World Health Organization

SEVENTH MEETING OF THE WORKING GROUP ON SUSTAINABLE FINANCING
Geneva, 25–27 April 2022

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21 April 2022

Rationale for an increase in assessed contributions

Background document

INTRODUCTION

1. At the sixth meeting of the Working Group on Sustainable Financing on 10 and 11 March 2022, Member States raised four specific questions regarding an assessed contributions increase, which would need to be answered and justified to national governments if an assessed contributions increase were to be considered. This paper sets out to address them. They are:

1. Why is an increase in assessed contributions required?

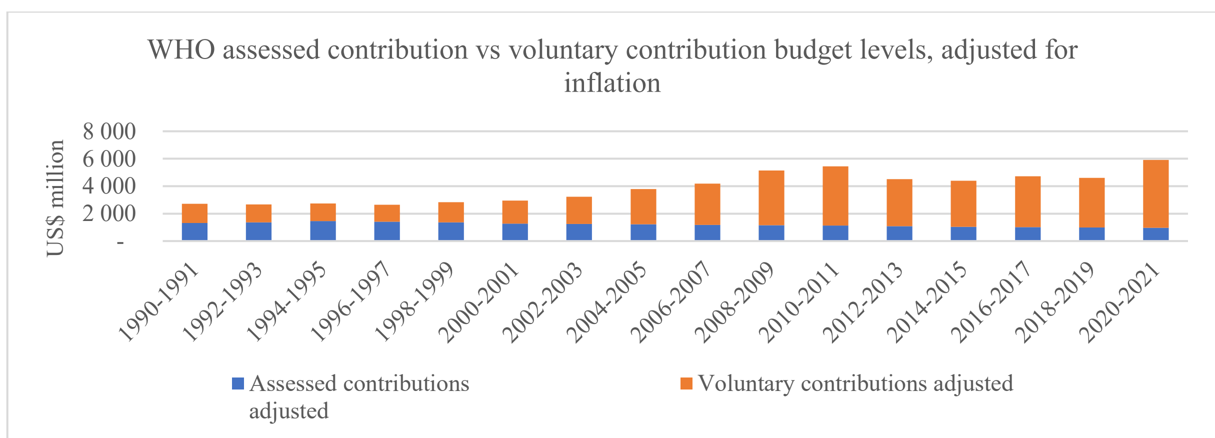
2. Why is the target of 50% of the base segment of the approved Programme budget 2022–2023 proposed?

3. How would such an increase in assessed contributions be used?

4. Why can assessed contributions not be appropriated in the Programme budget?

1. WHY IS AN INCREASE IN ASSESSED CONTRIBUTIONS REQUIRED?

2. In 1948, 61 governments financed most of WHO's approximately US$ 15 million budget with assessed contributions. Seven decades later, WHO has a Programme budget of US$ 5.8 billion, an approximately 580% growth in real terms since 1948, but financed to only 16% by assessed contributions. The rest comes from voluntary contributions at the discretion of donors.



3. This presents a number of challenges that an increase in assessed contributions would help to rectify or even solve. A large reliance on voluntary contributions leads to a situation in which funding is not inherently sustainable. Document EB/WGSF/1/3 defined sustainable financing as flexible, predictable, medium-to-long-term, not dependent on a small number of donors and supporting predominantly the base segment of the Programme budget. Assessed contributions are therefore the best, if not the only, option for providing the necessary sustainable funding since other options are not guaranteed to be sustainable because of their reliance on sources external to the governance and control functions of the Organization.

Member State ownership of the Programme budget and its priorities

4. The Health Assembly approves the priorities of WHO through its Programme budget. However, when the Programme budget is funded predominantly by voluntary contributions this makes it extremely difficult to ensure that the priorities set out by the Health Assembly are adequately financed. Setting priorities is not a realistic exercise if it is done by one party while financed by a second party at the second party's discretion.

5. As a result, the setting of priorities in a meaningful manner must be accompanied by a discussion of how these priorities should be financed in a realistic manner that can be determined by those who actually set them. The most effective and efficient solution would be for the same Member States that approve the priorities to finance them directly through assessed contributions as the majority share of funding. The Working Group stressed that "Member States as a collective must match their willingness to fund the Organization with the demands that they place on it" (document EB/WGSF/5/4, paragraph 38(d)).

Address pockets of poverty

6. One of the most pressing concerns raised by the lack of sustainable financing is the issue of so-called "pockets of poverty". As a significant proportion of WHO's voluntary contributions is earmarked for activities, areas of work or geographical locations that contributors prefer to support, this leads to a situation of both underfunding and overfunding across Programme budget segments, major offices and levels of the Organization (Table 1). Even if the Organization as a whole appears to be fully funded, if some areas are funded over 100%, the inflexibility of funding may prevent the excess funds being used where most needed. The Organization makes every effort to rebalance the financing levels between severely underfunded and well-funded technical areas; however, with very limited amounts of assessed contributions or flexible funding with which to invest in underfunded areas, a true balance can never be achieved. These pockets of poverty will persist and are likely to increase as long as the sustainable financing of WHO remains at its current level.

