) will expire at the end of the biennium 2022–2023 and needs to be revised, it is useful to note that the budget shares of each major office for 2024–2025 still align well with those of the model (Fig. 12).[1] This remains the case despite two major developments that were not considered in the model: the mainstreaming of the polio essential public health functions into the base budget that has occurred since 2020–2021 and the emergence of the COVID-19 pandemic in 2020 and the resulting revision of the Programme budget 2022–2023, which affected the distribution of the budget across regional offices and their respective shares of the budget.

[1] To calculate the budget share that is relevant for the strategic budget space allocation, only country budgets for technical outputs from outcomes 1.1 to 4.1 are considered. These amounts are added by major office and then compared against the totals for all regions, excluding headquarters. The resulting percentages are indicated in Fig. 11, as compared with model C recommended in document A69/47.

Fig. 12. Evolution of strategic budget space allocation for technical cooperation at the country level, for segment 1 only (%)



Base programmes budget, by outcome and strategic priority

106. The proposed distribution of the base programmes budget by outcome as shown in Table 5 is the result of the aggregation of the bottom-up process by all major offices, which inform the distribution of their own overall budget across the regional levels and country offices, based mainly on country prioritization, historical patterns (mainly set by human resources and voluntary contributions) and resource projections.[1] The key highlights of Table 5 include the following:

- Compared with the budget levels of the biennium 2020–2021, most outcomes have experienced an increase, with the exception of outcomes 2.2 (*Epidemics and pandemics prevented*); 3.1 (*Safe and equitable societies through addressing health determinants*); 3.2 (*Supportive and empowering societies through addressing health risk factors*) and 3.3 (*Healthy environments to promote health and sustainable societies*). Outcome 2.2 was originally decreased from US$ 380.4 million in 2020–2021 to US$ 231.8 million in 2022–2023 due to the budget of the polio transition accounted for under outcome 2.2 in 2020–2021 being integrated into the relevant technical outcomes (outcomes 1.1 and 2.3) in 2022–2023. With the emergence of the COVID–19 pandemic and the resulting budget revision that followed, this outcome was revised upwards to US$ 311.7 million. For 2024–2025, it was revised upwards again to almost reach the original 2020–2021 levels. In the case of the outcomes related to strategic priority 3, these experienced a change in programmatic structure between the 2020–2021 and 2022–2023 bienniums, which affected their scoping. This made their budget levels not comparable with those of the first biennium. Grouped together, these outcomes also represent a slight increase with respect to 2020–2021 amounts.
- To reflect priority-setting in the budget costing while maintaining same budget levels, it is necessary to increase some outcomes while decreasing others. All outcomes except outcomes 2.2 (*Epidemics and pandemics prevented*) and 4.3 (*Financial, human and administrative resources managed in an efficient, effective, results-oriented and transparent manner*), experienced a reduction with respect to the biennium 2022–2023.
- Priority-setting plays a major role in budget allocation, although it is not the only factor to be considered when establishing budget amounts at the outcome level. Three of the top four outcomes prioritized by Member States – outcomes 1.1 (*Improved access to quality essential health services*); 2.1 (*Countries prepared for health emergencies*); and 2.3 (*Health emergencies rapidly detected and responded to*) – have the largest budget increase with respect to 2020–2021 (48%, 71% and 80%, respectively). Outcome 1.1, the highest prioritized by Member States, encompasses actions related to essential

[1] A budget explainer on budget costing is under development.

health services for all diseases and conditions and has the largest budget size of all outcomes; despite its large size and while pockets of poverty remain within, this outcome is generally able to fund its gap with voluntary contributions. On the other side of the spectrum, outcome 3.2 (*Supportive and empowering societies through addressing health risk factors*) is the only outcome that has been highly prioritized but that experienced a budget reduction; this outcome traditionally scores very high in prioritization exercises but is not as attractive to donors, making it more reliant on flexible funding, with chronic funding gaps, and therefore subject to smaller budget levels. This calls again for the importance of introducing sustainable financing in order to match Member States' ambitions and demands with the financial realities of the Organization.

Table 5. Base programmes, by outcome across programme budgets of the GPW 13 (US$ millions)

Outcomes	2020–2021 Approved programme budget (US$ millions)	2022–2023 Revised approved Programme budget (US$ millions)	2024–2025 Draft proposed programme budget (US$ millions)	Change (relative to 2020–2021)
1.1 Improved access to quality essential health services	997.0	1 491.1	1 479.7	48%
1.2 Reduced number of people suffering financial hardship	98.9	113.9	112.3	14%
1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	262.9	324.5	325.5	24%
2.1 Countries prepared for health emergencies	231.1	431.8	394.5	71%
2.2 Epidemics and pandemics prevented	380.4	311.7	372.8	-2%
2.3 Health emergencies rapidly detected and responded to	277.3	507.0	498.0	80%
3.1 Safe and equitable societies through addressing health determinants*	141.9	108.6	107.6	-1%
3.2 Supportive and empowering societies through addressing health risk factors*	194.9	171.5	160.9	-6%
3.3 Healthy environments to promote health and sustainable societies*	94.3	175.2	168.4	-4%
4.1 Strengthened country capacity in data and innovation	287.5	400.4	373.9	30%
4.2 Strengthened leadership, governance and advocacy for health	443.6	533.7	510.9	15%
4.3 Financial, human, and administrative resources managed in an efficient, effective, results-oriented and transparent manner	358.9	399.0	463.9	29%
Grand total	**3 768.7**	**4 968.4**	**4 968.4**	**32%**

* Due to changes in the result structure of strategic priority 3 that occurred between the 2020–2021 and 2022–2023 bienniums, for this strategic priority the percentage change indicated in the last column is calculated relative to 2022–2023.

107. As some major offices are still in the process of finalizing their priority-setting, it is expected that further budget adjustments between the country and regional levels and among strategic priorities and outcomes, as well as budgetary shifts within headquarters, will follow the prioritization exercise, to better align the budget to the prioritization, as needed. Further fine tuning will include the high-level costing by activity and workforce by Programme budget result, which will be presented to the Member States in the Proposed programme budget 2024–2025 that will be submitted to the Health Assembly in May 2023. The Secretariat also continues to finetune the output narratives and output indicators baselines and targets (Annex), which will be finalized in time for consideration by the Seventy-sixth World Health Assembly.

108. The detailed results of the latest proposed budget allocation of the base programmes budget across the three levels of the Organization and by outcome, as well as the results for all budget segments by major office, the three levels of the Organization and outcome, are presented in Tables 6 and 7, respectively.

109. Figure 13 summarizes the trend of the budget by strategic priority across the bienniums of the GPW 13, while also highlighting the main outcomes that drive the budget size and/or increase for each priority. The following trends are notable.

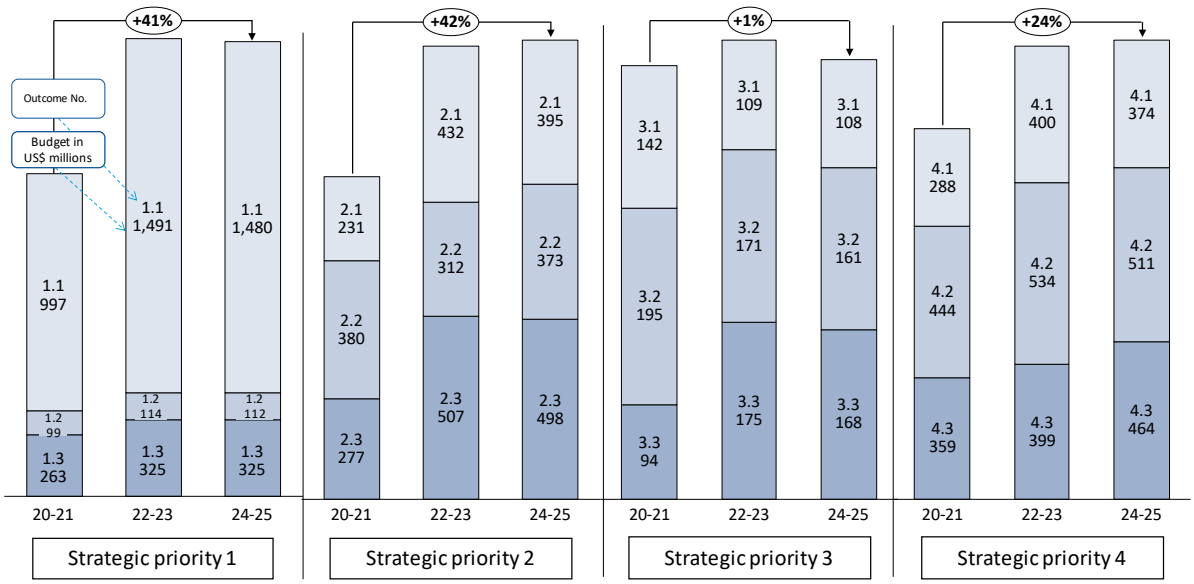
(a) From the start of the GPW 13, the budget of strategic priority 1 has grown 41%, with the main increase between 2020–2021 and 2022–2023; as noted above, outcome 1.1 constitutes the major driver of the budget for this strategic priority.

(b) In the case of strategic priority 2, outcomes 2.1 and 2.3 were both largely revised as a result of the budget revision for the 2022–2023 biennium, giving a total proposed increase of 42% for the budget of this strategic priority over the course of the three bienniums.

