MINISTRY OF FOREIGN AFFAIRS
OF DENMARK
Danida

Danish Organisation Strategy for

World Health Organization

2024-2028

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1 Objective

Denmark's cooperation with the World Health Organization (WHO) is shared between the Ministry of the Interior and Health (MIH), which provides and manages the Danish *assessed* contribution, and the Ministry of Foreign Affairs (MFA), which provides financial support for the Danish *voluntary* contribution to WHO as well as contributions to emergency appeals as appropriate. The two ministries closely coordinate the Danish contributions and cooperation with WHO.

This strategy (hereinafter 'The Strategy') forms the basis for Denmark's *voluntary* contribution to WHO for 2024-2028 and is the central platform for the MFA's dialogue and partnership with WHO. The budget for the strategy period is DKK 390 million over five years (see Section 6 for detailed budget).

The overall objective of Denmark's support is to contribute to the achievement of the health-related United Nations (UN) Sustainable Development Goals (SDGs), in particular SDG 3 (good health and well-being), 5 (gender equality), 10 (reduced inequalities), and 17 (partnerships).

The Strategy outlines the selection and alignment of Danish priorities with WHO's *The Fourteenth General Programme of Work 2025-2028* (GPW 14).[1] Three Danish thematic areas and one WHO organisational effectiveness priority area have been chosen based on WHO's GPW 14 (see Box 1). GPW 14 is structured around WHO's three strategic objectives: (i) promote health, (ii) provide health, and (iii) protect health (see details in section 2 below).

Box 1: Priority areas

Priority 1: Health systems strengthening to achieve universal health coverage.

Priority 2: Pandemic, health emergencies and global health risk preparedness.

Priority 3: Human rights and gender equality, including sexual and reproductive health and rights.

Priority 4: A more effective and efficient WHO, that also contribute to the efficiency reform efforts of the United Nations Development System.

Support to WHO is directly in line with the strategy "*The World We Share"* -Denmark's strategy for development cooperation. *The World We Share* underlines that Denmark's overriding aim in international development cooperation is *to fight poverty, enhance sustainable growth and development, and promote economic freedom, peace, stability, equality, and rules-based international order.* This includes Denmark's steadfast commitment to Agenda 2030 and the SDGs, in general. In the context of global health, Denmark's support to WHO contributes to SDG 3, *"Ensure healthy lives and promote wellbeing for all at all ages*".

Access to basic health services is important for preventing disease and helping people in urgent need. Denmark sees access to strong health systems and primary healthcare as prerequisites for achieving results in the rest of the health field and as foundational to achieving the SDGs. As *The World We Share* points out, a healthy physical and mental life is essential for enabling people to unlock their life opportunities. The need for equitable access to quality health services has become even more pronounced during the COVID-

[1] The World Health Assembly GPW 14 draft of May 2024 (latest available) has been consulted https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_16-en.pdf

19 pandemic, which has exacerbated the pressure on already weak health systems and reduced the life opportunities of particularly vulnerable and marginalised groups.

Denmark's human rights-based approach applies the principles of non-discrimination, participation, transparency, and accountability in all phases of development cooperation. WHO works to attain the highest possible level of health for all people as a fundamental right of every human being. Promoting gender equality, health equity, and human rights is part of WHO's concept of *Leaving No One Behind*.

This Strategy will be implemented in line with Danish How-To-Notes.[2] Universal Health Coverage (UHC) is central to the *How-To Note for Social Sectors and Social Safety Nets,* which explicitly states that Denmark, at the global level, will contribute to health security through WHO, promoting implementation and compliance with the International Health Regulations (IHR) and establishing a global pandemic agreement.

Access to health is a right that encompass people's physical, mental and social well-being. The Strategy reflects Denmark's position that sexual and reproductive health and rights (SRHR) encompass the right to decide over one's own body. Comprehensive sexuality education (CSE), modern forms of contraception, and access to safe abortion are at the heart of the full enjoyment of these rights. SRHR is not only about girls and women. Men and boys also have such rights and play an important role in securing SRHR access for all. Healthcare should be available, free of prejudice (e.g. against LGBT+) and affordable. *The How-To Note on Human Rights and Democracy* reinforces these priorities and promotes youth and civil society engagement, as well as national legislation and policies that protect the rights of women and girls to bring about concrete changes in gender relations and the underlying power structures. The *How-To Note on the Green Transformation of Agri-Food Systems, Agri-and Food Production, Business and Food Security* points to the importance of WHO involvement in the One Health Initiative that provides an integrated, unifying approach to balancing and optimising the health of people, animals and ecosystems and responds to the gaps and lessons learned from the COVID-19 pandemic.

Synergies and coherence with health-related support through Organisation Strategies. Denmark's organisation strategy for WHO complements other Danish organisation strategies, including for the cooperation with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Vaccine Alliance (GAVI), the United Nations Fund for Population Activities (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).[3] Each of these Danish multilateral engagements in the health sector reflects the principle of dynamic partnerships (SDG 17) that underpins *The World We Share*. These multilateral Danish partnerships mirror the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), established in 2019. WHO plays a key role in this global partnership, that brings together thirteen multilateral health, development and humanitarian agencies. This includes other UN agencies that Denmark collaborates with, including UNWOMEN, UNICEF, UNDP, UNFPA as well as the

[2] These can be accessed here
[3] Note on 11 organisations as per UNAIDS strategy

World Bank. The latter manages the in 2022 established Pandemic Fund, to which Denmark contributes. It is important to highlight WHO's unique added advantages compared to these other organisations and initiatives. WHO's central role in global health governance, as the directing and coordinating authority on international health within the UN system, gives it a distinct position. Unlike other health-focused organisations which target specific diseases or areas (like AIDS, tuberculosis, or vaccines), WHO's mandate is broader, encompassing the overall health of populations.

2 The organisation

Relevance. WHO plays a pivotal role in the UN Development System (UNDS) by focusing on global public health and ensuring that all people have access to essential health services. As the UN's specialised agency for health, WHO provides leadership on health matters, sets global health standards, and offers technical guidance to countries. Founded in 1948, WHO is mandated to be the directing and coordinating authority on international health within the United Nations (UN) system. WHO has an integrated health focus covering the full spectrum of promotive, preventive, curative and rehabilitative health services and palliative care accessible to all – in line with the aspirations of its Constitution: "Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

WHO's work on SDG 3 is crucial for broader global development. Health is a cornerstone of human capital, driving economic growth, reducing poverty, and enhancing education outcomes. WHO's efforts to improve healthcare access, reduce maternal mortality, and combat diseases, directly support economic productivity by creating healthier workforces and reducing health-related financial burdens on families. Additionally, its work promotes gender equality, environmental sustainability, and global health security, all of which are vital for long-term social stability and resilience.

WHO provides normative leadership on global health issues, including pandemics. It is responsible for setting evidence-based global technical norms and standards, monitoring global health trends and providing policy options and assistance to member states.

In addition to WHO's normative role, a growing demand to take on country-level implementation places new demands on WHO. Since the COVID-19 pandemic, WHO has seen a marked increase in demand for its support in strengthening health systems at the country level and responding to protracted crises and sudden-onset emergencies that are increasing due to climate change. WHO works at country level through Country Cooperation Strategies (CCS) set out strategic priorities for WHO and each country to work together in alignment with national and global priorities. CCS provide input to the development of the health component of the United Nations Sustainable Development Cooperation Framework (UNSDCF), which is a core instrument for providing a coherent, strategic direction for UN development activities by all UN entities at country level.