Table 1. Heatmap of Programme budget 2020–2021 financing by outcome and major office

Global outcomes	AF Africa	AM Americas	EM Eastern Mediterranean	EU Europe	SE South East Asia	WP Western Pacific	HQ Headquarters	Grand Total
1.1 Improved access to quality essential health services	105%	100%	151%	118%	100%	101%	192%	131%
1.2 Reduced number of people suffering financial hardship	59%	94%	38%	92%	72%	85%	120%	80%
1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	78%	76%	51%	80%	61%	63%	116%	92%
2.1 Countries prepared for health emergencies	77%	130%	61%	71%	42%	62%	85%	73%
2.2 Epidemics and pandemics prevented	89%	62%	167%	61%	66%	32%	63%	84%
2.3 Health emergencies rapidly detected and responded to	108%	19%	108%	63%	132%	86%	78%	87%
3.1 Determinants of health addressed	78%	92%	62%	69%	110%	71%	179%	109%
3.2 Risk factors reduced through multisectoral action	20%	49%	74%	91%	90%	70%	93%	64%
3.3 Healthy settings and Health-in-All Policies promoted	18%	15%	38%	72%	81%	40%	88%	47%
4.1 Strengthened country capacity in data and innovation	84%	52%	36%	60%	78%	58%	105%	84%
4.2 Strengthened leadership, governance and advocacy for health	54%	143%	74%	101%	69%	94%	134%	96%
4.3 Financial, human, and administrative resources managed in an efficient, effective, results-oriented and transparent manner	118%	85%	94%	109%	94%	102%	109%	105%
Grand Total	**84%**	**75%**	**103%**	**92%**	**84%**	**82%**	**125%**	**99%**

7. Assessed contributions are the single largest source of what is considered the flexible funding of WHO. This means that it can be distributed and implemented in support of any part of the approved Programme budget in any major office (i.e. regions or headquarters). A significant increase would provide an immediate solution to the disparities in financing represented here.

Predictability and timeliness

8. Assessed contribution funding is the only fully predictable source that Member States can provide. It also avoids a problem of voluntary contributions that can be encountered sooner or later over the course of a biennium and seriously hampers the full implementation of planned results even if those results appear, at the end of the biennium, to have been fully funded. Assessed contributions, because they are considered to be available from the start of the biennium, eliminate this problem. The Working Group recommended that funding be found for WHO that "is fully flexible or at least thematic in nature, as well as sustainable and predictable" (EB/WGSF/5/4, paragraph 39(e)(i)). This also improves the strategic planning of activities, as most assessed contribution allocations are committed at the start of the biennium, as a key input for managers during the operational planning process.

Perception of impartiality

9. For the Organization to carry out its duties effectively in any circumstances, it has to be able to act without concerns about where financing is coming from, not least in terms of potential conflicts of interest. Assessed contributions provided by their own Member States gives it full confidence to act with impartiality and without having to consider the perceptions associated with heavy donor reliance. This was specifically called for by the Independent Panel for Pandemic Preparedness and Response (IPPPR), among others. Furthermore, the Director-General stated that "WHO's reliance on voluntary contributions to fund over 80% of the approved Programme budget threatens its ability to deliver the impartial and world-class normative work that Member States expect" (EB/WGSF/4/3, paragraph 2).

10. An assessed contribution increase would ensure that the Organization could depend on core costs covered without any concern regarding predictability or flexibility and without any need for additional donor support.

Maintaining WHO's relevance and timely response to the changing public health environment

11. Sustainable funding is critical for responding to the changing public health environment and addressing areas – such as emergency preparedness, noncommunicable diseases and universal health

coverage – that traditionally do not appeal to a broad spectrum of voluntary contributors. In the biennium 2020–2021, in the midst of the COVID-19 pandemic, Programme budget outcomes corresponding to the "One billion more people better protected from health emergencies" target were among the least funded areas of WHO.

12. Likewise, WHO's important role has been highlighted in current global health architecture forums. The normative and standard-setting functions of WHO have been stressed and the increased demand on a strong WHO – or else the creation of alternate global health mechanisms – has been discussed. It has been recognized that for WHO to play the global role that has been assigned to it, it is key to improve the way it is financed so that it is ready to face the challenges vested upon it as the key major player in global health.

Quality of work: attracting talent

13. The strength of WHO as an organization lies in the excellence of its staff. However, owing to the fact that the bulk of WHO's current financing is strictly earmarked and not predictable and given that the largest cost component of the Organization's expenditure is for workforce contracts (both staff and non-staff), effective workforce planning and management have proven difficult. This, in turn, ultimately impedes the Organization's ability to attract and retain the best professionals in global health. The current financing patterns lead to negative consequences, such as:

- incentivizing independent fundraising efforts and/or the acceptance of voluntary contributions to complement insufficient core funding for staff, which may not be fully aligned with key priorities;

- rendering longer-term forward planning (i.e. beyond a one to two-year time period) challenging or even impossible;

- restricting the Organization's ability to change course or reprioritize when new challenges arise or new skills are required;

- creating delays in recruitments, which limit the Secretariat's ability to respond; and

- reducing the attractiveness of the Organization as an employer not only to prospective candidates but also to the existing workforce.

