Geography must not decide who lives

DR. GEVORG TAMAMYAN

“It is my Government’s firm belief that Dr. Tamamyan is ideally placed to serve in this role as the Organization’s chief technical and administrative officer.

At a moment when multilateral institutions are under strain as rarely before, my Government believes the answer is not a diminished WHO but a demonstrably effective one. And a country that has confronted the limits of its own health system knows what effectiveness must mean.

I have met Dr. Tamamyan and satisfied myself that his commitment to those who are furthest from care is not rhetorical, and it is on that basis, and not on any other, that Botswana puts his name forward.”



DUMA GIDEON BOKO
President of the Republic of Botswana

OUR COMMITMENT

The World Must Have WHO. WHO for U

WHO has extraordinary people working under immense pressure. My first responsibility will be to empower them: aligning authority with responsibility, giving technical leaders room to act, and holding all of us accountable for results. Reform will not be directed against WHO or its people. It will remove the barriers that prevent exceptional people from delivering. We must make WHO the best place to work and attract the best global talent.

The World Health Organization is, first and foremost, its Member States, working together to serve the people of the world. Its priorities must be defined with countries, grounded in science, and guided by the needs and right to health of the people it exists to protect. My leadership will build on the commitments Member States have already made, while changing how the Organization delivers them.

Geography is not the only source of inequality. Poverty, gender, disability, displacement and discrimination must not determine who receives care or who survives.

A Results-Oriented WHO Fit for the 21st Century

What gets measured gets done. What gets delivered builds trust.

My governing discipline will be simple

> **Problem → decision → responsibility → measurable result.**

Every major commitment must show who is responsible, what is funded, what depends on Member States or partners, how progress will be demonstrated, and what corrective action follows when delivery falls behind.

Time, including staff time, is as finite and precious as funding. Success will not be judged by documents, meetings or resolutions, but **by the changes we help countries achieve and the lives we improve.**

> **Prevent the preventable. Detect the detectable. Treat the treatable. Keep care going in a crisis.**

A WHO Focused on What Only WHO Can Do: WHO as an Orchestrator of Global Action

WHO cannot do everything, and should not try to. But fewer things does not mean fewer diseases.

Polio, malaria, tuberculosis, HIV, maternal health, universal health coverage, prevention and other commitments made by Member States will remain central to WHO's work. **So what should WHO stop doing?**

First, WHO should lead, not compete.

Its strengths - global legitimacy, scientific credibility, normative authority, convening power and neutrality in crises - allow WHO to bring governments, institutions and partners together. WHO is the global table where Member States come together as equals to protect the health of the world. Keeping that table united, and making what is decided there happen, is our responsibility.

And how do we lead without competing? We will establish a tier-based partnership model, bringing together implementation partners, scientific and advocacy organizations, WHO Collaborating Centers and civil society, including patients, survivors and families, as partners in design and evaluation, not only in consultation. Each will have clear responsibilities, transparent selection and measurable contributions.

Where others are better positioned to deliver, WHO should hand over implementation and help them succeed, without compromising its scientific independence or responsibilities to Member States. We will be inclusive, but disciplined, and not afraid to say no when impact, equity or independence are compromised.

The global health architecture is changing: UN80, the Lusaka Agenda, the Accra Reset, and the Member State-led review of the architecture that WHO itself is hosting. WHO should help shape that change, not wait for it. At country level, we will work to bring partners behind one nationally owned, costed health plan, with coordinated financing and reporting and no unnecessary duplication. We will do this in close cooperation with UN Resident Coordinators and UN country teams, wherever they operate, while respecting WHO's technical mandate and the leadership of national health authorities.

The same applies to digital health and artificial intelligence. WHO will not build systems or hold national data. As it has done through the International Classification of Diseases, WHO will set standards that let a laboratory in N'Djamena, a registry in Santiago and a pharmacy in Lahore speak the same language. It will provide guidance on safe AI while leaving countries in control of their own data.

Technology must also serve the health worker, not burden them with another screen or another report. WHO will help countries use digital tools and safe AI for decision support, training, supervision, referrals, translation and reduced paperwork, so nurses, doctors and community health workers spend more time with patients and less time fighting systems.

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Today, Member States require a leader who can modernize WHO’s operating system, strengthen its technical core, and rebuild trust across all blocs. Dr. Gevorg Tamamyan is uniquely prepared and equipped to meet that moment.

The Honorable Hugh Dugan (USA), Former Special Assistant to the US President and Senior Director for International Organization Affairs at US National Security Council

WHO requires a leader with outstanding professional expertise, long-term strategic vision, and unwavering dedication to universal equitable healthcare. Dr. Tamamyan perfectly fits this profile: he pairs solid oncology clinical experience with extensive experience in high-level global health diplomacy.