(c) For strategic priority 3, results by outcome are not comparable due to the changes in the results structure that affected all three outcomes of this priority; budget increases in this priority are traditionally conservative due to the different cost of interventions compared with those of strategic priorities 1 and 2 and the historical challenges of resource mobilization.

(d) Lastly, for strategic priority 4 three separate main revisions have occurred. The first, which is related to the adoption of the global digital health strategy and the strengthening of science and research functions, directly affected the budget envelope of outcome 4.1 for the Programme budget 2022–2023. Second, for the programme budget 2022–2023 and its revision, Member States requested WHO to strengthen the accountability, compliance and risk management functions of WHO, with a special focus on strengthening PRSEAH, which had an impact on outcome 4.2. Third, there was an increase in outcome 4.3 for the draft Proposed programme budget 2024–2025 in order to further strengthen the accountability, compliance and risk management functions.

Fig. 13. Evolution of budget by strategic priority, from 2020–2021 to draft Proposed programme budget 2024–2025 (in millions)



Enabling functions

110. Member States have increased their call for a stronger, transparent, accountable, more efficient Organization. At their core, the discussions of the Agile Member States Task Group centred on recommendations

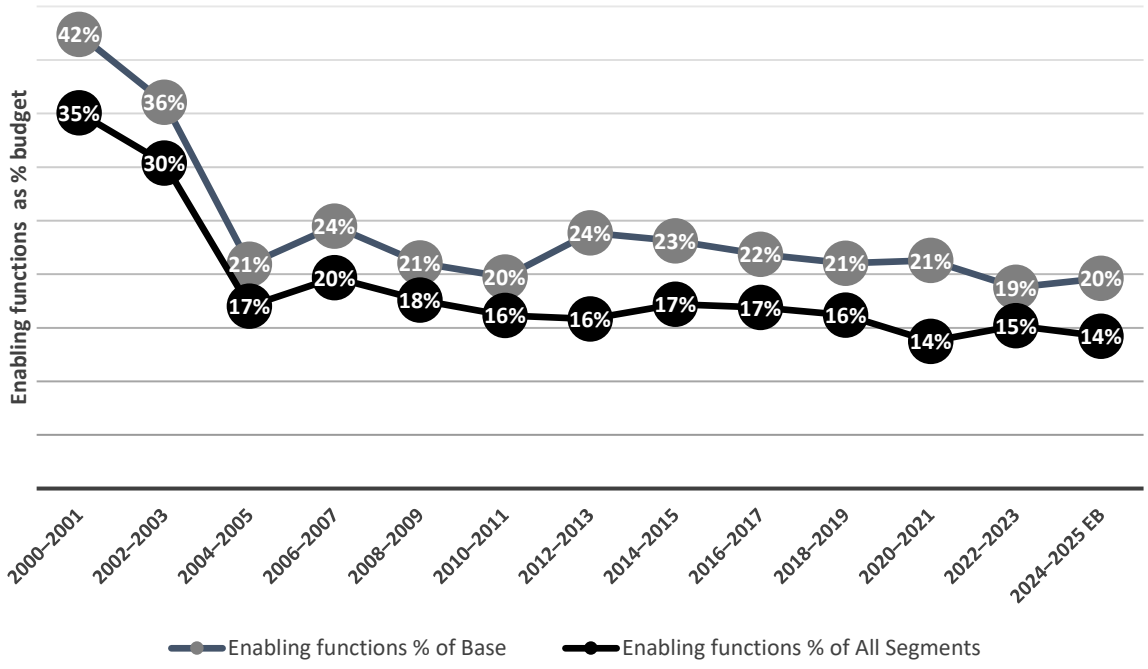
for long-term improvements, based on the analysis of the challenges facing the Secretariat in the areas of governance for transparency, efficiency, accountability and compliance.

111. Member States also recognize that those long-term improvements require investment in WHO, in particular in the Secretariat's enabling functions. At the same time, the Secretariat has been tasked to find ways to conduct its business more efficiently and, where possible, to contain or reduce costs, while still offering maximum value-for-money through its work and without putting at risk its due accountability towards its Member States.

112. The draft Proposed programme budget 2024–2025 will continue the work already started in 2022–2023 in terms of strengthening the accountability, compliance and risk management functions of WHO, with a special focus on strengthening PRSEAH. The draft Proposed programme budget 2024–2025 will focus on further consolidating these investments and continuing the work started in 2022–2023. The approved US$ 50 million budget investment into strengthening the accountability, compliance and risk management functions of WHO for 2022–2023 will be prioritized in 2024–2025 and matched with a similar budget allocation for the coming biennium in order to ensure continuity of actions.

113. Together, enabling functions total US$ 974.7 million, representing 20% of base programmes and 14% of the total proposed budget 2024–2025 (Fig. 14). It is important to note that an increase in budget levels for enabling functions will likely need to be financed through flexible funds, given that most donors traditionally do not finance enabling functions. For that reason and given the limited availability of flexible funding, it is likely that most of this budget increase will remain unfunded.

Fig. 14. Enabling functions: evolution of budget as share of base programmes and as share of total programme budget (%), 2000–2001 to 2024–2025



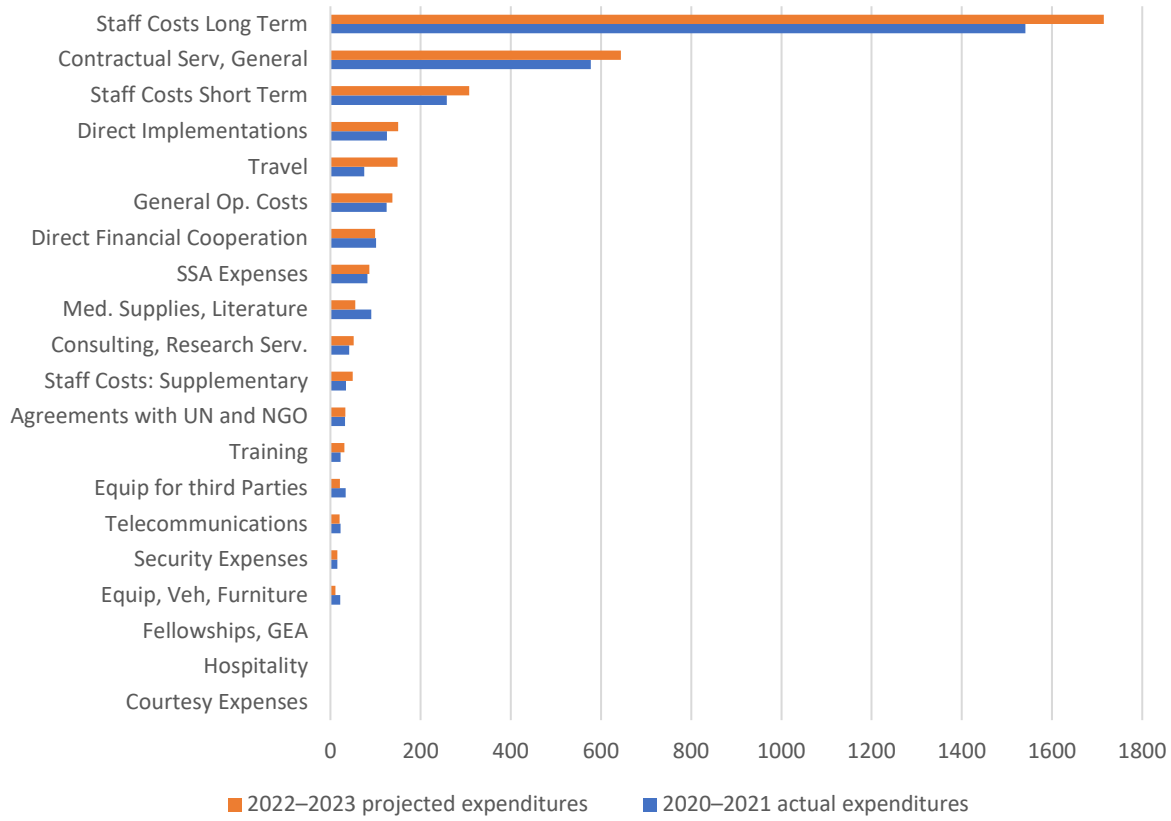
Projection of expenditures within base programmes

114. To cost the programme budget, the Secretariat remains committed to the main principles of results-based management, according to which the expected results will justify the resource requirements, which are derived from and linked to the outputs required to achieve such results. In that regard, the focus on costing is based on the major deliverables required to achieve results and not on the specifics of the expected expenditures. Therefore, the costing of the programme budget is done at the higher level of the main

deliverables to achieve output and the human resources required. Lower-level information, such as the expected detail of expenditures, is not available at this early costing stage and will become the focus of the operationalization of the budget once approved.

115. However, unless there is a major event that affects the work of the Organization in a highly unexpected way (such as the COVID-19 pandemic), it is not expected that the major categories of expenses will vary greatly from one biennium to the other. Figure 15 shows the main types of expenditure for the biennium 2020–2021 and the projected expenditures for the biennium 2022–2023. It is to be expected that the level of expenditure by expenditure type will remain similar in the coming biennium, including long-term staff costs, short-term staff costs and contractual services, which represent close to 75% of the entirety of the costs incurred by the Organization. This is consistent with the normative, standard-setting and technical support type of work of the Organization.