WHO is a central actor in the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), which plays a significant role in health, development, and humanitarian

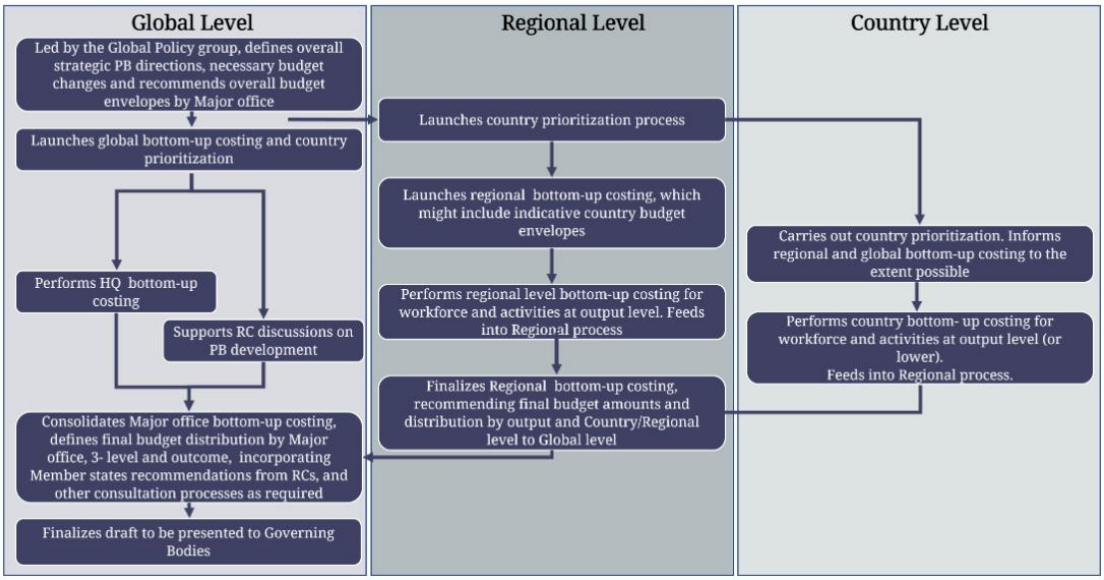
responses.[4] Moreover, WHO has a critical leadership role within the UNs humanitarian efforts as lead of the Global Health Cluster, coordinating international health responses in humanitarian crises. In this role, WHO provides secretariat support to the Inter-Agency Standing Committee (IASC), the UN's primary humanitarian response coordination mechanism.[5] WHO leads the Cluster to ensure timely, effective, and well-coordinated health interventions, working with various partners like UN agencies, civil society organisations, and national governments. In fragile and conflict-affected settings, WHO also plays a critical role in health emergency preparedness and response, ensuring that essential health services are available even in the most challenging environments. By working within the broader UN framework, WHO leverages resources and expertise from across the UN system to address complex health challenges at the country level.

Governance and management. WHO is governed by the World Health Assembly (WHA), which is held annually in Geneva, Switzerland among its 194 member states[6] and supported by an Executive Board of 34 members. Denmark was a member of the Executive Board from 2021-2024. WHO's Secretariat is headquartered in Geneva, and is responsible for the management and administration of the organisation. It has six regional offices located in Africa, the Americas, the Eastern Mediterranean, Europe, Southeast Asia and the Western Pacific as well as 150 country offices. The organisation has more than 8,000 staff spread across these offices. The regional offices play an important role in WHO's organisational and management structure, providing the link between HQ and country offices for policy-setting, planning, implementation, results, and data-related functions. WHO's regions have a degree of autonomy, with their distinct governance structures and procedures for selecting regional directors. Regional directors are responsible for implementing strategies and programmes across regions and country offices. Each country office develops a Country Co-operation Strategy (CCS) – or, for the regional office for Europe (EURO), a Biennial Collaborative Agreement – to guide its work. The European regional office is based in the UN-city in Copenhagen. Since 2017, WHO has been headed by Director-General Dr Tedros Adhanom Ghebreyesus (Ethiopia).

The WHO budgeting cycle is characterised by a global bottom-up costing and country prioritisation process (see Figure 1) that, at the global level, entails the development of a central budget developed by the Programme, Budget and Administration Committee (PBAC) in consultations with the regional offices for approval by the WHA.[7] A portion of WHO's overall budget, derived from assessed contributions, is then allocated to regional offices to cover essential operations and region-specific initiatives.

[4] https://www.who.int/initiatives/sdg3-global-action-plan/about
[5] https://healthcluster.who.int/about-us
[6] With a slightly different membership than UN (Lichtenstein is currently not a member of WHO, while Cook Island and Niue are members of WHO but to this date not UN)
[7] https://apps.who.int/gb/ebwha/pdf_files/eb131/b131_r2-en.pdf

Figure 1 – WHO bottom-up budget preparation cycle



Source: WHO Overview of the programme budget costing process[8]

Operational focus. WHO's General Programme of Work sets a high-level roadmap and agenda for global health and is the organisation's overall strategic document. It identifies WHO's priorities and strategic direction for a specified period and provides a framework for resource allocation and decision-making. In May 2024, the WHA approved GPW 14 for 2025-2028 (Box 2).

Box 2: GPW 14 strategic objectives

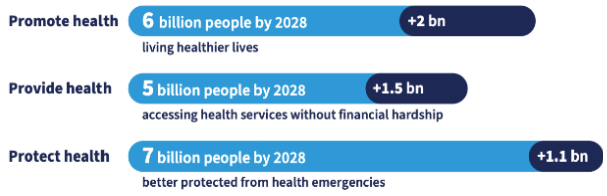
Promote health: Respond to climate change and accelerating health threats; Address health determinants and root causes of ill health.

Provide health: Advance primary healthcare and essential health systems capacities for universal health coverage.

Protect health: prevent, mitigate, and prepare for health risks from all hazards; rapidly detect and sustain response to health emergencies.

GPW 14 has been developed based on lessons learned from the COVID-19 pandemic, an independent evaluation of GPW 13[9] (see section 3) and consultations with WHO Member States. GPW 14 advances the SDG targets and calibrates WHO's "triple billion goals" introduced in GPW 13 (Box 3). Anchored in the health-related SDGs, the GPW 13 provided a roadmap to increase healthy lives and well-being for all. The conceptual framework for this was to achieve the Triple Billion targets by 2025: 1 billion more people; 1) living with better health and well-being, 2) benefiting from universal health coverage, 3) better protected from health emergencies. In GPW 14, these targets have been recalibrated

Box 3: calibrated triple billion goal



[8] https://www.who.int/about/accountability/budget/programme-budget-digital-platform-2024-2025/overview-of-the-programme-budget-costing-process

[9] https://cdn.who.int/media/docs/default-source/evaluation-office/evaluation-report-gpw13.pdf?sfvrsn=215b2a79_4&download=true

to account for changes in the health context and improved impact measurement. They now reflect absolute population coverages to be achieved by 2028. The preliminary targets are 6 billion people living healthier lives, 5 billion people accessing health services without financial hardship, and 7 billion people better protected from health emergencies.

Box 4: GPW 14 continues WHO's Transformation Agenda

1. an impact-focused, data-driven strategy.
2. a collaborative, results-focused culture.
3. an aligned three-level operating model (better integrating global, regional, and national activities).
4. a new approach to partnerships.
5. predictable and sustainable financing.

Importantly, compared to GPW 13, GPW 14 has integrated the impact of climate change on health at the strategic objective level and integrated this in its results framework.

In 2017, WHO launched the Transformation Agenda, an extensive restructuring process. This long-term transformation required the introduction of structural reforms alongside stronger accountability and transparency mechanisms. Various new tools were introduced, including the Triple Billion dashboard to track reform actions.[10] GPW 14 continues this agenda (Box 4).