14. The Organization has thus increasingly had to rely on larger numbers of short-term staff and consultants, which results in higher administrative and transaction costs and increased employee/employer dissatisfaction and is not sustainable in the long run.

Donor reliance

15. WHO's significant reliance on voluntary contributions is further intensified by its dependence on a somewhat narrow donor base, with only a few large donors. The top five donors of voluntary contributions represent 30–60% of the financing for the outcomes of the Programme budget 2020–2021. Withdrawal of any of these major donors would leave an immediate and substantial funding gap that could not be bridged easily due to the very limited amounts of sustainable, flexible and predictable financing.

Increasing efficiencies by reducing the administrative burden on managing many small grants

16. Besides flexible funding and significant grants from a handful of contributors, WHO relies on a very large number of medium and smaller amounts of voluntary contributions. For example, Programme budget outcome 1.1, "Improved access to quality essential health services", currently has 191 distinct contributions. As a result, within one biennium the Secretariat manages thousands of awards across hundreds of budget centres, a significant administrative burden. The negotiation, mobilization, management, implementation and reporting on these grants also takes away from the time that technical teams could have dedicated to technical cooperation activities and often also requires the hiring of extra support to help manage or monitor grants, which again diverts funds that otherwise could be used for core work.

2. WHY IS THE TARGET OF 50% OF THE BASE SEGMENT[1] OF THE APPROVED PROGRAMME BUDGET 2022–2023 RECOMMENDED?

17. Among the range of recommendations made by various high-level technical and political expert bodies convened to assess how WHO responded to the COVID-19 pandemic, a consistent theme was that the Organization should be financed sustainably and the different bodies were united in calling for an increased level of assessed contribution investment. The IPPPR called for WHO base programmes to be 67% funded by assessed contributions. The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme and the more broadly focused Independent Expert Oversight Advisory Committee (IEOAC) both called for as high a proportion of base programmes of WHO as possible, even up to 100%, to be financed by assessed contributions. In their opinions, the integrity, independence and effectiveness of the Organization would all depend on sustainable financing and an increase in assessed contributions would be the only guaranteed way through which to provide this adequately.

18. Several Member States in the Working Group acknowledged the validity of financing the entire Programme budget by assessed contributions as the ultimate goal to pursue[2] but also recognized that this would be ambitious and aspirational. The Member States that participated in the third meeting of the Working Group on Sustainable Financing agreed to pose a question to the Member States of the Regional Committees for their consideration as to whether they shared the view that WHO's base segment of the Programme budget should be at least 50% funded by assessed contributions in order to ensure integrity and safeguard the independence of WHO. This target was envisaged by the Bureau of the Working Group after Member States considered a range of different ways through which to define and cost essential functions of the Organization.

19. The main rationale for the proposed target of 50% of the base segment budget funded by assessed contributions concerns its importance for effective governance of the Organization.

20. The Member States of WHO are represented in the World Health Assembly, which controls the priorities and directions of the Organization through the approval of its General Programme of Work and its constituent Programme budgets, as well as through the adoption of resolutions and decisions. Resolutions and decisions are accompanied by reports on their administrative and financial implications.

[1] For the budget segment definition, see document EB/WGSF/2/3.

[2] See document EB/WGSF/3/3.

21. However, neither the Programme budget, which is 84% funded by voluntary contributions, nor the resolutions and decisions are adopted with available resources. Between 2017 and 2021, the Health Assembly approved a total of three Programme budgets and 396 resolutions and decisions, of which the latter were costed at a total level of US$ 12.3 billion (US$ 8.7 billion approved by the World Health Assembly, US$ 3.6 billion by the Executive Board). While much of this will go on to form the basis of future Programme budgets, it still represents a massive amount of public health priorities for which there is no sustainable financing.

22. Many Member States have noted how this is currently a "now or never" moment in which to strengthen WHO in the wake of the COVID-19 pandemic, when the need for WHO's role has been made overwhelmingly clear, as have the shortcomings in its sustainability. This can be seen from the discussions of Member States themselves in the World Health Assembly, its Executive Board and in regional committees. Urgent matters are further being negotiated in several working groups, including on establishing an intergovernmental negotiating body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. Other working groups are considering emergency preparedness and response, and indeed the question of sustainable financing itself.

23. An increase in assessed contributions would therefore serve as one key component of strengthening the WHO governance mechanism and aligning it more closely with planning and budgeting under the full oversight of the WHO governing bodies. The process would allow Member States even greater control of the Organization's strategic focus.