Fig. 15. Expenditure levels by expenditure type for the base segment of the budget, 2020–2021 actual expenditures, and 2022–2023 projected expenditures by type (US$ millions)



Contribution of base programmes to the Sustainable Development Goals

116. For illustrative purposes only, Figure 16 shows how the draft Proposed programme budget 2024–2025 will be allocated to the main Sustainable Development Goal targets. Given the inter-programmatic nature of the WHO programme budget, it is not expected that the results structure of the programme budget will maintain a one-to one relationship with the Sustainable Development Goals. Instead, under certain assumptions the Secretariat produced a basic mapping of the programme budget results to the Goals and attributed their respective budget to the specific Sustainable Development Goal target. This will provide Member States with a very generic idea of the approximate resources that the Secretariat devotes to contributing to the achievement of the Goal targets that are more intrinsically related to WHO's work.

Fig. 16. Base segment of the draft Proposed programme budget 2024–2025 and its estimated contribution to Sustainable Development Goal targets (US$ millions)

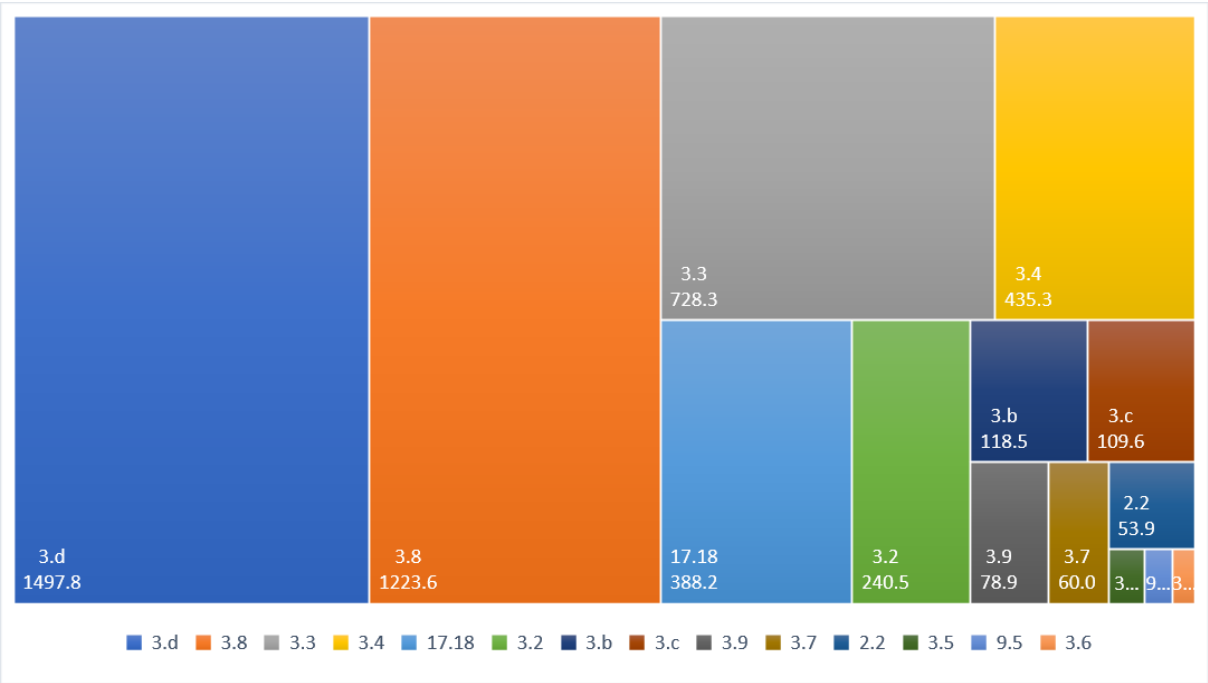


Table 6. Base programmes: approved levels of GPW 13 programme budgets and levels for the draft Proposed programme budget 2024–2025, by outcome and the three levels of the Organization (US$ millions)

Outcomes	Country offices			Regional offices			Headquarters			Total			
	2020–2021 Approved Programme budget	2022–2023 Revised approved Programme budget	2024–2025 Draft Proposed programme budget	2020–2021 Approved Programme budget	2022–2023 Revised approved Programme budget	2024–2025 Draft Proposed programme budget	2020–2021 Approved Programme budget	2022–2023 Revised approved Programme budget	2024–2025 Draft Proposed programme budget	2020–2021 Approved Programme budget	2022–2023 Revised approved Programme budget	2024–2025 Draft Proposed programme budget	Change (compared with 2020–2021)
1.1 Improved access to quality essential health services	492.5	802.5	872.2	248.6	340.2	272.9	255.9	348.4	334.6	997.0	1 491.1	1 479.7	48%
1.2 Reduced number of people suffering financial hardship	56.2	68.7	73.6	17.0	21.2	15.6	25.6	24.1	23.1	98.9	113.9	112.3	14%
1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	89.8	122.2	132.2	43.8	57.9	54.4	129.3	144.4	138.8	262.9	324.5	325.5	24%
2.1 Countries prepared for health emergencies	112.7	240.0	211.6	60.8	86.2	81.4	57.5	105.6	101.5	231.1	431.8	394.5	71%
2.2 Epidemics and pandemics prevented	219.5	151.0	245.6	67.6	71.6	41.6	93.3	89.0	85.6	380.4	311.7	372.8	-2%
2.3 Health emergencies rapidly detected and responded to	131.1	244.6	223.2	74.0	104.7	123.0	72.3	157.8	151.7	277.3	507.0	498.0	80%
3.1 Safe and equitable societies through addressing health determinants	59.4	48.9	54.5	38.3	31.0	25.6	44.3	28.6	27.5	141.9	108.6	107.6	
3.2 Supportive and empowering societies through addressing health risk factors	91.7	94.7	90.3	47.6	38.8	34.2	55.6	38.0	36.5	194.9	171.5	160.9	
3.3 Healthy environments to promote health and sustainable societies	42.9	71.6	71.1	26.3	48.2	44.1	25.1	55.3	53.2	94.3	175.2	168.4	
4.1 Strengthened country capacity in data and innovation	88.3	124.3	121.6	61.3	92.4	75.7	137.9	183.7	176.6	287.6	400.4	373.9	30%
4.2 Strengthened leadership, governance and advocacy for health	153.1	191.6	181.6	136.2	159.3	146.4	154.2	182.9	182.9	443.6	533.7	510.9	15%
4.3 Financial, human, and administrative resources managed in an efficient, effective, results-oriented and transparent manner	119.8	141.6	185.2	96.6	100.9	122.2	142.5	156.5	156.5	358.9	399.0	463.9	29%
Total base programmes	**1 657.1**	**2 301.8**	**2 462.8**	**917.9**	**1 152.3**	**1 037.0**	**1 193.7**	**1 514.3**	**1 468.6**	**3 768.7**	**4 968.4**	**4 968.4**	**32%**

Budget segment of emergency operations and appeals

117. This segment of the draft Proposed programme budget 2024–2025 includes WHO's operations in emergency and humanitarian settings, including protracted crises, as well as WHO's response to acute events. These increasingly protracted, complex and multidimensional crises demand multifaceted responses and greater resources than ever before.

118. For WHO's response operations during protracted crises, the financial requirements are planned for a 12-month period, aligning with the cycle of the humanitarian response plans of the United Nations Office for the Coordination of Humanitarian Affairs. For acute events, financial requirements are by nature event-driven and the level of the budget in this segment is therefore an estimate that is subject to increase as necessary.

119. Historically, the level of the emergency operations and appeals budget is baselined against that of the previous biennium. The level of the emergency operations and appeals budget in the bienniums 2020–2021 and 2022–2023 to date has been unprecedented as a result of the response to the COVID-19 pandemic, as well as the overall increase of people in need of health assistance as a result of emergencies and humanitarian crises.

120. With the onset of the COVID-19 pandemic, WHO moved towards an annual appeal for this budget segment. In 2020, WHO appealed for US$ 1.74 billion under the Emergency operations and appeals segment in order to respond to the COVID-19 pandemic. In 2021, WHO appealed for another US$ 1.96 billion for the COVID-19 pandemic response alone. As a result, the actual budget and implementation level for the emergencies operations and appeals segment of the Programme budget 2020–2021 exceeded by far the approved planned budget of US$ 1 billion. The final implementation level in 2020–2021 was 2.5 times the approved budget level.

121. In 2022, WHO moved towards a full-fledged annual operational planning process, involving all six regions, for the emergency operations and appeal segment of the programme budget and launched the Organization's first-ever consolidated Global Health Emergency Appeal, seeking US$ 2.7 billion for its work in responding to ongoing emergencies, including for the COVID-19 pandemic response in 2022.[1] For upcoming years, the Global Health Emergency Appeal will be published as a corporate product early in the year on an annual basis with regular updates for acute onset emergencies and/or the scale-up of existing responses.

122. As WHO plans for the emergency operations and appeals segment for 2023 and as the acute phase of the COVID-19 pandemic response draws to a close, 2023 will have its own set of challenges. The number of people and populations in need of health assistance is increasing, as a result of climate change, poverty and conflict, coupled with stretched and strained health systems worldwide, particularly in countries and regions that are dealing with emergencies and humanitarian crises. At the end of 2022, WHO was responding to 53 graded emergencies, including 13 grade-3 emergencies.