Box 5: Africa highlight

WHO plays a crucial role in strengthening health systems across Africa. WHO works closely with local governments and international partners to ensure that health interventions are sustainable and integrated into national systems. This coordinated approach is vital for achieving Universal Health Coverage (UHC) and reducing health disparities across the continent. WHO AFRO, the regional office for Africa, is particularly active in improving health security and addressing communicable diseases, all while deploying technical support and promoting community-based healthcare solutions.

Particularly in fragile and conflict-affected settings where health services are often compromised due to conflict, displacement, and socio-political instability, WHO's efforts focus on building resilience through disease surveillance, emergency preparedness, and improving essential health services.

Regarding health and climate change, WHO recognises the increasing risks climate change poses to health systems in Africa. The rise in extreme weather events, including droughts and floods, worsens public health by increasing the spread of waterborne and vector-borne diseases, such as malaria and cholera. WHO AFRO supports countries in building climate-resilient health systems, develop early warning systems, and implement health adaptation strategies that address the impacts of climate change on vulnerable populations.

Source: WHO Regional Office for Africa

Human rights, gender equality and SRHR. In line with WHO's mandate, integrating human rights and gender equality into WHO are foundational principles and key strategies for achieving the Triple Billion goals. Its poverty focus applies the *Leaving No One Behind* principle in achieving the health-related SDGs. WHO's work is based on the principles of health equity, gender equality and the right to health. It prioritises overcoming barriers and delivering to the unreached and those in situations of poverty and vulnerability, including

[10] https://www.who.int/about/transformation/a-transformative-journey

migrants and displaced populations and persons with disabilities. A 2021 evaluation of the integration of gender, equity and human rights in the work, WHO's own Evaluation Office found significant weaknesses in WHO's execution of this mandate (see section 3)[11]. Thus, since then WHO has made efforts to strengthen the Department of Gender, Rights and Equity and a roadmap for the WHO Secretariat on Advancing Gender Equality, Human Rights and Healthy Equity 2023-30 has been developed.

SRHR are integral to WHO's life-course approach and efforts to ensure universal access to sexual and reproductive health services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes in line with targets 3.7 and 5.6 of the SDG. WHO sees SRHR as integral to human rights and the right to health and operationalised SRHR in GPW 14 in line with SDGs 3 and 5.[12] While the effect of climate change on health and wellbeing has been incorporated in GPW 14 more work is needed to articulate how WHO will incorporate actions on the intersection of climate change, gender equality and SRHR.[13]

PRSEAH. WHO has acknowledged that sexual exploitation, abuse and harassment (SEAH) is a risk for the organisation, its staff and members of the communities it serves, and added SEAH as a principal risk for the organisation. In 2023 it initiated a three-year strategy for preventing and responding to sexual exploitation, abuse, and harassment (PRSEAH)[14] and operates a related portal.[15] MOPAN 2024 notes that WHO, underpinned by dedicated and clear leadership, has significantly strengthened its infrastructure and capacity related to PRSEAH.

Financial situation. WHO's budget for GPW 14 (2025-2028) is USD 11 billion, of which 4.1 billion is financed through assessed contributions plus a need for USD 7.1 billion in voluntary contributions. In a new approach towards fundraising, WHO will launch an Investment Round for the end of 2024 to mobilise funding for WHO's core work for the full four-year period of GPW 14 instead of the usual two-year biennium funding cycles.[16] In recent years, income from assessed contributions has been static in absolute terms and has declined as a share of the total to just 14 per cent in the 2022-2023 biennium (see details in Annex 3). Against this background, WHO Member States in the May 2023 World Health Assembly agreed to a 20 per cent increase in assessed contributions. MOPAN 2024 flagged the importance of implementing WHO's funding model reforms to achieve a level of 50 per cent assessed funding.

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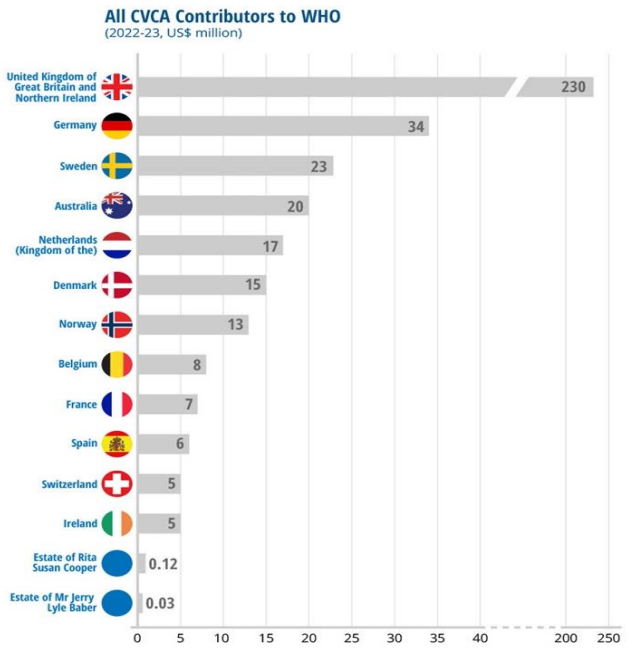
[11] https://cdn.who.int/media/docs/default-source/documents/about-us/evaluation/gehr-report-september-2021.pdf
[12] https://www.who.int/health-topics/sexual-and-reproductive-health-and-rights#tab=tab_1
[13] Cf. "The intersections between climate change and gender equality and sexual and reproductive health and rights" https://via.ritzau.dk/files/2012662/13999713/122449/daSee also Annex 2.2 on WHO review of IPCC Evidence on climate change, health and well-being (2022) https://cdn.who.int/media/docs/default-source/climate-change/who-review-of-ipcc-evidence-2022-adv-version.pdf?sfvrsn=cce71a2c_3&download=true
[14] https://www.who.int/publications/i/item/9789240069039
[15] https://www.who.int/initiatives/preventing-and-responding-to-sexual-exploitation-abuse-and-harassment
[16] https://www.who.int/about/funding/invest-in-who/investment-round

It is a significant challenge for WHO that 88 per cent of voluntary contributions are earmarked. This undermines the organisation's managerial flexibility. In addition, WHO's dependency on relatively few countries providing voluntary contributions is underscored by the fact that the UK's contribution is larger than the total of the next ten countries (see Figure 1). As noted by MOPAN 2024, WHO's dependence on a narrow donor base for voluntary contributions has made resources less predictable.

Danish financing. Denmark ranked sixth among providers of voluntary core contributions to WHO in 2022-2023. Denmark's annual voluntary contribution of DKK 35 million projected in Denmark's organisation strategy for WHO 2020-2023 was increased to DKK 70 million from 2021 onwards and will remain at this level. In 2023 Denmark's assessed contribution to WHO under the Ministry of the Interior and Health amounted to around DKK 22 million.

The voluntary contribution is in addition to assessed contributions, in-kind support to WHO's Regional Office for Europe in Copenhagen, and contributions to Humanitarian Appeals.

Figure 2– WHO core voluntary contributions in million USD (2022 Annual Report)



Source: https://www.who.int/about/funding

3 Lessons learnt, key strategic challenges and opportunities

3.1 Partner Assessment

The Multilateral Organisation Performance Assessment Network (MOPAN) launched its most recent assessment of WHO in June 2024[17]. The assessment reviews WHO's organisational performance and capabilities against the commitments set out in GPW 13 and its Transformation Agenda from 2017(see Annex 3.4). According to MOPAN, WHO needs to (i) better demonstrate how its activities and outputs make a plausible contribution to the health outcomes it seeks to achieve; (ii) accelerate reforms to build high-performance capacity at the country level; (iii) carry through reforms to WHO's funding model so that more than 50 per cent of funding is in the form of assessed contributions; (iv) strengthen its evaluation function in line with its own and UN norms to improve both accountability and corporate learning further; and (v) maintain the attention on prevention and response to SEAH to achieve permanent culture change.