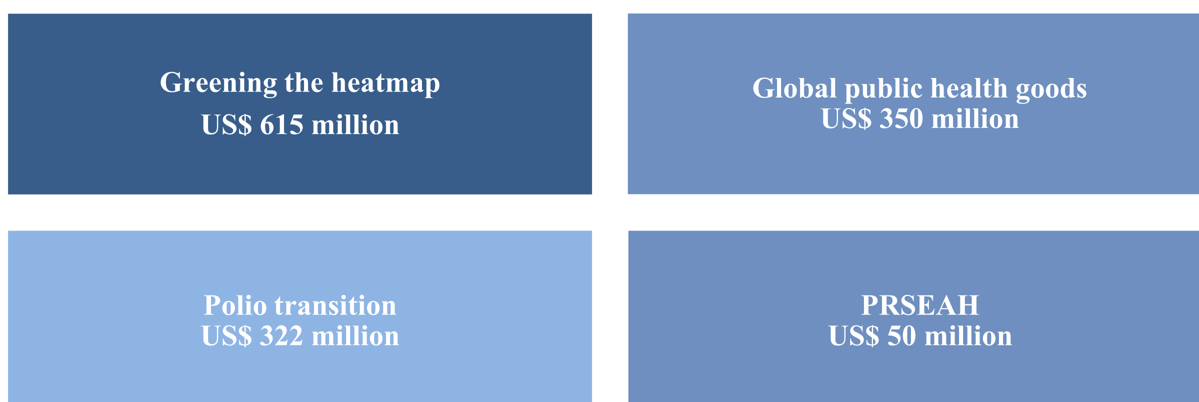
3. HOW WOULD SUCH AN INCREASE IN ASSESSED CONTRIBUTIONS BE USED?

24. There are several options for identifying key areas that could be strengthened or delivered if an increase in assessed contributions to fund 50% of the base budget 2022–2023 were approved.

Option 1. Gap-based option

25. On understanding that the need to increase the assessed contributions is not only gap-driven but primarily needed to ensure a strong, independent, agile, sustainably financed WHO with sound budgetary governance, this option looks specifically at which areas of WHO's work and commitments could immediately benefit from flexible and predictable assessed contribution funding. Figure 1 presents 4 such areas and the rationale for their sustainable financing is set out below.

Figure 1. Areas to benefit from the increased assessed contributions



26. The total need for the four areas identified is approximately US$ 1.3 billion, as described below.

Greening the heatmap

27. The question may be raised as to why the Organization should not rely more heavily on voluntary contributions provided by government donors who are themselves representatives of Member States. This defeats the logic of Member States' equality, ownership and inclusiveness; however, since it risks financing becoming increasingly concentrated and dependent on a small number of high-income Member States to the potential exclusion of others. Many Member State donor agencies are also constrained by national regulations to provide highly specified contributions that are aligned with their specific country priorities. This type of voluntary contribution is very gratefully received and makes a massive contribution to WHO's work, but it does not necessarily maintain a sustainable and guaranteed equitable source of financing in the longer term. Moreover, the strict earmarking of voluntary contributions does not allow rebalancing of the financing across different results, major offices and levels of the Organization.

28. This is clearly demonstrated by the Programme budget 2020–2021, which overall was 99% funded. However, this is the sum of overfunded and underfunded areas. If all underfunding at the level of individual budget centres and outputs (the lowest level of results referred to in the Programme budget) is summed up, the Organization has closed the 2020–2021 biennium with a US$ 615 million gap (Annex, Table B).

29. Of this gap, US$ 312 million (or more than 50% of the total gap) is at the country level. Much of the country office level funding is project funding, received over the course of the biennium. This funding is often short-term, often unpredictable and almost always highly restricted. To support Member States in achieving the goals of the Thirteenth General Programme of Work (GPW 13) and the targets of Sustainable Development Goal 3, a more sustainable and predictable financing at country level is required.

Table 2. Absolute gaps by outcome and organizational level of the approved Programme budget 2020–2021 (US$ million)

Outcome long text	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	Grand total
1.1 Improved access to quality essential health services	56.9	2.4	22.8	16.8	23.4	10.5	48.3	181.2
1.2 Reduced number of people suffering financial hardship	5.1	0.5	0.5	1.4	1.7	1.4	8.7	19.3
1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	16.5	1.7	3.8	1.5	2.0	2.3	20.8	48.6
2.1 Countries prepared for health emergencies	13.1	1.1	4.3	4.3	7.6	7.0	10.9	48.2
2.2 Epidemics and pandemics prevented	17.0	3.6	9.9	1.5	12.6	2.4	14.1	61.0
2.3 Health emergencies rapidly detected and responded to	11.1	4.4	6.2	2.0	5.4	6.7	17.8	53.7
3.1 Determinants of health addressed	13.3	0.8	1.8	2.3	2.7	4.8	4.9	30.4
3.2 Risk factors reduced through multisectoral action	8.8	1.5	2.4	3.6	2.8	5.9	6.2	31.3
3.3 Healthy settings and Health-in-All Policies promoted	5.4	2.8	1.0	1.1	1.2	1.2	3.5	16.2
4.1 Strengthened country capacity in data and innovation	12.1	0.0	4.2	1.6	10.3	4.0	24.4	56.7
4.2 Strengthened leadership, governance and advocacy for health	16.8	0.2	5.3	2.0	3.0	3.8	9.8	40.7
4.3 Financial, human and administrative resources managed in an efficient, effective, results-oriented and transparent manner	12.3	0.1	4.0	1.0	5.0	2.2	3.3	27.8
Grand total	**188.4**	**19.0**	**66.2**	**39.1**	**77.7**	**52.3**	**172.6**	**615.3**

Global public health goods

30. The GPW 13 requires WHO to build on its normative role, working seamlessly across programmes and all three levels of the Organization and, within the context of a reformed United Nations system, achieving measurable improvements in the health of all people. Development of the highest quality standards for global public health goods forms the foundation of WHO’s normative work. Global public health goods include all normative and standard-setting products, data products and products describing priority-setting for innovation and research.