123. Similar to other bienniums, the total amount has been set as US$ 1 billion and will be increased upwards, depending on the degree and severity of events that occur in 2024–2025.

124. While the Secretariat response to scaled up emergencies and public health events is provided with support and collaboration from across the entire spectrum of the programme budget, this budget segment is most intrinsically related to results grouped in strategic priority 2, in particular outcome 2.3 (*Health emergencies rapidly detected and responded to*) and its outputs 2.3.1, 2.3.2 and 2.3.3.

[1] WHO's Global Health Emergency Appeal, 2022. Geneva: World Health Organization; 2022 (https://www.who.int/publications/m/item/who-global-health-emergency-appeal-2022#:~:text=Download%20(14.8%20MB)-,Overview,%2C%20including%20COVID%2D19%20response, accessed 5 August 2022).

Budget segment of polio eradication

125. The budget increase in this segment explains the totality of the increase in the draft Proposed programme budget 2024–2025, as all remaining budget segments remain unchanged with respect to their approved budget levels of 2022–2023.

126. The Polio Eradication Strategy 2022–2026[1] lays out a road map to securing a lasting polio-free world, by the end of 2026.

127. While global epidemiology cannot be predicted with certainty, the WHO polio programme as part of the Global Polio Eradication Initiative – consisting of WHO; Rotary International; the United States Centers for Disease Control and Prevention; the United Nations Children's Fund (UNICEF); the Bill & Melinda Gates Foundation; and Gavi, the Vaccine Alliance – is working towards the goal of achieving the interrupted transmission of all remaining wild poliovirus strains in endemic countries and stopping all outbreaks of circulating vaccine-derived poliovirus by the end of 2023. Thus, the focus in 2024–2025 will be to begin the preparatory phase for the certification of poliovirus eradication by 2025, as well as to make initial preparations for the eventual cessation of the use of all oral polio vaccines from routine immunization programmes (to be implemented following global certification) and ensure that the global laboratory containment of polioviruses is fully implemented in line with resolution WHA71.16 (2018).

128. At the same time, efforts will continue to transition the polio programme infrastructure and assets into broader public health systems. The first phase of transition will be completed during 2022–2023, involving the more than 50 countries that are currently supported through WHO's base programmes. The next phase of transition will focus on shifting core capacities for polio – such as surveillance, immunization, research and containment – to other programmes in order to sustain them beyond eradication. This will be outlined in the revised post-certification strategy that will be submitted to the Health Assembly in the biennium 2024–2025. WHO will continue to disseminate best practices and lessons learned in the course of eradicating poliomyelitis, which will help countries to develop future health policies, goals and interventions.

129. The proposed budget level for the polio segment of US$ 694 million for the biennium 2024–2025 will consist largely of the cost of undertaking supplemental immunization activities in Afghanistan and Pakistan in order to keep population immunity high through certification, as well as a substantial placeholder budget to enable surge support to countries wherever and whenever there are virus detections or outbreaks. The polio programme will also continue to make investments in gender mainstreaming and activities to encourage and enable integration.

130. The secretariat of the Global Polio Eradication Initiative, through WHO, will continue to report, through the regular governing bodies mechanisms, on the progress towards achieving a lasting polio-free world to Member States.

131. Polio eradication activities in this budget segment are interlinked with outputs 1.1.3 (*Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course*), 2.2.4 (*Polio eradication plans implemented in partnership with the Global Polio Eradication Initiative*) and 2.3.1 (*Potential health emergencies rapidly detected, and risks assessed and communicated*).

[1] See document A74/19.

BUDGET SEGMENT OF SPECIAL PROGRAMMES

132. **The United Nations Development Programme (UNDP)/United Nations Population Fund/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction** is the main instrument of the United Nations system for research in human reproduction. It supports and coordinates research on a global scale; synthesizes research through systematic reviews of literature; builds research capacity in low-income countries; and develops norms and standards to support the efficient use of its research outputs. Support for the country-level delivery of outputs of the Programme is provided by all the Programme's cosponsors, including through WHO's regional and country offices. A portfolio review process for the Programme for 2023 is under way and will result in updated priorities of the Programme as needed.

133. The proposed budget level for the Programme in the biennium 2024–2025 is US$ 72 million, which will be reviewed with the Programme's cosponsors in December 2022 and submitted for approval by the Policy and Coordination Committee in April 2023.

134. For the **UNICEF/UNDP/World Bank/World Bank/WHO Special Programme for Research and Training in Tropical Diseases**, the biennium 2024–2025 is the start of a new six-year strategy, which is aligned with the Sustainable Development Goals and contributes to the cosponsors' objectives, including the GPW 13 triple billion targets. The Programme will continue to address the same three strategic priority areas: research for implementation, capacity strengthening for health research, and engaging with global and local stakeholders for increased impact and sustainability.

135. The 2024–2025 budget for the Programme will support the Programme's vision of using research and innovation to improve the health of those burdened by infectious diseases of poverty. The Programme will continue to focus on identifying and overcoming barriers to effective health interventions. The Programme's approach is to respond to local and regional needs and priorities, while at the same time pursuing long-term flagship initiatives that can change the health landscape. The pandemic has proved the value of the Tropical Disease Research approach, which has established an in-country institutional and individual research capacity that is able to both support the COVID-19 pandemic response and build resilience in disease-control programmes in countries that are burdened by infectious diseases of poverty.

136. The proposed budget for the Programme in the biennium 2024–2025 was discussed and agreed by the Programme's Standing Committee and the Joint Coordination Board in 2022. It is aligned with the Programme's governing bodies review cycle, which ensures their full engagement in the budget development, approval and revision processes. The consultation process that will lead to the development and prioritization of the final Programme's workplan will give consideration to adding the cross-cutting themes recommended by the Seventh External Review of the Programme (2022), such as research on multisectoral approaches and One Health, evidence of increased resilience to climate change, promoting gender equity, etc. This will also benefit from a broad consultation on the Programme's future strategy that will include its cosponsors, WHO regional focal points, disease control departments, the Scientific and Technical Advisory Committee, external scientific working groups, and the disease-endemic countries appointed by the six regional offices, contributor constituencies and partner organizations, which are all represented on the Joint Coordination Board.

137. The proposed budget of US$ 50 million for the Programme for the biennium 2024–2025 was approved by the Joint Coordination Board in June 2022.

138. The implementation of **the Pandemic Influenza Preparedness Framework** in 2024–2025 will focus on strengthening influenza pandemic preparedness through a whole-of-society approach that ensures a more equitable response by building stronger and resilient country capacities. The Framework's priorities will be set in accordance with the high-level implementation plan for 2024–2030. An iterative process will be conducted in 2023 to develop country, regional and global activities of work that deliver against the results expected for the biennium 2024–2025, while ensuring alignment with national priorities and Member States' commitment. The work will build on implementation since 2014, during which gains have been made on strengthening laboratory and surveillance capacities, focusing on the WHO Global Influenza Surveillance and Response System; a better

understanding of influenza's health and economic burden; and enhanced planning and readiness for an influenza pandemic through regulatory preparedness, risk communication and community engagement systems, product deployment and exercising contingency plans.

139. Major changes to the proposed budget for the Framework are not expected. The proposed budget level for 2024–2025 is US$ 37.3 million, with 70% of partnership contributions directed towards preparedness work at regional and country levels. This level has been stable over the years.

140. Activities for the special programmes are linked to the results in the draft Proposed programme budget 2024–2025 as follows. Research and Training in Tropical Diseases is linked to work in output 4.1.3 (*Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries*); and output 1.1.2. (*Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results*). Research Training in Human Reproduction is also linked to output 4.1.3 noted above. The Pandemic Influenza Preparedness Framework is linked to output 2.2.3. (Mitigate *the risk of the emergence and re-emergence of high-threat pathogens and improve pandemic preparedness*).

Table 7. Total draft Proposed programme budget 2024–2025, by major office, functional level, segment and outcome (US$ millions)