[17] At the time of writing, a WHO management response to MOPAN was not yet available

The assessment period was heavily influenced by COVID-19, which given WHOs mandate presented the organisation with unprecedented challenges. Moreover, MOPAN's scores are based on available data that is considered weak. With this general caveat, MOPAN finds that WHO's overall performance ratings over the review period are satisfactory for organisational architecture and financial framework achievements, cross-cutting issues, operational model and resources support relevance and agility, cost and value consciousness, financial transparency, planning and intervention design, and partnerships. Performance on results focus and evidence-based planning are scored as unsatisfactory. Outcome scores on achievement of results, relevance, efficiency and sustainability received satisfactory scores, except for environmental and climate change results.

MOPAN highlights that fundamentally different skills and operational preparedness are required for WHO's dual role of setting norms, guidance and standards and increasingly operationally responding to crises and emergencies at the country level. The assessment highlights that WHO, during the COVID-19 pandemic, showcased capabilities for speed and agility that are critical and need to be accelerated as part of ongoing reforms. Furthermore, MOPAN emphasises that WHO continues to demonstrate clear leadership among global health institutions.

3.2 Challenges

Changing geopolitics and a growing number of crises further complicate efforts to leave no one behind. In the health domain, consequences of great power contestation and the rise of populism include an anti-gender trend seeking to roll back or hinder the advancement of sexual and reproductive health and rights (SRHR) and comprehensive sexuality education (CSE), including within the UN System. Politicisation and push-back against gender transformative and SRHR-related language in resolutions and decisions has been an increasing trend in the WHA. In the most recent WHA (2024) this was reflected in an unprecedented number of instances where voting (instead of consensus) was required to pass resolutions.

Agenda 2030 is off track. WHO estimates that less than 15 per cent of the health-related SDGs are on track. The COVID-19 pandemic seriously compromised planned health activities from 2020 to 2023. Progress has been made, but the pace of progress is insufficient to meet the SDG targets by 2030. The number of children missing out on vaccinations is rising. Non-communicable diseases (NCDs) have become the leading cause of premature death, particularly in lower-income countries. Mental health disorders are more prevalent than anticipated. Antimicrobial resistance (AMR) threatens a century of medical progress.

The lack of progress towards the SDGs that underpin key determinants of health, including poverty and social protection (SDG 1) and the lack of prioritisation of gender equality (SDG 5) has far-reaching negative consequences for individual health and well-being; the capacity of health systems to ensure that women and girls can access all the services they need without discrimination, including sexual and reproductive health services; and women's empowerment in the health and care sector. The COVID-19 pandemic impacted the already lagging progress on education (SDG 4), which is a key health determinant.

Unhealthy diets and malnutrition are now estimated to account for nearly one-third of the global burden of disease (SDG 2). The modest progress on childhood stunting and wasting is at risk, including through conflict and worsening food insecurity: 735 million people face chronic hunger, and 333 million people were acutely food insecure in 2023. Between 2.2 billion and 3.5 billion people still lack access to safely managed drinking water and sanitation, respectively (SDG 6), and 2.3 billion people rely primarily on polluting fuels and technologies for cooking (SDG 7).

Climate change is a growing threat to human health. Climate change impacts the resilience of health systems. Extreme weather events affect the lives of millions of people, increasing and changing the disease burden and the risk of future disease outbreaks, disrupting vital systems and undermining health determinants that disproportionately impact already vulnerable populations. Severe weather events, air and chemical pollution, microbial breaches across the animal–human-environment interface and climate-sensitive epidemic diseases are increasing in frequency across the globe, with a disproportionate impact in particularly vulnerable areas.[18]

Human migration and displacement have reached unprecedented levels. An estimated 1 billion people have chosen to migrate or have been forcibly displaced, either within or beyond their country, owing to economic, environmental, political, conflict and other forces. Conflict, insecurity and displacement crises are increasing; attacks and casualties among healthcare workers and damage to health facilities have escalated.

Financing. WHO faces significant funding challenges primarily due to its heavy reliance on voluntary contributions, which comprise nearly 80 per cent of its funding. Lack of core funding is a general issue for UN agencies and with core funding at 20 per cent, WHO is under the minimum 30 per cent target of the UN Funding Compact. This hinders WHO's flexibility and predictability in financial planning, making it difficult to allocate resources efficiently according to its strategic priorities. The lack of predictable funding also hampers WHO's ability to respond promptly to emerging health crises and maintain a consistent level of support for its core programs. The current funding model's constraints have also led to a shortage of resources for key health areas, such as prevention, and created competition for resources between WHO departments. This situation encourages siloed operations rather than collaborative efforts, inhibiting WHO's agility and effectiveness in addressing global health challenges.

3.3 Lessons

Results-based management. An overarching theory of change now articulates how WHO's core work enables the joint actions needed by Member States, WHO and partners to achieve the GPW 14 strategic objectives and joint outcomes. WHO's strategic objectives and joint outcomes emphasise priorities on health system resilience, global health equity and access, climate change and disease prevention. An enhanced draft results framework includes "joint" and "corporate" outcomes, recalibrated measurement indices and updated

[18] WHO Draft fourteenth general programme of work. 3 May 2024 page 6

outcome indicators. On data collection and management, the GPW 14 emphasises stronger data foundations, with a specific outcome on stronger country health information, data and digital systems and a corporate emphasis on improving WHO's own data management systems and capacities for producing timely, reliable, accessible and actionable data.

Gender equality and human rights. The 2021 WHO evaluation of its integration of gender, equity and human rights (GER) concluded that WHO needs to make significant changes in driving and investing in gender, equity and human rights throughout the organisation. The evaluation found that country-level work on gender, equity and human rights has not been supported effectively, resulting in variable degrees of integration. Applying lessons learned, GPW 14 commits to advancing gender equality, health equity and the right to health by ensuring relevant actions in all GPW 14 outcomes, especially in the areas of health leadership and advocacy, programme planning and implementation, data and measurement, reporting, and workforce policies and practices. GER has been incorporated into WHO's corporate scorecard, containing the following attributes: (i) gender equality and empowerment analysis, (ii) reducing inequities, (iii) meaningful participation, and (iv) increasing inclusion in the health sector for persons with disabilities.

3.4 Opportunities

Overall, the opportunity for Denmark lies in the convergence with Danish priorities**.** Denmark and WHO share a commitment to Agenda 2030, its principles and the SDGs. A shared premise for Denmark's Organisation Strategy and GPW 14 is that the world has changed in fundamental ways and will continue to do so in with profound implications for human health and well-being, particularly for the poorest and most vulnerable. Specific opportunities include the fact that WHO in GPW 14 has elevated its response to climate change to a strategic level objective.

4 Priority areas and results to be achieved

The following priority areas have been chosen based on the linkages between Danish and WHO strategic priorities to achieving the health-related United Nations' SDG and lessons learned from previous support. Annex 1 shows Danish development cooperation priorities for WHO and their relation to WHO outcome and output indicators to be used to monitor implementation and progress on this Strategy 2025-2028[19].

Priority 1: Health systems strengthening to achieve universal health coverage

Strong health systems, including reinforced health security and emergency preparedness and responses, are the enablers of good health and critical for well-functioning health programmes and resilient health systems. WHO plays a key role in supporting countries in strengthening their health systems, including primary health care, to ensure increased and better access for the millions of people who are unable to obtain the health services they need, particularly the poor and marginalised. Achieving Universal Health Coverage (UHC) is at the core of WHO's 'provide health' strategic priority in line with SDG target 3.8. This includes financial risk protection, access to quality essential health services, including

[19] For 2024 the indicators from GPW 13 will be used.