31. Starting from the Programme budget 2020–2021 and continuing to the Programme budget 2022–2023, the Secretariat invested effort and time into the prioritization and planning of the process of developing global public health goods. This is a crucial step towards ensuring that the Organization can target its resources on the delivery of global public health goods that deliver measurable impacts at country level. This is consistent with the vision of the GPW 13 and the transformation agenda.

32. In the Programme budget 2022–2023, US$ 350 million are allocated to global public health goods. The funding of normative work has traditionally been a combination of assessed contributions and specified voluntary contributions. However, in order to ensure the impartiality and independence of

WHO, there is a case for considering that its normative work should be fully funded by assessed contribution funds in order to:

- avoid any perception of potential undue influence of donors;
- avoid reliance on a very narrow donor base; and
- advance all global public health goods that have been identified as priorities as opposed to only those outcomes that can obtain voluntary contribution financing.

Polio transition

33. Over the course of the last three decades, the Global Polio Eradication Initiative (GPEI) set up an infrastructure in the countries of the global South that goes far beyond eradicating polio. The networks established by the polio programme in the African, Eastern Mediterranean and South-East Asia Regions provide valuable support for immunization, vaccine-preventable disease surveillance, outbreak preparedness, detection and response, as well as more recently for COVID-19 response, COVID-19 vaccine roll-out and immunization recovery.

34. The Programme budget 2022–2023 covers the biennium in which many countries will completely transition out of GPEI support, due to the increasing focus of the programme on finishing the job in the two remaining endemic countries (Afghanistan and Pakistan) and stopping the circulation of vaccine-derived poliovirus disease outbreaks in high-risk countries. The majority of these countries that will transition out of GPEI support are countries with weak health systems in the African and Eastern Mediterranean regions, which will require continued support from WHO to sustain their essential public health functions.

35. The Secretariat conducted a comprehensive three-level planning exercise to develop country-by-country integrated workplans for the Programme budget 2022–2023. The total cost of polio transition was estimated at US$ 322 million and at the start of the biennium this was a fully unfunded need. WHO prioritized its existing flexible funding for 2022–2023 to cover the most essential needs of US$ 322 million through its strategic resource allocation approach. In the zero-sum environment, this means that polio transition was prioritized over other areas that would have otherwise benefited from flexible funding.

Strengthen leadership, accountability, compliance and risk management, with a special focus on the Organization's capacity to prevent and respond to sexual exploitation, abuse and harassment (PRSEAH)

36. The proposed Programme budget 2022–2023 revision puts forward a request to increase the approved Programme budget by US$ 50 million to enable the Secretariat to deliver on meeting WHO's goals of ensuring zero tolerance of sexual exploitation and abuse of the communities it serves and zero tolerance of sexual harassment within the WHO workforce, as well as zero tolerance of inaction against both. The proposed increase will also provide further investment towards the sustainable impact of PRSEAH work across all accountability functions. Member States require the Organization to ensure that work on PRSEAH, in particular the PRSEAH management response plan, permeates all functions of the Organization in the future.

37. Similar to the polio transition area described above, the immediate work on PRSEAH is currently funded through the strategic reallocation of flexible funds and some voluntary contributions. However,

this area requires stable, flexible and predictable financing in order to ensure sustainability of actions and their uptake; it is therefore expected that a similar funding requirement will be needed in upcoming bienniums.

Option 2. Fully financed critical expenditure

38. According to the IEOAC estimate, an assessed contributions increase of 191% would enable the sustainable financing of the critical items of expenditure of WHO, which would have to be financed for the Organization to function no matter what. These are:

Cost element	US$ million/biennium
Staff cost	2 233
Travel	165
General operating expenses	243
Equipment, vehicles and furniture	69
Total	**2 710**

39. An assessed contribution increase to this level of financing would ensure that the Organization could depend on these costs being met without any concern regarding predictability or flexibility and without any need for additional donor support. This in turn would provide greater efficiency and effectiveness – and most importantly, would provide full integrity and impartiality of the Organization, which would never be faced with a conflict of interest in maintaining its core capacity. Technical staff of the Organization would focus on delivering the results set out in the Programme budget instead of on mobilizing resources to pay their own and their teams' salaries. Enabling functions would invest time in compliance and accountability instead of in managing thousands of grants.

40. A variation of this option could involve defining what portion of salaries should be funded sustainably, such as:

- senior management, programme managers, regional advisers, coordinators for technical areas, i.e. WHO staff who should focus on leading the delivery of technical work instead of on fundraising for their own staff costs;

- all country office staff, who would be freed to focus their attention on the goals of the GPW 13 in working towards impacts at country level; and

- staff in enabling areas, who are traditionally not funded by donors, with very few exceptions.