Outcome	Africa			The Americas			South-East Asia			Europe			Eastern Mediterranean			Western Pacific			Head quarters	Total
	Country offices	Regional offices	Total	Country offices	Regional offices	Total	Country offices	Regional offices	Total	Country offices	Regional offices	Total	Country offices	Regional offices	Total	Country offices	Regional offices	Total		
1.1 Improved access to quality essential health services	368.8	54.2	423.0	55.8	33.9	89.7	213.8	41.9	255.6	54.3	55.1	109.4	94.9	36.5	131.5	84.6	51.3	135.9	334.6	1479.7
1.2 Reduced number of people suffering financial hardship	23.4	3.1	26.5	3.0	2.4	5.4	6.7	1.6	8.3	10.6	4.0	14.5	22.1	1.8	23.9	7.9	2.7	10.6	23.1	112.3
1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	38.5	15.0	53.5	11.2	10.1	21.3	16.6	7.1	23.8	6.3	9.7	16.1	45.1	6.6	51.7	14.4	5.9	20.3	138.8	325.5
2.1 Countries prepared for health emergencies	70.4	19.1	89.5	24.4	7.5	31.9	18.8	6.4	25.2	14.5	18.2	32.7	52.6	16.0	68.6	30.9	14.1	45.0	101.5	394.5
2.2 Epidemics and pandemics prevented	161.1	6.2	167.3	24.8	4.7	29.5	7.0	3.6	10.6	4.5	10.1	14.6	40.7	10.1	50.8	7.6	6.9	14.4	85.6	372.8
2.3 Health emergencies rapidly detected and responded to	119.4	49.1	168.5	11.1	4.1	15.2	18.9	5.2	24.1	9.7	15.3	24.9	50.4	30.7	81.1	13.8	18.7	32.5	151.7	498.0
3.1 Safe and equitable societies through addressing health determinants	22.9	7.6	30.5	3.0	3.4	6.4	7.7	2.1	9.8	3.1	6.4	9.5	13.1	2.1	15.2	4.7	4.0	8.7	27.5	107.6
3.2 Supportive and empowering societies through addressing health risk factors	21.3	5.3	26.6	13.4	7.1	20.5	13.4	2.2	15.6	6.9	10.7	17.7	17.0	3.8	20.7	18.3	5.0	23.3	36.5	160.9
3.3 Healthy environments to promote health and sustainable societies	10.7	5.7	16.4	10.1	5.6	15.7	7.4	4.3	11.7	5.6	17.1	22.7	13.6	3.7	17.3	23.7	7.7	31.4	53.2	168.4
4.1 Strengthened country capacity in data and innovation	38.2	18.4	56.7	5.5	9.3	14.8	14.7	9.1	23.8	3.5	13.0	16.5	42.3	17.9	60.2	17.3	8.0	25.3	176.6	373.9
4.2 Strengthened leadership, governance and advocacy for health	82.8	36.3	119.1	10.0	9.7	19.7	20.5	18.5	39.1	24.0	37.9	61.9	26.2	21.4	47.7	18.1	22.4	40.5	182.9	510.9
4.3 Financial, human and administrative resources managed in an efficient, effective, results-oriented and transparent manner	99.1	50.0	149.0	12.8	12.8	25.6	19.7	20.1	39.7	12.2	11.0	23.2	29.7	19.9	49.7	11.7	8.4	20.1	156.5	463.9
Subtotal base programmes	1 056.5	270.1	1 326.6	185.0	110.6	295.6	365.3	122.1	487.4	155.1	208.6	363.7	447.9	170.5	618.4	253.0	155.1	408.1	1 468.6	4 968.4
Polio eradication	-	20.2	20.2	-	-	-	-	-	-	-	-	-	320.2	22.6	342.8	-	-	-	331.2	694.3
Special programmes	-	3.6	3.6	-	4.3	4.3	-	3.9	3.9	-	4.1	4.1	-	3.8	3.8	-	3.4	3.4	176.7	199.7
Emergency operations and appeals	-	274.0	274.0	-	13.0	13.0	-	46.0	46.0	-	105.0	105.0	-	334.0	334.0	-	18.0	18.0	210.0	1 000.0
Total draft Proposed programme budget 2024–2025	**1 056.5**	**567.8**	**1 624.4**	**185.0**	**127.9**	**312.9**	**365.3**	**172.0**	**537.3**	**155.1**	**317.7**	**472.8**	**768.1**	**530.9**	**1299.0**	**253.0**	**176.5**	**429.5**	**2 186.5**	**6 862.4**

FINANCING OUTLOOK OF THE DRAFT PROPOSED PROGRAMME BUDGET 2024–2025

141. "A healthy return",[1] the investment case for a sustainably financed WHO, highlights the catalytic nature of investing in WHO: funds invested in WHO are used to support Member States in tackling health issues. Accordingly, the ability to finance the draft Proposed programme budget 2024–2025 will determine whether WHO's Secretariat and its Member States can collectively achieve the triple billion targets set out in the GPW 13. In working towards this common goal, the investment case highlights the substantial quantifiable return on investment in WHO: estimates stand at a US$ 35 return for every US$ 1 invested.

142. Specific financing objectives for GPW 13 include increasing country capacity, through improving funding quality, i.e more flexibility, predictability and aligning financing to WHO's programme budget results. These objectives will need to be operationalized through improved sustainable financing.

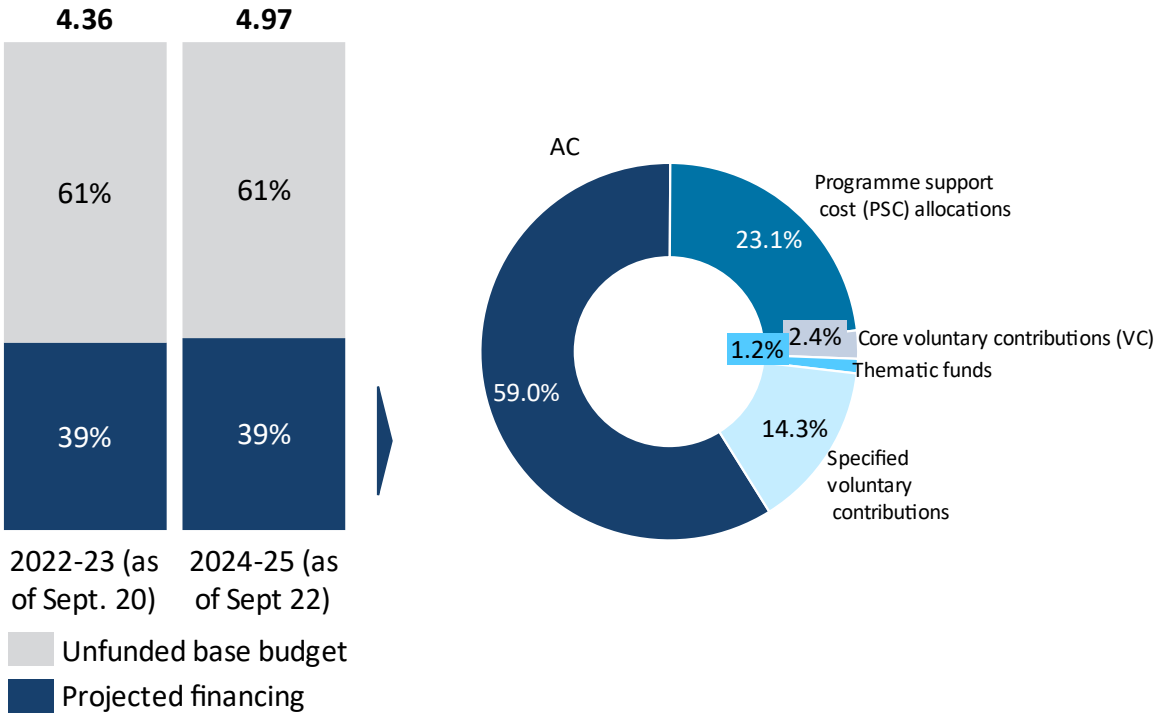
143. In this regard, the Secretariat welcomes the decision WHA75(8) (2022) on sustainable financing, which aims to improve WHO's ability to make an impact where it is most needed, at the country and regional levels. The increase in assessed contributions by 20% over 2022–2023 levels is a key driver in improving projected financing of the 2024–2025 programme budget. Continued increases in core voluntary contributions and thematic funding are crucial to give the Secretariat the means to ensure sufficient financing across all areas, including those that are underfunded.

144. Beyond volume and flexibility, the predictability and timeliness of financing is crucial. Providing appropriate financing for WHO's programme budget early in the biennium is key to ensuring timely implementation. For this reason and although it is still early in the process, the Secretariat will monitor future available financing as part of the further development of the draft Proposed programme budget 2024–2025. The analysis presented below is indicative of estimated financing levels at the time of preparation of this report and will be updated throughout the budget development process.

145. As at end-September 2022, the projected available financing for the draft Proposed programme budget 2024–2025 stood at US$ 2055 million, US$ 1947 million of which is for the base segment. This represents 39% of the base segment of the draft Proposed programme budget 2024–2025. These levels are similar to what was projected for the Programme budget 2022–2023 in September 2020 (Fig. 17).

[1] See *A healthy return: Investment case for a sustainably financed WHO*. Geneva: World Health Organization; 2022 (https://www.who.int/about/funding/invest-in-who/investment-case-2.0, accessed on 16 December 2022).

Fig. 17. Comparison of the level of projected financing for the proposed base budget segment for the biennium 2024–2025 with a similar stage in the biennium 2022–2023



146. A more detailed look at the composition of this funding, however, shows a different pattern of funding. Currently, projected financing largely consists of assessed contributions from Member States (US$ 1148 million or 59% of projected financing), driven by the expected 20% assessed contributions increase mentioned above. Other sources of flexible funds are core voluntary contributions and projected programme support costs allocations. Together, they make up 84.5% of the projected financing for 2024–2025. This number was 93% at a similar point at this stage in the last biennium. This indicates lower levels of predictability and flexibility as we head into the next biennium: projections currently foresee higher levels of specified voluntary contributions, while core voluntary contributions make up just over 2% of the current projections for 2024–2025.[1] Projected thematic funding has also declined compared with projected levels in 2020.

147. The projections will evolve throughout the remainder of the current biennium and usually the financing pattern will evolve more clearly towards the end of 2023.

148. The Secretariat looks forward to continuing to engage with donors through strategic dialogues and technical meetings and briefings on WHO funding needs, WHO's norm and standard-setting work and on the impact of WHO'S work in countries.

[1] Projections are conservative estimates of future financing. For core voluntary contributions, they include only contributions for which multiyear agreements going into 2024–2025 have already been signed. They do not include funding from traditional core voluntary contributions contributors for which no agreement has yet been signed.