SRHR services, and access to safe, effective, quality and affordable essential medicines and vaccines for all. Health systems must have sufficient capacity and resilience to be prepared for and respond to emergencies, including in relation to the effects of climate change on health and health systems.

Denmark will work to ensure that WHO sets normative standards and guidelines for essential health preparedness and services and supports countries in developing strong, resilient and affordable health systems based on primary health care strategies as the main way towards achieving UHC and health security.

WHO GPW 14 outcomes: 1.1, 3.2, 4.1, 4.3

Priority 2: Pandemic, health emergencies and global health risk preparedness
As requested by Member States in December 2021, WHO has been convening meetings of the Intergovernmental Negotiating Body (INB) and facilitating the drafting of a convention, agreement or other international instrument under WHO's Constitution to strengthen pandemic prevention, preparedness and response[20] with a view to adopt a legally binding framework at latest by WHA in May 2025.

Health systems and services are at risk globally when microbes become resistant to antimicrobials such as antibiotics and start to spread. WHO has classified antimicrobial resistance (AMR) as one of the top 10 threats to global health.

GPW 14 addresses the increasing frequency and intensity of health emergencies globally, exacerbated by climate change, environmental degradation and pollution, urbanisation, political instability and conflict, against the backdrop of weak health systems that the COVID-19 pandemic has further debilitated. Due to a combination of conflict, climate change, and protracted situations, in 2023, an unprecedented 340 million people needed life-saving humanitarian assistance. This number continues to increase due to the historically high number of health emergencies worldwide. Emphasising prevention and resilience is the most efficient approach to health emergencies through a humanitarian-development-peacebuilding (HDP) nexus approach.

Denmark will support pandemic preparedness and response, and the AMR and vaccine agendas through multilateral efforts to build more resilient healthcare systems and work for increased equitable access to medical countermeasures. Denmark will support access to health services in countries affected by fragility and conflict, focused on vulnerable people, not least among women, children and young people. This includes helping vulnerable displaced people and affected local communities in getting effective access to basic health services along with mental health and psychosocial support when crisis, conflict or disaster strikes.

WHO GPW 14 outcomes 4.1, 5.1, 5.2, 6.2

[20] Pandemic prevention, preparedness and response accord (who.int)

Priority 3: Human rights and gender equality, including SRHR

Denmark applies human rights as a core value in partnerships and uses principles of non-discrimination, participation, transparency and accountability in all parts of development cooperation. Denmark places a strong emphasis on gender equality and the rights of women and girls and views sexual and reproductive health and rights as vital to improving health for all at all ages. WHO has, through GPW 14, committed to a human rights-based "leave no one behind" approach in achieving health for all and to address gender as a determinant for health. WHO has committed to strengthening WHO advocacy for health on human rights, equity and gender and to the acceleration of achieving SDG 3.7 and 5.6.

Denmark will work to ensure that WHO continues to develop and strengthen its human rights and gender policies and uses evidence to include gender-transformative approaches to remove barriers to accessing services and to promote sexual and reproductive health and rights, including comprehensive sexuality education and safe abortions, both in WHO policies, guidelines etc., but also at country level. Denmark will also urge WHO to address the linkages between gender inequality, SRHR and climate vulnerability.

WHO GPW 14 outcomes: 3.1 and 4.2

Priority 4: A more effective and efficient WHO, that also contributes to the efficiency reform efforts of the United Nations Development System

WHO will continue deepening reforms initiated during the previous organisation strategy. WHO Corporate Outcome 4 is focused on enhancing WHO's Secretariat's organisational performance. Four areas of focus will be the basis for developing corporate indicators.

1. Ensuring a motivated, diverse, empowered and fit-for-purpose WHO workforce operating in a respectful and inclusive workplace, with organisational change fully institutionalised.
2. Strengthening WHO country office presence and core capacities to drive measurable impact.
3. Enhancing the effectiveness and efficiency of ought and accountability functions across the three levels of WHO.
4. Strengthening results-based management through a strong programme budget, supported by transparent resource allocation and sound financial management.

Denmark will support continued institutional reform efforts to ensure sound financial management and an effective, efficient and accountable WHO. The aim is a WHO able to strengthen its normative and technical functions, address the increasingly complex challenges of global health by agreed priorities and in close cooperation with relevant partners and aligned with UN development reform.

WHO GPW 14 corporate outcome 4

Other priorities and areas of cooperation

In addition to the main priorities outlined above, Denmark will seek cooperation and dialogue with WHO to support other areas of joint Danish and WHO interests, such as Mental Health and non-communicable diseases (NCDs). Denmark will for the time being carry forward the funding for the global NCD work as in the former strategy and will also provide direct funding to the regional efforts to prevent and respond to NCDs in the EURO region (see Section 6). Denmark will continue to work toward strengthening WHO in health emergencies, including providing support to specific health emergency appeals as appropriate. Denmark will also engage WHO on common interests, including, but not necessarily limited to, areas of Danish expertise and private sector partnerships and cooperation. This includes, as a priority, continued focus and effort to improve coordination and collaboration between WHO and other health actors. Denmark will continue to work for a meaningful engagement between WHO and relevant health actors, including civil society representatives.

5 Danish approach to engagement with the organisation

Working closely with The Ministry of the Interior and Health (MIH), the Danish Health Authority (DHA), and other stakeholders, the MFA will engage WHO's Secretariat in addressing the priorities described in the Strategy.

Thus, Denmark will actively participate in WHO's formal governance structures, namely WHO's Executive Board and the annual World Health Assembly, to influence WHO's strategies and operating model. Denmark will also take part in meetings of the Programme, Budget and Administration Committee when possible. Denmark is represented by a joint delegation from MFA, MIH and DHA at official meetings. Moreover, Denmark will use formal and informal channels to hold WHO accountable on its commitments set out in GPW 14 and to influence the direction of new and existing initiatives. Denmark will, to the extent possible, engage in preparatory meetings relating to financial management, budgeting, accounting, auditing, anti-corruption as well as WHO's work in preventing and responding to sexual exploitation, abuse, and harassment.

Denmark will work closely with Members States of the European Union to jointly influence resolutions and decisions on key shared priorities. Beyond the EU, Denmark will also leverage the existing well-functioning collaboration among Nordic-Baltic countries and will work with other like-minded countries taking joint initiatives on key priorities to achieve results in WHO. To inform its collaboration with WHO further, Denmark will also engage with other relevant stakeholders, such as the private sector and civil society.

Denmark will hold WHO accountable for its commitment to strengthening its positions as an evidence-based technical global health organisation and its accountability and transparency in monitoring performance and progress on its strategic priorities, as stated in GPW 14. Denmark will emphasise effective monitoring and reporting on the Danish priorities specified in Section 4 and Annex 1 and encourage follow-up on MOPAN recommendations.

6 Budget

Denmark's total annual *voluntary contribution* to WHO is projected to be DKK 70 million per year. This is at the same level as 2021-23. For 2024, the Danish Finance Act set aside DKK 10.0 million for thematic funding for NCD initiatives and additional funding of DKK 20.0 million towards NCD activities under the auspices of WHO's EURO office in Copenhagen. Funding levels and the use of earmarking or thematic funding beyond 2025 will be determined in the Finance Act for 2026. Updated budget information for 2026-2028 will be part of the Annual Action Plans.

In line with WHO's shift to a four-year funding period (from earlier 2-year budget cycles), Denmark's voluntary contribution will be a commitment covering the full GPW 14 period 2025-2028. The funding will be monitored against the agreed Danish priorities using WHO's annual reporting of progress to the World Health Assembly in May each year.