41. Based on the discussions of the Working Group on Sustainable Financing around the assessed contributions increase, the Secretariat will develop a set of proposed process indicators to track progress in fulfilling the commitment to the strategic allocation of assessed contribution funds, oriented towards addressing the challenges outlined in this document arising from insufficient sustainable financing and how such challenges could be addressed through increased assessed contributions.

4. WHY CAN ASSESSED CONTRIBUTIONS NOT BE APPROPRIATED IN THE PROGRAMME BUDGET?

42. Some Members of the Working Group have indicated that Member States need to have a plan of how exactly the assessed contributions of the Organization will be used. This means returning to the model of WHO as it existed initially, whereby the entire Programme budget was approved at the same time as assessed contributions were appropriated. This provided a tightly controlled budget that did not grow significantly in real terms and any additional work to be undertaken was approved separately from the assessed contribution envelope and only to a small degree.

43. There are several concerns with returning to this model:

1. Appropriating assessed contributions de facto would mean tightly earmarking such funds. This in itself will defy the main objectives of the Working Group to propose solutions of sustainable financing that is not only predictable but also fully flexible while ensuring alignment.

2. It would also further aggravate some of the challenges outlined in this paper, most notably the governance of WHO. WHO needs a strong and capable governance mechanism that is properly informed and empowered to oversee the work of the Secretariat in allocating, managing and implementing the full range of resources available to deliver the results approved by the Member States in the Programme budget.

3. Such a model would not work in the increasingly complex and expanding public health environment in which WHO plays a leadership role today and in which it needs to retain the flexibility and capacity to adapt to a changing environment and new challenges. The Working Group itself recognized this from the outset:[1]

> Since its establishment in 1948, the scope of WHO and the deliverables expected from it have increased dramatically. External factors, such as demographic and economic expansion, have driven the increased demand for what WHO can and must provide. WHO has evolved from a predominantly research and norms-driven body to an Organization that also considers the development perspective and assumes a position of proactive leadership on global health issues, including the international response to outbreaks, crises and emergencies. Together with the United Nations system, it has moved from having a vertical, disease-driven outlook to a more holistic approach to public health, focusing on the entire spectrum of the health sector and promoting broader community engagement at all levels.

4. In addition, such an appropriation would inevitably oblige WHO to abandon the concept of a fully results-based and integrated Programme budget. In effect, the assessed contributions would primarily be used to cover and maintain enabling and leadership functions while relying on voluntary contributions to deliver the wider Programme budget.

44. Perhaps a better and stronger alternative to the appropriation of assessed contributions or a de facto specific allocation of these resources into specific programmes or activities is the Working Group's proposal to strengthen WHO budgetary governance. This would be intended, to take a few examples, to further the dialogue between the Secretariat and its Member States about priority-setting and Programme budget development, and to provide more frequent and comprehensive information on the progress of

[1] Document EB/WGSF/1/4, paragraph 2.

Programme budget financing and implementation so that Member States can provide more real-time guidance and control.

CONCLUSION

45. Increasing assessed contributions is not a question of Member States responding to a request for support from the Secretariat as if made to a donor. It is a question of a genuine investment in the Organization, which those Member States themselves own, in order to maximize the benefits of the public health goods that they request and receive and that are provided for the ultimate benefit of the global population whom they represent and whom WHO serves.

46. There are many areas of overlap and the full investment of any assessed contribution increase would take many of these factors into account at once. The most significant consideration, however, is that it would serve to provide Member States with the WHO that they ask for, that they control and that they need.

47. The Director-General himself summarized this best when he stated that "The mission to deliver health for all is at the heart of all WHO does. But delivery of this mission relies on the state of our financial health. Investing in WHO, and in health, is the best medicine for us all."

ANNEX

METHODOLOGY AND ASSUMPTIONS ASSOCIATED WITH "GREENING THE HEATMAP"

Current analysis of 2020–2021 end-of-biennium data shows a US$ 615 million gap across the Organization (Table A). More than 50% of the total gap is observed at the country level (Table B).

Assumptions

- Planned costs as at 31 December 2021 represent a fair level of activity costing (or needs) for the whole biennium.
- Award budget (funding) as at 31 December 2021 represents the level of financing available for a given output within a budget centre (organizational unit representing a country office or a department/division in a regional office or at headquarters).
- Defining absolute funding gaps based on the above dimensions before aggregation at a higher level represents the best way to quantify the total funding gap.
- Excess of funding in one output or budget centre cannot be shifted to another (reflecting traditional inflexibility of specified voluntary contributions)

Methodology

- Both planned costs and award budget as at 31 December 2021 are used as guiding metrics.
- Granularity is obtained at the level of both output (result structure) and budget centre (organizational structure).
- Absolute unit gaps can then be aggregated at higher levels (major office/organizational level/strategic priority/global outcome).