PROGRAMME BUDGET 2024–2025 PRESENTATION AND DIGITAL PLATFORM

149. Three main objectives have motivated the redesigned presentation of the draft Proposed programme budget 2024–2025:

- improve transparency, clarity and accountability towards Member States;
- provide both high-level strategic information and specific costing and prioritization details in order to equip Member States to fully and efficiently exercise their strategic oversight; and
- facilitate the reading and understanding of the draft Proposed programme budget 2024–2025 and its underlying development process.

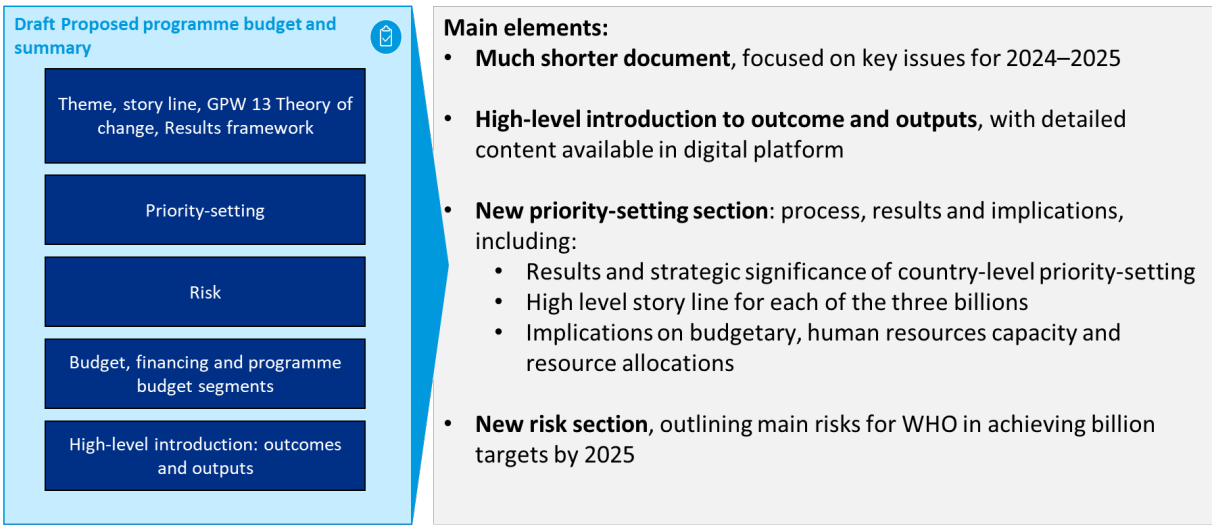
150. The three objectives are closely interlinked and respond to the concerns of Member States that they do not find the budget in its current format sufficiently clear and adequate for them to provide effective oversight. Member States have also requested a better overview and a shorter and more comprehensible document, but with enhanced detail in some areas. The new structure of the draft Proposed programme budget was designed on the basis of those Member States' concerns, while also reviewing the programme budgets of other United Nations agencies and organizations to build on best practices.

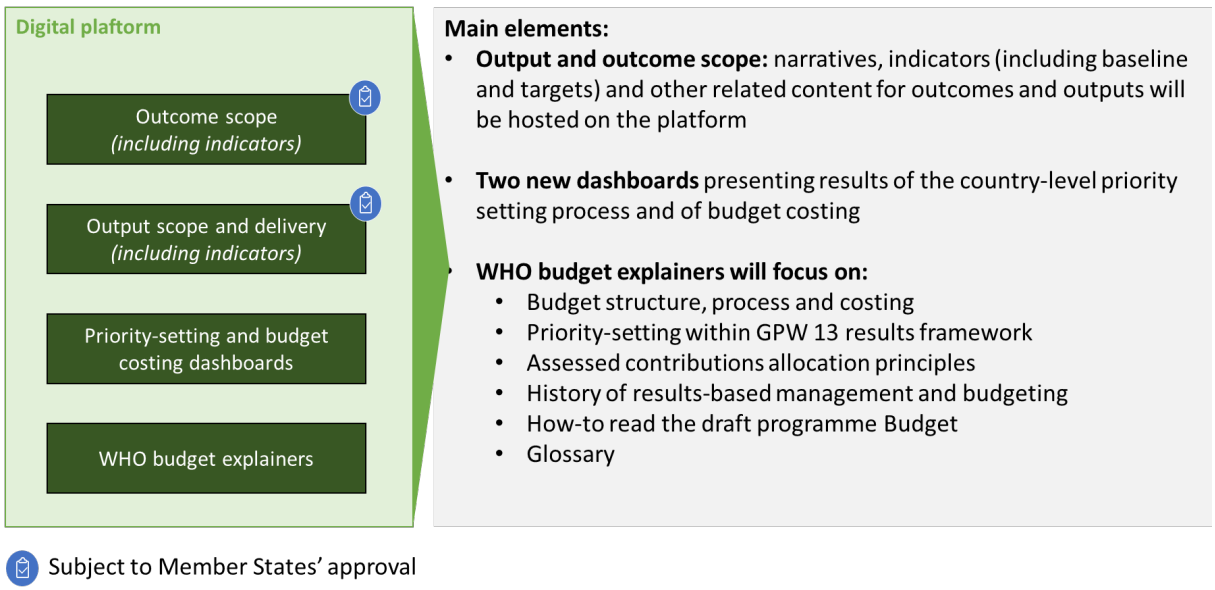
151. In terms of the presentation format of the draft Proposed programme budget 2024–2025, the following improvements and enhancements are being implemented:

- **More adequate information for strategic oversight.** The draft Proposed programme budget 2024–2025 is bringing forward more explicitly several elements that have been considered key by Member States. Among them, the document describes in more detail the results and strategic significance of priority-setting, and the expected implications that the prioritization would have on resource allocations. Similarly, it touches upon the relationship between costing and the budget. All of this is to provide Member States with quality information that permits them to better understand how the draft Proposed programme budget 2024–2025 is costed and developed under the overall principles of results-based management.
- **Structural and design-related improvements.** The draft Proposed programme budget 2024–2025 will have a modular structure, with sections that can be read independently (such as an executive summary and outcome-level and output-level narratives). The document has been structured in two main dimensions:
    - The programme budget framework and summary document, which will contain the major aspects that are subject to Member States approval, with the exception of the detail of the outcomes and outputs (upper panel of Fig. 18). The overall storyline will follow a "funnel" approach, starting at a high level, and then becoming more detailed and focused on the base budget only.
    - The digital platform is still under construction and will include traditional as well as new components (see Fig. 18, lower panel).
        - Still subject to Member States approval, the key elements of accountability for results, i.e. the outcomes and outputs, are being moved to the digital platform. They will include a newer, reformatted view, consisting of narratives with their respective scope of work and indicators, and in the case of the outputs, the main Secretariat's deliverables to achieve the results proposed. Complementing this information, each outcome and output will also include useful information such as previous biennium budget, financing, performance and the future biennium's main results of the prioritization and costing.
        - Two new digital dashboards will complement and provide further detail on the results of the prioritization and costing by major office.

- Adding supporting documentation ("explainers") to aid comprehension. These explainers will describe underlying budgetary principles, the prioritization processes and other elements in order to ensure an aligned and common understanding.

Fig. 18. Draft Proposed programme budget 2024–2025: main components of the framework and summary document and of the digital dimension