Table 2 – Indicative budget for Denmark's voluntary engagement with WHO (DKK million)/1 cf. Finance act 06.36.03.12

	2024	2025	2026	2027	2028	**Total**
Core voluntary contribution	70	70	70	70	70	**350**
Incl. Thematic funding NCD/2	*10*	*10*	*tbd*	*tbd*	*tbd*	***20***
Funding to NCD EURO/2	20	20	*tbd*	*tbd*	*tbd*	**40**
Total	90	90	70	70	70	**390**

1/subject to annual parliamentary approvals

2/The NCD EURO funding is earmarked, reference is made to [Finanslov for finansåret 2024 Tekst og anmærkninger § 6. Udenrigsministeriet page.112]

7 Risk and assumptions

Contextual risks. Global health is directly affected by major world challenges concerning economic, political, environmental and climate change and thus WHO's ability to meet its objectives is beyond its direct control. Epidemic outbreaks are an increasing global health security risk requiring a broad focus on global preparedness and response beyond health systems. Increased geopolitical contestations and tensions may undermine WHA decision-making and agility and seek to roll back progress on SRHR, gender equality and health-related aspects of gender-diversity agendas.

Box 6 – Climate Change and Gender Equality and SRHR

There is a significant gap between the stated goals of gender equality and SRHR in climate policies and their on-the-ground implementation, with women frequently excluded from decision-making processes. To address these challenges, there is an urgent need for gender-sensitive climate finance and a strategic focus on including women in all aspects of climate action. Additionally, supporting women's organisations and networks is essential to ensure that gender equity and SRHR are integrated into climate policies relevant to the health sector. These impacts underscore the urgency for WHO to promote climate-resilient and environmentally sustainable health systems and integrate health into broader climate adaptation and mitigation strategies.

Source: Danish Ministry of Foreign Affairs May 2024 Climate Change and Gender Equality and Sexual and Reproductive Health and Rights.

Economic downturn or decrease in domestic public health spending could negatively impact basic services on health and present challenges for the fulfilment of WHO's strategic goals. Health challenges and disease burden often exceed the ability to pay in

several developing countries, and increased efforts to ensure a better balance could improve health and human capital to benefit such countries.

Climate change exacerbates health risks by directly damaging health facilities, disrupting service delivery, and increasing the burden of vector-borne and other climate-sensitive diseases. It is also widening health inequities, particularly affecting disadvantaged groups and vulnerable populations. Climate change is intensifying existing inequalities, disproportionately impacting women and marginalised groups who often lack access to resources needed for resilience (Box 6 above).

Programmatic risk. Follow-through on WHO organisational transformation and related corporate goals is essential, as pointed out in MOPAN 2024. WHO programme budget for GPW 14 risks underfunding and earmarking. A resulting lack of flexible funding could negatively affect Danish priorities. Increasing flexible funding remains a key strategic issue for WHO. Ameliorative actions to manage this risk are built into WHO's financing strategy, including initiatives like the new Health Impact Investment Platform partnership between Multilateral Development Banks, WHO and low- and middle-income countries (LMICs) to strengthen primary healthcare (PHC). The platform is a key part of an effort to unlock € 1.5 billion in concessional loans and grants to expand and improve PHC services in LMICs, namely in the most vulnerable communities. [21]

It also includes the novel approach to have a funding cycle of four years instead of two years, which provides greater transparency, predictability and financial response time for WHO and donors alike. In this regard, the WHO Investment Round is an innovation in WHO financing strategy aiming at greater predictability and flexibility of funding and increased response time to address projected shortfalls. Denmark supports this WHO initiative. Furthermore, Denmark will when possible support WHO in broadening its donor base to lessen the high dependence on a small number of donors and encourage the development of new types of partnerships. Moreover, WHO's reform efforts will also contribute to the mitigation of some of the challenges arising from the low levels of flexible funds.

The annual reporting wheel (Annex 2) the AAP and ASR will provide GVAMIS with information and the opportunity to monitor and manage the specific risk that Danish priorities may be affected by the overall WHO financing situation.

Reputational risks. Denmark will continue following WHO's efforts to strengthen ethics and risk management and zero tolerance for corruption, harassment, sexual exploitation and abuse, and misuse of power. Denmark will also promote a strong and independent evaluation policy.

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[21] https://www.who.int/news/item/23-09-2024-who-and-multilateral-development-banks-kick-off-primary-health-financing-platform-with-new-funds-and-launch-of-first-investment-plans-in-15-countries

Annex 1: Summary results matrix

The matrix below shows the chosen Danish priority results (cf. chapter 4) and the related set of outcomes, outputs and indicators from WHO's GPW 14 as per the GPW draft results framework of June 2024. It should be noted that the final GPW 14 results framework is expected to be approved by the World Health Association in its session in May 2025.

Danish priority results area 1: Health system strengthening to achieve universal health coverage		
WHO GPW 14 Outcomes: 1.1, 3.2, 4.1, 4.3		
WHO objective	**WHO Outcomes**	**Outcome Indicator (draft)[22]**
Respond to climate change, an escalating health threat in the 21st century	1.1 More climate-resilient health systems are addressing health risks and impacts	Index of national climate change and health capacity
3 Advance the primary health care approach and essential health system capacities for universal health coverage	3.2 Health and care workforce, health financing and access to quality-assured health products substantially improved	Government domestic spending on primary health care as a share of total primary health care expenditure
4 Improve health service coverage and financial protection to address inequity and gender inequalities	4.1 Equity in access to quality services for noncommunicable diseases, mental health conditions, and communicable diseases while addressing antimicrobial resistance.	SDG indicator 3.8.1. Coverage of essential health services
	4.3 Financial protection improved by reducing financial barriers and out-of-pocket health expenditures, especially for the most vulnerable.	Incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional definitions where available) Incidence of impoverishing out-of-pocket health spending (related to SDG indicator 1.1.1 and regional definitions where available)

Danish priority results area 2: Pandemic, health emergencies and global health risk preparedness		
WHO GPW 14 Outcomes: 4.1, 5.1, 5.2, 6.2		
WHO objective	**WHO Outcomes**	**Outcome Indicator (draft)**
4 Improve health service coverage and financial protection to address inequity and gender inequalities	4.1 Equity in access to quality services improved for noncommunicable diseases, mental health conditions and communicable diseases, while addressing antimicrobial resistance	SDG indicator 3.d.2. Percentage of bloodstream infections due to selected antimicrobial-resistant organisms
5 Prevent, mitigate and prepare for risks to health from all hazards	5.1 Risk of health emergencies from all hazards reduced and impact mitigated	Probability of spillover of zoonotic diseases

[22] Based on: https://cdn.who.int/media/docs/default-source/documents/ddi/gpw14-results-framework_outcome-indicators_metadata.pdf?sfvrsn=fb0df704_10&download=true

	5.2 Preparedness, readiness and resilience for health emergencies enhanced.	SDG indicator 3.d.1. International Health Regulations (2005) capacity and health emergency preparedness
6 Rapidly detect and sustain an effective response to all health emergencies	6.2 Access to essential health services during emergencies is sustained and equitable.	Proportion of vulnerable people in fragile settings provided with essential health services (%)

Danish priority results area 3: Human rights and gender equality, including SRHR		
WHO GPW 14 Outcomes: 3.1, 4.2		
WHO objective	**WHO Outcomes**	**Outcome Indicator (draft)**
3 Advance the primary health care approach and essential health system capacities for universal health coverage	3.1. The primary health care approach renewed and strengthened to accelerate universal health coverage	3.9 Gender equality advanced in and through health
4 Improve health service coverage and financial protection to address inequity and gender inequalities	4.2. Equity in access to sexual, reproductive, maternal, newborn, child, adolescent, and older person health and nutrition services and immunization coverage improved	SDG indicator 3.1.1. Maternal mortality ratio SDG indicator 5.6.1. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care SDG indicator 5.2.1. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age SDG indicator 3.7.1. Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods SDG indicator 3.7.2. Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group