Table A. Approved Programme budget 2020–2021: absolute gaps at output and major office levels

Output long text	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	Grand total
1.1.1 Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages	20.1	1.0	3.1	6.7	3.2	1.9	9.1	45.0
1.1.2 Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results	22.4	1.0	7.5	6.0	16.3	5.6	16.2	74.9
1.1.3 Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course	9.5	0.1	11.0	2.3	1.8	1.5	0.2	26.4
1.1.4 Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities	2.3	0.3	0.2	1.3	1.3	0.8	2.7	9.0
1.1.5 Countries enabled to strengthen their health workforce	2.6	0.1	1.0	0.5	0.8	0.7	20.1	25.9
1.2.1 Countries enabled to develop and implement more equitable health financing strategies and reforms to sustain progress towards universal health coverage	3.3	0.3	0.3	0.8	1.3	0.8	3.1	9.8
1.2.2 Countries enabled to produce and analyse information on financial risk protection, equity and health expenditures and to use this information to track progress and inform decision-making	1.4	0.2	0.2	0.6	0.2	0.3	1.7	4.5
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	0.4	0.0	0.1	0.0	0.2	0.4	4.0	5.1
1.3.1 Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists	5.5	0.1	1.3	0.3	0.6	0.2	2.4	10.4
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	5.9	1.2	0.1	0.2	0.3	0.9	3.2	11.9
1.3.3 Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved	0.9	0.2	0.6	0.2	0.2	0.7	10.3	13.2
1.3.4 Research and development agenda defined and research coordinated in line with public health priorities	0.6	0.0	0.4	0.1	0.0	0.0	1.4	2.6
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	3.5	0.2	1.3	0.7	0.9	0.5	3.5	10.6
2.1.1 All-hazards emergency preparedness capacities in countries assessed and reported	6.5	0.2	1.4	0.2	1.5	1.8	2.4	13.9
2.1.2 Capacities for emergency preparedness strengthened in all countries	4.9	0.6	1.7	3.0	4.3	5.1	3.7	23.3
2.1.3 Countries operationally ready to assess and manage identified risks and vulnerabilities	1.7	0.3	1.1	1.1	1.8	0.1	4.8	11.0
2.2.1 Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards	0.3	0.3	0.9	0.2	0.2	0.0	1.9	3.8
2.2.2 Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale	6.2	1.5	1.4	0.4	4.0	1.8	1.9	17.2
2.2.3 Mitigate the risk of the emergence and re-emergence of high-threat pathogens	1.5	0.0	2.0	0.3	3.9	0.5	1.1	9.5

Output long text	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	Grand total
2.2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative	9.0	1.8	5.5	0.5	4.5	0.1	9.2	30.6
2.3.1 Potential health emergencies rapidly detected, and risks assessed and communicated	2.6	2.1	2.3	0.3	2.4	2.9	4.8	17.5
2.3.2 Acute health emergencies rapidly responded to, leveraging relevant national and international capacities	3.3	1.1	2.2	1.1	2.0	3.7	9.2	22.6
2.3.3 Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings	5.2	1.1	1.7	0.7	1.1		3.8	13.5
3.1.1 Countries enabled to address social determinants of health across the life course	8.1	0.4	0.9	1.3	1.7	1.5	1.5	15.4
3.1.2 Countries enabled to address environmental determinants of health, including climate change	5.1	0.4	0.9	1.0	1.0	3.3	3.3	15.1
3.2.1 Countries enabled to develop and implement technical packages to address risk factors through multisectoral action	5.7	0.9	1.8	3.3	2.0	3.5	4.9	22.0
3.2.2 Multisectoral determinants and risk factors addressed through engagement with public and private sectors, as well as civil society	3.2	0.7	0.7	0.2	0.9	2.4	1.4	9.3
3.3.1 Countries enabled to adopt, review and revise laws, regulations and policies to create an enabling environment for healthy cities and villages, housing, schools and workplaces	3.5	2.1	0.6	0.8	0.9	1.2	1.4	10.6
3.3.2 Global and regional governance mechanisms used to address health determinants and multisectoral risks	1.9	0.7	0.3	0.3	0.3	0.0	2.1	5.6
4.1.1 Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts	8.6	0.0	2.4	1.0	5.6	3.2	8.9	29.8
4.1.2 GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored	1.5	0.0	0.7	0.2	1.7	0.4	7.7	12.3
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	2.0	0.0	1.1	0.3	3.0	0.3	7.9	14.6
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	11.8	0.1	2.6	1.6	1.9	3.0	5.7	26.6
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	1.4	0.0	1.2	0.2	0.3	0.2	1.7	4.9
4.2.3 Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships	0.7	0.0	0.5	0.0	0.1	0.3	1.1	2.7
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	2.2	0.0	0.6	0.0	0.5	0.2	0.6	4.1
4.2.5 Cultural change fostered and critical technical and administrative processes strengthened through a new operating model that optimizes organizational performance and enhances internal communications	0.3	0.0	0.3	0.0	0.1	0.0	0.1	0.9
4.2.6 “Leave no one behind” approach focused on equity, gender and human rights progressively incorporated and monitored	0.4	0.0	0.0	0.1	0.2	0.1	0.7	1.6
4.3.1 Sound financial practices and oversight managed through an efficient and effective internal control framework	5.5	0.1	0.7	0.1	0.6	0.1	1.4	8.5
4.3.2 Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery	2.4	0.0	0.7	0.3	0.4	0.1	0.0	3.9