ANNEX. DRAFT PROPOSED OUTPUT INDICATORS

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
1.1	**Improved access to quality essential health services irrespective of gender, age or disability status**				
1.1.1	**Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages**				
1.1.1.IND1	Number of countries with comprehensive essential service packages defined based on integrated models of care				
1.1.1.IND2	Number of countries with quality strategies aligned with national health policies or plans				
1.1.1.IND3	Number of countries with up-to-date performance assessments on the provision of primary health care				
1.1.2	**Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results**				
1.1.2.IND1	Percentage of countries that report on the key health indicators on communicable and noncommunicable diseases identified and recommended by WHO	62%	67%	71%	There is a target lag, compared with previous bienniums, due to fewer countries reporting during the COVID-19 pandemic on the hepatitis, neglected tropical diseases, noncommunicable diseases and vaccine preventable diseases components of this indicator. In addition, the component for neglected tropical diseases has been expanded from 17 to 20 diseases.
1.1.2.IND2	Number of countries that developed multi-disease approaches to elimination (countries targeting three or more conditions or diseases for elimination)	0	6	10	
1.1.2.IND3	Percentage of countries implementing WHO norms and standards to address conditions and diseases most relevant for the respective country	47%	55%	63%	The baseline takes into account the change in tuberculosis component to using a 6-month bedaquiline-pretomanid-linezolid (BPaL) and bedaquiline-pretomanid-linezolid-moxifloxacin (BPaLM) regimen for people with rifampicin-resistant tuberculosis.
1.1.3	**Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course**				
1.1.3.IND1	Number of countries that have developed multisectoral programmes for integrated childhood development	20		40	
1.1.3.IND2	Number of additional countries transitioning out of support from Gavi, the Vaccine Alliance, that have increased their allocation to vaccine procurement compared with the 2019 allocation	7		5	
1.1.3.IND3	Number of countries that have introduced human papillomavirus tests for cervical screening	25			
1.1.4	**Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities**				
1.1.4.IND1	Number of countries that have a comprehensive national health sector policy/strategy/plan with goals and targets that have been updated within the last five years				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
1.1.4.IND2	Number of countries that have monitored the progress of their national health policy/strategy/plan during the biennium				
1.1.4.IND3	Number of countries that have an inclusive societal dialogue process in place for health policy development				
1.1.5	**Countries enabled to strengthen their health and care workforce**				
1.1.5.IND1	Number of countries implementing National Health Workforce Accounts: data reported by Member States through the National Health Workforce Accounts platform	180		185	
1.1.5.IND2	Number of countries reporting on migrant health workers (as measured by foreign-born/foreign-trained health workers): data reported by Member States through the National Health Workforce Accounts platform and/or the WHO Global Code of Practice on the International Recruitment of Health Personnel	145		155	
1.1.5.IND3	Number of countries reporting on the production of health workers (mainly the number of graduates of schools of dentistry, medical, midwifery, nursing or pharmacy): data reported by Member States through the National Health Workforce Accounts platform	130		140	
1.2	**Reduced number of people suffering financial hardship**				
1.2.1	**Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage**				
1.2.1.IND1	Number of countries supported showing evidence of progress in their health financing arrangements	0	35	50	
1.2.2	**Countries enabled to produce and analyse information on financial protection, equity and health expenditures and to use this information to track progress and inform decision-making**				
1.2.2.IND1	Increased number of countries producing country-specific health accounts using classifications from *A System of Health Accounts 2011: Revised edition*	116	118	120	
1.2.2.IND2	Increased number of countries that have completed or updated an analysis of financial protection since 2015	52			
1.2.3	**Countries enabled to improve institutional capacity for transparent decision-making in priority-setting and resource allocation and analysis of the impact of health in the national economy**				
1.2.3.IND1	Increased number of countries systematically incorporating economic evidence when developing new products (for example, packages of essential services and investment cases) or improving decision-making processes (for example, health technology assessments) with the aim of increasing efficiency	9		31	
1.3	**Improved access to essential medicines, vaccines, diagnostics and devices for primary health care**				
1.3.1	**Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists**				
1.3.1.IND1	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
1.3.2	**Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems**				
1.3.2.IND1	Number of countries updating/developing/implementing medicines pricing policies and monitoring systems				
1.3.2.IND2	Number of countries initiating a national priority medical devices list, including essential in vitro diagnostics				
1.3.2.IND3	Number of countries regularly reporting prices of medicines				
1.3.3	**Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services**				
1.3.3.IND1	Number of products prequalified annually				
1.3.3.IND2	Number of countries with improved regulatory systems				
1.3.3.IND3	Number of countries with well-functioning regulatory status (National Regulatory Authority maturity level 3)				
1.3.3.IND4	Number of countries with a risk–based approach for regulating in vitro diagnostic medical devices				
1.3.3.IND5	Number of countries with improved regulatory preparedness for public health emergencies				
1.3.4	**Research and development agenda defined and research coordinated in line with public health priorities**				
1.3.4.IND1	Development of a global priority and research agenda for addressing antimicrobial drug resistance in fungal infections				
1.3.4.IND2	Priorities identified for paediatric formulations (e.g. HIV, tuberculosis, hepatitis, essential medicines) and support provided for research and development to deliver them	0	3	5	
1.3.4.IND3	Introduction of a standardized target product profile development process across WHO	0	5	10	
1.3.5	**Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices**				
1.3.5.IND1	Number of countries implementing government-approved multisectoral antimicrobial resistance national action plans that involve relevant sectors and have a monitoring framework	103	106	112	
1.3.5.IND2	Number of countries having an antimicrobial resistance surveillance system and providing data to WHO	91	95	100	
1.3.5.IND3	Number of countries with national systems in place to monitor the consumption and use of antimicrobials in human health	85	100	110	
2.1	**Countries prepared for health emergencies**				
2.1.1	**All-hazards emergency preparedness capacities in countries assessed and reported**				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
2.1.1.IND1	Number of countries that have used findings resulting from the International Health Regulations Monitoring and Evaluation Framework to develop or update their national action plan				
2.1.1.IND2	Number of countries that submitted a State Party Self-Assessment Annual Reporting Tool				
2.1.2	**Capacities for emergency preparedness strengthened in all countries**				
2.1.2.IND1	Number of countries with national strategies or plans to strengthen country capacities for all-hazards preparedness to reduce health risks and consequences of emergencies and disasters				
2.1.2.IND2	Number of global and regional strategies or plans to strengthen country capacities for all-hazards preparedness to reduce health risks and consequences of emergencies and disasters				
2.1.2.IND3	Number of relevant global public health programmes that integrate or incorporate emergency preparedness and response considerations				
2.1.3	**Countries operationally ready to assess and manage identified risks and vulnerabilities**				
2.1.3.IND1	Number of priority countries which have developed a multi-hazards health emergency risk profile in the previous three years	31		41	The measure for 2024-2025 is three years (for 2022–2023 it was four years). The Strategic Tool for Assessing Risks (STAR) recommends a risk assessment every two to three years.
2.1.3.IND2	Number of priority countries with a documented, national emergency response plan or other arrangement based on health emergency risk-mapping	50		60	
2.1.3.IND3	Number of priority countries that have assessed operational readiness capability for their priority risk(s) using WHO recommended readiness assessment methodology and tools	60		60	The measure for 2024–2025 is readiness "capability" (it was readiness "capacities" in 2022–2023), in line with the current revision of the readiness concept.
2.2	**Epidemics and pandemics prevented**				
2.2.1	**Research agendas, predictive models and innovative tools, products and interventions available for high-threat pathogens**				
2.2.1.IND1	Number of target product profiles for product and medical countermeasures developed for high-threat pathogens				
2.2.1.IND2	Number of policy advice materials (expert advisory panel or committee recommendations, guidelines, public health research and policy briefs) developed for high-threat pathogens and high-impact events				
2.2.2	**Proven prevention strategies for priority/epidemic-prone diseases implemented at scale**				
2.2.2.IND1	Proportion of countries with implementation plans for the global strategy to eliminate yellow fever epidemics (EYE) for the period 2017–2026 or with comprehensive multiyear strategic plans detailing yellow fever routine immunization introduction or with improvement activities and reporting coverage in the joint reporting form on immunization				
2.2.2.IND2	Number of countries with fully funded multisectoral cholera control plans aligned to Ending Cholera – A Global Roadmap to 2030				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
2.2.2.IND3	Proportion of countries with a budgeted meningitis preparedness and response plan				
2.2.2.IND4	Proportion of priority countries with a budgeted preparedness and response plan for the pathogen(s) responsible for viral haemorrhagic fevers (Ebola, Marburg, Lassa and Arenaviridae and Crimean-Congo haemorrhagic fevers, Rift Valley Fever, Nipah virus disease and those associated with henipavirus and hantavirus infections) that are endemic in the countries concerned				
2.2.3	**Mitigate the risk of the emergence and re-emergence of high-threat pathogens and improve pandemic preparedness**				
2.2.3.IND1	Number of hot spots that have been supported to develop risk mitigation measures for high-threat pathogens				
2.2.3.IND2	Number of countries incorporating influenza programmes into national action plans that include strategies for nonpharmaceutical interventions, vaccines and antiviral drugs				
2.2.4	**Polio eradication plans implemented in partnership with the Global Polio Eradication Initiative**				
2.2.4.IND1	Number of WHO regions that have maintained wild poliovirus-free status				
2.2.4.IND2	Number of WHO regions that have remained free of circulating vaccine-derived poliovirus (cVDPV) outbreaks				
2.2.4.IND3	Number of WHO regions that have fully transitioned away from the Global Polio Eradication Initiative (GPEI) support for core capacities				
2.3	**Health emergencies rapidly detected and responded to**				
2.3.1	**Potential health emergencies rapidly detected, and risks assessed and communicated**				
2.3.1.IND1	Percentage of critical acute public health events for which a formal rapid risk assessment is completed and circulated within one week				
2.3.1.IND2	Percentage of signals verified under the International Health Regulations (2005) within 24–48 hours				
2.3.2	**Acute health emergencies rapidly responded to, leveraging relevant national and international capacities**				
2.3.2.IND1	Percentage of newly graded emergencies for which a strategic response plan has been issued within 30 days				
2.3.2.IND2	Percentage of newly graded emergencies for which an Incident Management System is activated at country-level within 72 hours				
2.3.2.IND3	Percentage of times, during a Grade 2 or 3 emergency, that a critical items shipment has been loaded to destination within the first 72 hours after signature of an emergency request				
2.3.3	**Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings**				
2.3.3.IND1	Percentage of fragile, vulnerable or conflict-affected situations that have a humanitarian response plan (or equivalent) that includes a health sector component				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
2.3.3.IND2	Percentage of fragile, vulnerable or conflict-affected situations with known attacks on health care that report to the surveillance system for attacks on health care				
2.3.3.IND3	Percentage of country health clusters with a dedicated, full time health cluster coordinator				
3.1	**Safe and equitable societies through addressing health determinants**				
3.1.1	**Countries enabled to address social determinants of health across the life course**				
3.1.1.IND1	Number of countries that have enacted or changed legislation or policies to address injuries (road safety, violence prevention, drowning prevention)				
3.1.1.IND2	Number of countries that have strengthened their multisectoral governance for health/Health in All Policies capacities and actions				
3.1.1.IND3	Number of countries that have integrated social determinants of health and health equity in their planning, implementation and monitoring of health policies/programmes				
3.1.2	**Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach**				
3.1.2.IND1	Number of countries covered with WHO-aligned standards for iron fortification of staple foods and/or condiments				
3.1.2.IND2	Number of countries with national foodborne disease surveillance or having endorsed the One Health approach in food safety policies	18			This is one of the progress indicators of the WHO global strategy for food safety 2022–2030. Since the strategy is in the early stages of implementation, the end-of-biennium target will be provided at a later stage.
3.1.2.IND3	Number of countries implementing most provisions of the International Code of Marketing of Breast-milk Substitutes				
3.1.2.IND4	Number of countries with a functioning multisectoral antimicrobial resistance coordination committee	86	88	90	
3.2	**Supportive and empowering societies through addressing health risk factors**				
3.2.1	**Countries enabled to address risk factors through multisectoral actions**				
3.2.1.IND1	Number of countries covered by tobacco advertisement regulations and/or smoke-free environment policies	101	103	105	
3.2.1.IND2	Number of countries covered by a national policy or strategy on physical activity	150		160	Indicates the national priority and planning on physical activity; and implementation of the WHO recommendation to all countries to develop, resource and implement a comprehensive national approach to increase physical activity. In 2022–2023, this indicator was approved to measure a 3% decrease in insufficient physical activity for adults and adolescents.
3.2.1.IND3	Number of countries covered by best practice policies to reduce, eliminate industrially produced trans-fatty acids in the food supply	48			In 2022–2023, this indicator was approved to also measure the restricted marketing of unhealthy foods and beverages to children; and/or a reduction in population mean food salt intake.
3.2.2	**Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures**				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
3.2.2.IND1	Number of countries with health laws, standards or policies at national and subnational levels governing health-related activities across sectors				All countries have health laws, creating a methodological challenge in creating a single general indicator to measure progress on health laws.
3.2.2.IND2	Number of countries with health promotion approaches, mechanisms and instruments to address health risks to foster health and well-being				
3.2.2.IND3	Number of countries with established mechanisms of risk assessment and management of conflict of interest (in the technical scope of this output)				
3.3	**Healthy environments to promote health and sustainable societies**				
3.3.1	**Countries enabled to address environmental determinants, including climate change**				
3.3.1.IND1	Number of countries with water-safety planning policies				
3.3.1.IND2	Number of countries that have developed health adaptation plans for climate change				
3.3.1.IND3	Number of countries with improvement in air quality based on the latest three-year mean				
3.3.2	**Countries supported to create an enabling environment for healthy settings**				
3.3.2.IND1	Number of countries that have adopted the WHO corporate framework on healthy cities including the urban governance framework				
3.3.2.IND2	Number of countries that have adopted the global standards for health-promoting schools				
3.3.2.IND3	Number of countries with community empowerment strategies to advance healthy settings				
4.1	**Strengthened country capacity in data and innovation**				
4.1.1	**Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts**				
4.1.1.IND1	Population-weighted average score of the performance of country civil registration and vital statistics systems	95%	97%	100%	
4.1.1.IND2	Number of countries that have implemented follow-up action based on assessments using the Survey, Count, Optimize, Review and Enable (SCORE) for Health Data technical package	189	189	189	
4.1.1.IND3	Number of regional and global partners in academia, research and international organizations that are working with WHO to support countries to increase efficiencies in data-related work	100	175	250	
4.1.2	**GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored**				
4.1.2.IND1	Percentage of global population that is covered with recent data for at least 75% of the health-related Sustainable Development Goal targets reported in World Health Statistics	90%	90%	90%	
4.1.2.IND2	Proportion of WHO data-related technical products on norms/standards, data and research that report data disaggregated by age or sex and at least one other dimension of inequality (area of residence, education level or socioeconomic factors)	45%	50%	58%	Technical products on norms/standards, data and research were formerly known as global public health goods.