Danish priority results area 4: A more effective and efficient WHO		
WHO GPW 14 Corporate Outcome 4		
WHO objective	**WHO Outcomes**	Outcome Indicator (draft)
A more effective and efficient WHO	Corporate outcome 4. A sustainably financed and efficiently managed WHO, with strong oversight and accountability and strengthened country capacities, better enables its workforce, partners and Member States to deliver the GPW 14	These indicators will measure the extent to which WHO's funding is aligned with GPW 14 priorities, the strengthening of WHO country office core capacities and capabilities, and transparency and joint accountability for results. The scope of these indicators will include assessing, for example: – how well WHO's budget for the GPW 14 priority outcomes is funded – the percentage of WHO country workforce positions that are filled and the roll out of the core predictable country presence model – the joint Member State-Secretariat assessment of GPW 14 results

Annex 2: Annual wheel

	WHO	GVAMIS
Quarter 1	• PBAC/1 meeting (January) • Main Executive Board meeting/2 (January)	• Commitment of annual contribution • To the extent possible participates in PBAC/consults with like-minded countries; Nordic + to inform the Executive Board through the PCAB
Quarter 2	• PBAC meeting (informs WHA) (May) • World Health Assembly/3 (approval or programme and financial reports) (May)	• Disbursement of annual contribution • Coordinates WHA participation with MiH (March-April) • To the extent possible participates in PBAC/consults with like-minded countries; Nordic +(April) • Participates in WHA as member of WEOG (May)
Quarter 3	• Regional committee meetings	• Prepares Annual Stock Taking Report (ASR) for the preceding year based on latest WHA information/2 (July) • Prepares draft Annual Action plan/2 (July)
Quarter 4	• EB preparations, including MS consultations and negotiations of resolutions	• Take part in relevant briefings, consultations and negotiations of resolutions. • Consults with like-minded countries; Nordic + to inform the Executive Board through the PCAB January meeting (December) • On biennial basis: High-Level Consultations with WHO management

/1 The Programme, Budget and Administration Committee (PBAC) is a subsidiary body of the Executive Board primary mandate is to provide detailed scrutiny and advice on matters related to the program planning, budget, and administration of the WHO. PBAC advises the WHO Board on these matters. https://apps.who.int/gb/gov/; https://apps.who.int/gb/pbac/e/e_pbac39.html

/2 The main Board meeting in January adopts the agenda for the forthcoming WHA. A second shorter meeting in May, immediately after the Health Assembly, for more administrative matters.

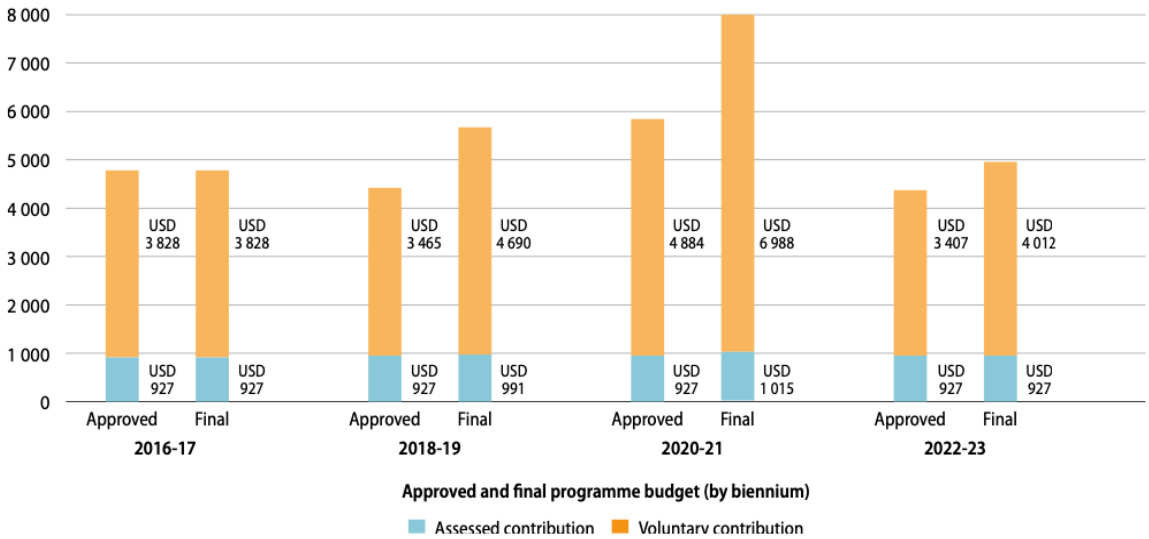
/3 Reviews and approves the Proposed programme budget. It similarly considers reports of the Executive Board.

For 2024, GVAMIS a preliminary ASR and preliminary AAP in December 2024 that will be updated and finalised in June 2025