Output long text	AFRO	AMRO	SEARO	EURO	EMRO	WPRO	HQ	Grand total
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	1.2	0.0	0.6	0.3	0.6	0.7	0.8	4.2
4.3.4 Safe and secure environment with efficient infrastructure maintenance, cost-effective support services, and responsive supply chain, including duty of care	3.1	0.0	2.1	0.3	3.3	1.4	1.1	11.3
Grand Total	**188.4**	**19.0**	**66.2**	**39.1**	**77.7**	**52.3**	**172.6**	**615.3**

Table B. Approved Programme budget 2020–2021: absolute gaps at output and organizational levels

Output long text	CO	RO	HQ	Grand total
1.1.1 Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages	24.6	11.3	9.1	45.0
1.1.2 Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results	46.9	11.8	16.2	74.9
1.1.3 Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course	21.8	4.4	0.2	26.4
1.1.4 Countries’ health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities	5.5	0.8	2.7	9.0
1.1.5 Countries enabled to strengthen their health workforce	4.6	1.2	20.1	25.9
1.2.1 Countries enabled to develop and implement more equitable health financing strategies and reforms to sustain progress towards universal health coverage	5.7	1.0	3.1	9.8
1.2.2 Countries enabled to produce and analyse information on financial risk protection, equity and health expenditures and to use this information to track progress and inform decision-making	2.0	0.8	1.7	4.5
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	0.9	0.2	4.0	5.1
1.3.1 Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists	5.9	2.0	2.4	10.4
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	6.1	2.6	3.2	11.9
1.3.3 Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved	1.9	1.0	10.3	13.2
1.3.4 Research and development agenda defined and research coordinated in line with public health priorities	0.3	0.9	1.4	2.6
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	5.4	1.7	3.5	10.6
2.1.1 All-hazards emergency preparedness capacities in countries assessed and reported	8.9	2.6	2.4	13.9
2.1.2 Capacities for emergency preparedness strengthened in all countries	13.1	6.5	3.7	23.3
2.1.3 Countries operationally ready to assess and manage identified risks and vulnerabilities	4.3	1.9	4.8	11.0
2.2.1 Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards	1.1	0.8	1.9	3.8

Output long text	CO	RO	HQ	Grand total
2.2.2 Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale	11.2	4.1	1.9	17.2
2.2.3 Mitigate the risk of the emergence and re-emergence of high-threat pathogens	8.1	0.3	1.1	9.5
2.2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative	15.5	5.8	9.2	30.6
2.3.1 Potential health emergencies rapidly detected, and risks assessed and communicated	7.6	5.0	4.8	17.5
2.3.2 Acute health emergencies rapidly responded to, leveraging relevant national and international capacities	8.7	4.7	9.2	22.6
2.3.3 Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings	5.2	4.5	3.8	13.5
3.1.1 Countries enabled to address social determinants of health across the life course	9.9	3.9	1.5	15.4
3.1.2 Countries enabled to address environmental determinants of health, including climate change	6.7	5.1	3.3	15.1
3.2.1 Countries enabled to develop and implement technical packages to address risk factors through multisectoral action	13.1	4.0	4.9	22.0
3.2.2 Multisectoral determinants and risk factors addressed through engagement with public and private sectors, as well as civil society	6.8	1.2	1.4	9.3
3.3.1 Countries enabled to adopt, review and revise laws, regulations and policies to create an enabling environment for healthy cities and villages, housing, schools and workplaces	5.4	3.9	1.4	10.6
3.3.2 Global and regional governance mechanisms used to address health determinants and multisectoral risks	1.6	1.9	2.1	5.6
4.1.1 Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts	13.9	7.1	8.9	29.8
4.1.2 GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored	2.7	1.9	7.7	12.3
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	2.3	4.4	7.9	14.6
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	10.9	10.1	5.7	26.6
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	1.5	1.7	1.7	4.9
4.2.3 Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships	1.0	0.6	1.1	2.7
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	1.7	1.8	0.6	4.1
4.2.5 Cultural change fostered and critical technical and administrative processes strengthened through a new operating model that optimizes organizational performance and enhances internal communications	0.5	0.2	0.1	0.9

Output long text	CO	RO	HQ	Grand total
4.2.6 "Leave no one behind" approach focused on equity, gender and human rights progressively incorporated and monitored	0.4	0.4	0.7	1.6
4.3.1 Sound financial practices and oversight managed through an efficient and effective internal control framework	6.2	0.9	1.4	8.5
4.3.2 Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery	2.0	1.9	0.0	3.9
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	2.0	1.4	0.8	4.2
4.3.4 Safe and secure environment with efficient infrastructure maintenance, cost-effective support services, and responsive supply chain, including duty of care	7.6	2.6	1.1	11.3
Grand total	**311.8**	**130.9**	**172.6**	**615.3**

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