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
4.1.2.IND3	Percentage change in population coverage to reach each of the triple billion targets (one billion people benefiting from universal health coverage)	2.30%	3.20%	4.20%	
4.1.2.IND4	Percentage change in population coverage to reach each of the triple billion targets (one billion more people better protected from health emergencies)	10.40%	11.60%	12.90%	
4.1.2.IND5	Percentage change in population coverage to reach each of the triple billion targets (one billion more people enjoying better health and well-being)	16.90%	19.80%	22.60%	
4.1.2.IND6	World Health Data – home for health data (Data.who.int) fully operationalized: all programmes using country portal for consultations, data lake and open access				New output indicator for 2024–2025
4.1.3	**Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries**				
4.1.3.IND1	Number of countries with research and innovation capacity to identify and scale up innovations and digital solutions in response to country demand				
4.1.3.IND2	Number of innovations scaled in response to country demand				
4.1.3.IND3	Number of countries that have established integrated mechanisms at national level for development, adaptation and implementation of evidence-informed clinical and public health guidelines using WHO guidelines, norms and standards	27		36	
4.1.3.IND4	Number of countries that have established national knowledge translation mechanisms for evidence-informed health policy-making	34		46	New output indicator for 2024–2025
4.1.3.IND5	Proportion of Member States that have developed a costed national digital health strategy or road map	20%		50%	New output indicator for 2024–2025
4.1.3.IND6	Proportion of Member States with mechanisms to develop or identify health system innovations for scale-up	10%		40%	New output indicator for 2024–2025
4.2	**Strengthened leadership, governance and advocacy for health**				
4.2.1	**Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform**				
4.2.2	**The Secretariat operates in an accountable, transparent, compliant and risk management-driven manner including through organizational learning and a culture of evaluation**				
4.2.2.IND1	Percentage of audit observations responded to in a timely manner, with an emphasis on addressing systemic issues				
4.2.2.IND2	Percentage of recommendations in corporate and decentralized evaluations implemented within agreed time frames				
4.2.2.IND3	Percentage of corporate critical risks with approved mitigation plans implemented				
4.2.3	**Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships**				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
4.2.3.IND1	Proportion of flexible and semi-flexible funding of the overall funding available for the biennium				
4.2.3.IND2	Number of contributors entering a strategic dialogue process with WHO				
4.2.3.IND3	Number of non-State actor partners publicly committing to improve their health impact				
4.2.4	**Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13**				
4.2.4.IND1	Proportion of priority outcomes at the country level with at least 75% funding by the end of the second quarter of the biennium				
4.2.4.IND2	Percentage of budget centres that have completed the output scorecard to assess programme budget performance according to corporate monitoring guidance				
4.2.5	**Cultural change fostered and organizational performance enhanced through coordination of the WHO-wide transformation agenda**				
4.2.5.IND1	Number of staff across the three levels of the Organization being informed by, and satisfied with, internal communications tools (including Workplace, newsletters, emails from Director-General, Intranet articles, staff seminars)				
4.2.5.IND2	Percentage of global WHO transformation initiatives rated as “on track” at the time of reporting				
4.2.6	**“Leave no one behind” approach focused on equity, gender and human rights progressively incorporated and monitored**				
4.2.6.IND1	Percentage of outputs with at least a score of 3 on the “Impactful integration of gender, equity and human rights” output scorecard dimension	N/A	70%	75%	
4.2.6.IND2	Number of countries implementing at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes	35	125	143	
4.2.6.IND3	Percentage of resolutions at global level that include gender-responsive, equity-oriented and human rights-based actions	70%	89%	90%	
4.2.6.IND4	Percentage of indicators that are met or exceeded in the United Nations accountability frameworks subscribed to by WHO, namely the United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women (UNSWAP) and the United Nations Disability Inclusion Strategy (UNDIS)	18%	72%	80%	
4.3	**Financial, human and administrative resources managed in an efficient, effective, results-oriented and transparent manner**				
4.3.1	**Sound financial practices and oversight managed through an efficient and effective internal control framework**				
4.3.1.IND1	Receipt of an unmodified audit opinion by the External Auditor on the yearly financial statements				
4.3.1.IND2	Compliance rate of global imprest accounts with imprest reconciliation requirements and attainment of an A rating				

	Outcome, output or output indicator	Baseline	Mid-term target	End-of-biennium target	Comments
4.3.2	**Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery**				
4.3.2.IND1	Number of international staff members moving between duty stations				
4.3.2.IND2	Overall male/female ratio among international professional staff				
4.3.2.IND3	Reduction in the number of unrepresented and under-represented countries over time (based upon the recruitment of international professional staff)				
4.3.2.IND4	Average duration of the selection process from the date of publication of a vacancy notice to the signature of the selection report by the decision-maker				
4.3.3	**Effective, innovative and secure digital platforms and services aligned with the needs of users, corporate functions, technical programmes and health emergencies operations**				
4.3.3.IND1	Percentage of locations with essential information technology infrastructure and services aligned with agreed organizational standards, including corporate and health systems applications				
4.3.3.IND2	Number of new platforms and services introduced in support of digitalization of WHO products, content and services, as well as internal innovation initiatives				
4.3.3.IND3	Level of implementation of cybersecurity road map in comparison with baseline established by the information technology security assessment				
4.3.4	**Safe and secure environment, with efficient infrastructure maintenance, cost-effective support services and responsive supply chain, including occupational health and safety**				
4.3.4.IND1	Ratio of expenditures on goods based on catalogue/long-term agreements versus those relating to non-catalogue/long-term agreements				
4.3.4.IND2	Number of security incidents with an impact on WHO personnel, premises and assets, and operations				
4.3.4.IND3	Rate of compliance with United Nations Minimum Operating Security Standards				