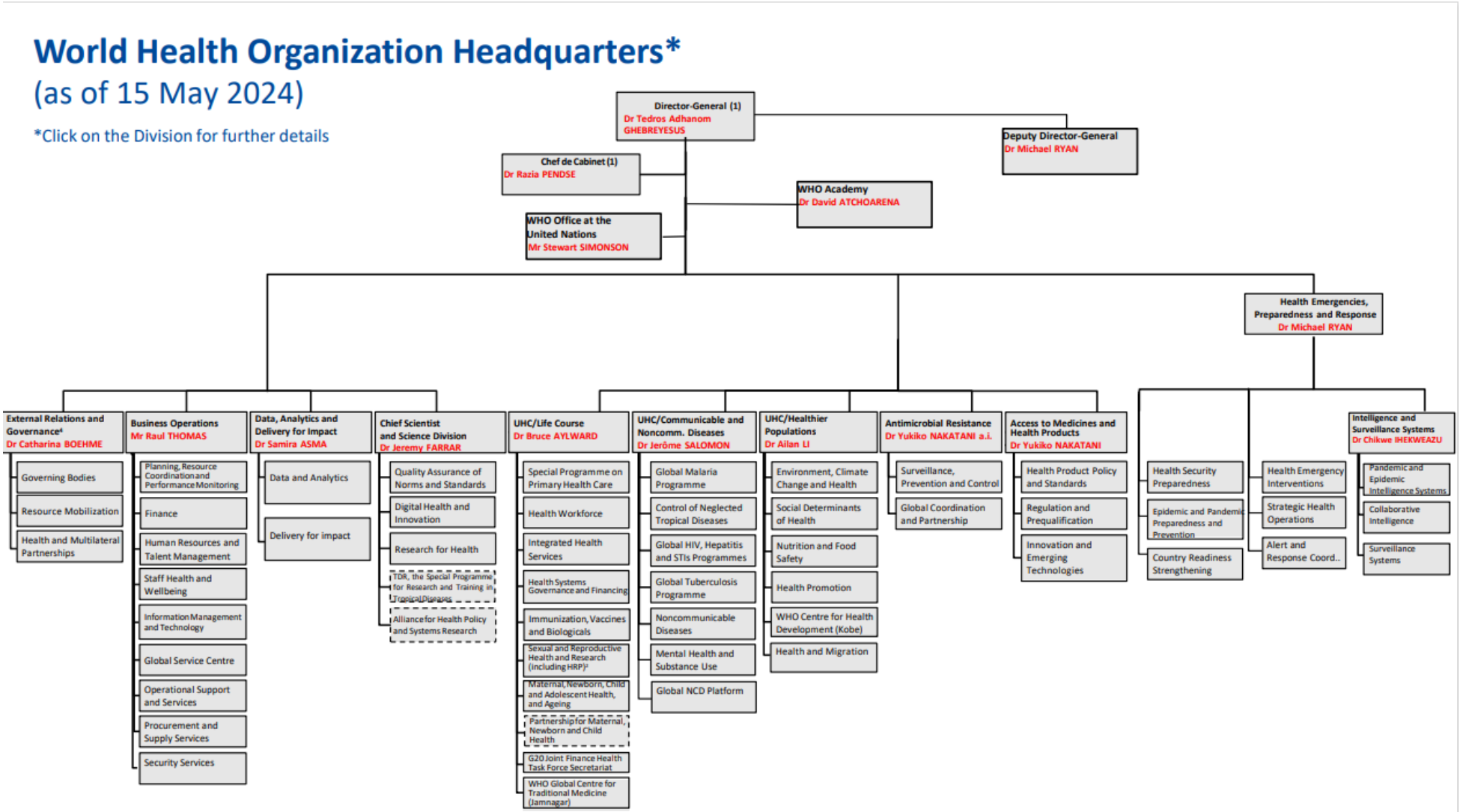
Annex 3: WHO background material

Annex 3.1 WHO assessed and voluntary contributions 2016-2023 (USD)

FIGURE 3: **ASSESSED AND VCs BASED ON FINAL AND APPROVED PBs (in USD millions)**



Annex 3.2 WHO Organisational structure



(1) Includes: Office of the Director General; Chief Nurse Office; Compliance and Risk Management and Ethics (CRE); Country Strategy and Support (CSS); Communication (DCO); Envoy for Multilateral Affairs (EMA); Evaluation Unit (EVL); Global Board of Appeal (GBA); Gender, Rights and Equity - Diversity, Equity and Inclusion (GRE); Global Preparedness Monitoring Board (GPMB); IOAC; Office of Internal Oversight Services (IOS); Office of the Legal Counsel (LEG); Office of the Ombudsperson and Mediation Services (OMB); Polio Eradication and Polio Transition Programme (POL); Prevention and Response to Sexual Exploitation (PRS); Transformation Implementation and Change (TIC).

(2) Research agenda coordinated with Chief Scientist

Annex 3.3 Intersection of Climate change and health: SDGs under WHO custodianship

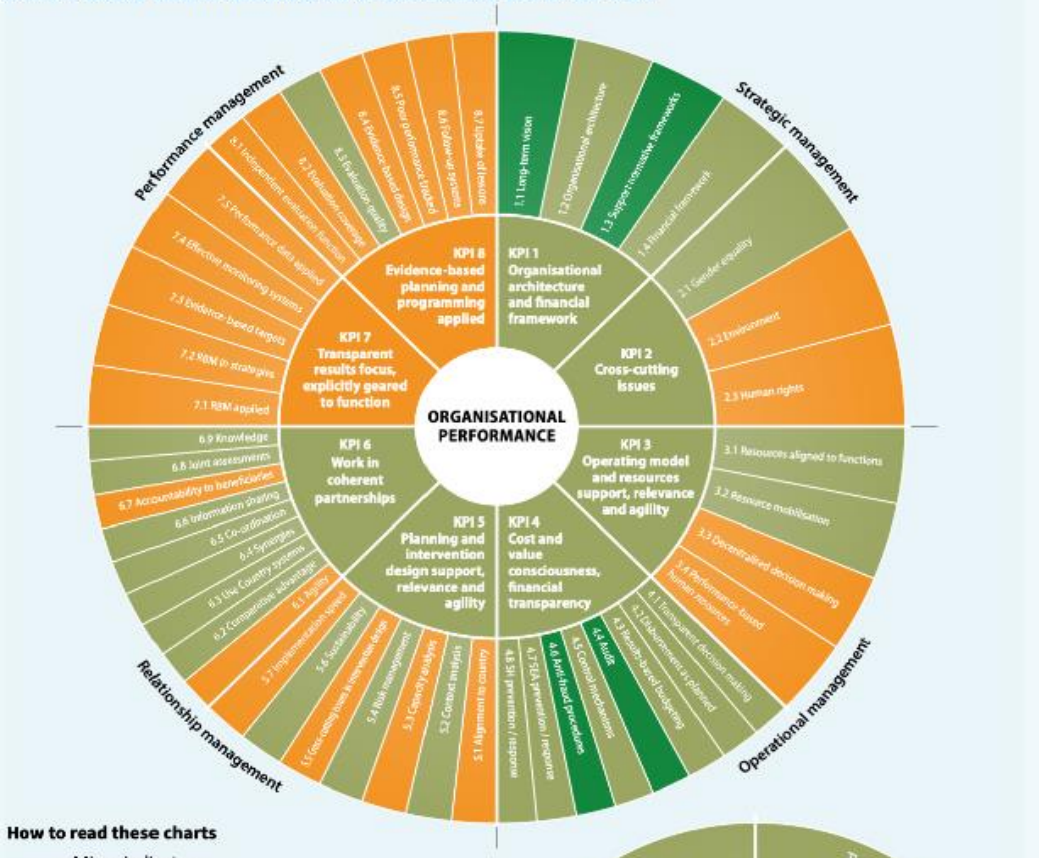
Table 4. Negative impacts to health-related SDGs due to climate change: indicators under WHO custodianship[a]

IPCC AR6 projections indicate negative impacts of climate change	IPCC AR6 evidence suggests negative impacts of climate change without specific projections	IPCC AR6 evidence indicates negative impacts from processes that drive climate change
2.2.1 Stunting under age 5 years *(13)*	**3.8.2** Household health expenditure *(10)*	**3.9.1** Mortality from indoor and outdoor air pollution
2.2.2 Malnutrition under age 5 years (wasting and overweight) *(13)*	**3.9.2** Mortality from unsafe WASH *(8, 17)*	**11.6.2** Mean levels of fine particulate matter in cities (e.g. PM2.5)
2.2.3 Anaemia in women aged 15–49 years *(13)*	**3.d.1** Health emergency preparedness *(12, 41)*	
3.3.3 Malaria incidence *(8)*	**5.2.1** Ever-partnered women and girls aged ≥15 years subject to physical, sexual or psychological violence by a partner *(8, 20)*	
3.3.5 Interventions needed for neglected tropical diseases *(13)*	**5.2.2** Women and girls aged ≥15 years subject to sexual violence by someone other than an intimate partner *(8, 20)*	
3.4.1 Mortality from cardiovascular disease, cancer, diabetes or chronic respiratory disease *(13)*	**6.3.1** Domestic and industrial wastewater flows safely treated *(13)*	
6.1.1 Use of safely managed drinking water services *(8, 17)*	**3.8.1** Coverage of essential health services	
6.2.1 Use of safely managed sanitation *(13)*		

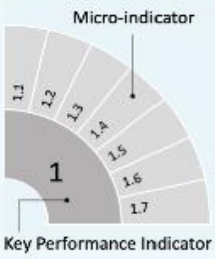
Source: https://cdn.who.int/media/docs/default-source/climate-change/who-review-of-ipcc-evidence-2022-adv-version.pdf?sfvrsn=cce71a2c_3&download=true

Annex 3.4 MOPAN 2024 WHO performance illustration

FIGURE 1: **WORLD HEALTH ORGANIZATION'S PERFORMANCE RATING SUMMARY**



How to read these charts



Highly satisfactory (3.51-4.00)

Satisfactory (2.51-3.50)

Unsatisfactory (1.51-2.50)

Highly unsatisfactory (0-1.50)

No evidence / Not applicable