Prof. Daiming Fan (China), President of China Anti-Cancer Association

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Empowering Countries and Health Workers

At the centre of every health system are people: patients and families, together with the nurses, doctors, community health workers, researchers and public health professionals who serve them.

Countries do not need another organization telling them what their problems are. They need a partner that listens, brings the best available science and expertise, helps mobilize the right institutions, and supports national leadership.

We will strengthen WHO's country presence, working with Regional Directors and Member States, so that decisions are taken closer to the people they affect. Our priorities will include strong national health workforces, primary health care, universal health coverage, financial protection, and health systems capable of serving everyone, including the most vulnerable.

Primary care is where every flagship in this document begins: the nurse who notices a pale child, the health worker who treats depression where there is no psychiatrist, the pharmacy that has the insulin, the clinic that reports the first unusual case. And people are living longer than the systems built to care for them; primary care is where that gap will be closed or lost.

In September 2028, the world marks fifty years since Alma-Ata. We will mark it not with a conference, but with a report showing, country by country, what primary health care actually delivers *(Dr. Hans Kluge also proposes a primary-care dashboard for this anniversary; the two should be one)*.

> **Strong countries make strong regions. Strong regions make a strong WHO.**

Built for Action and Delivering on Commitments

WHO must function as a living organization, not a bureaucratic system. We will align authority with responsibility, empower technical leaders, eliminate unnecessary processes and accelerate decisions.

Technical decisions must be made by technical leads. Decisions should be made at country and regional levels wherever possible, with headquarters responsible for what genuinely requires global coordination. Rules exist for a reason. **But process must never become an excuse for years of inaction.**

WHO resolutions must change lives, not remain on paper. Every commitment needs clear responsibility, realistic financing, measurable milestones and transparent reporting. **Unfunded mandates weaken execution. Unimplemented resolutions weaken trust.**

When resources fall short or progress fails, we must tell Member States openly and change course. **Honesty about what is not working is part of accountability.**

A Merit-Based, Future-Ready and Trusted WHO

That starts with its people: a culture where excellence is recognized, performance is addressed, and talent is empowered.

Outstanding young global health leaders should not have to wait for their biological age to become "acceptable" for leadership at WHO. **Young professionals are not only leaders of tomorrow. They must have opportunities to lead today**, with real authority and responsibility alongside experienced colleagues.

Trust also requires transparency, scientific independence and the courage to acknowledge mistakes.

Scientific independence must be protected from political and administrative interference. That protection needs clear institutional safeguards. WHO's guidelines and emergency recommendations will publicly disclose their supporting evidence, criteria, contributors and declared interests, and reasons for changes. An independent body will oversee the integrity of WHO's scientific advice and publish its findings in full *(as proposed in Dr. Hanan Al-Kuwari's program)*.



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Humble and humane, with refusal to give up. I have never seen anyone carry so much so gracefully.

Narine Mnatsakanyan
(Armenia), patient advocate

I wholeheartedly endorse his candidacy for WHO Director-General.

Prof. Tezer Kutluk (Turkey), Past-President of Union for International Cancer Control and European Cancer Leagues

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Independence is necessary, but it is not enough. WHO guidance must also arrive in time to be used. Today a guideline can take years to produce, and when it is published, nobody systematically checks whether countries use it or whether it changed anything. We will produce guidance faster, starting from what countries ask for, using modern tools including AI for evidence review, with the same scientific standards. And the same independent body will report not only whether WHO's advice is sound, but whether it is used, and what it changed.

> **If impact is invisible, trust cannot grow. And if problems are hidden, trust cannot survive.**

Persistence and Leadership

As a pediatric oncologist, I learned that we must always do our best, even when success is uncertain. When lives are at risk, we cannot remain passive. When our voice can make a difference, we should use it. And when we know we are working for the right mission, we must be persistent.

This persistence will define my leadership.

My promise is to empower WHO's people, strengthen its service to Member States, restore trust through delivery, and ensure that WHO remains the world's most trusted partner in health.



HOW IT WILL BE DELIVERED

A vision matters only if it changes what happens in countries and in people's lives. Here is how I intend to deliver it.

OUR 12 COMMITMENTS

I. WHO FOR PEOPLE

1 Our Children First

2 No Miracle Drug Without Access: On the Shelf in Every Country, Made in Every Region

3 Keep Care Going in a Crisis: Preparedness Before Panic

II. WHO FOR COUNTRIES

4 Strong Countries, Strong Regions

5 No Health Without Health Workers

6 Universality

III. WHO ACCOUNTABLE FOR RESULTS

7 No Empty Desks

8 The Best Place to Work, and a New Generation in Leadership

9 Zero Tolerance Must Be Measurable

10 Financing WHO

11 Focus on What Only WHO Can Do

12 Radical Transparency, Starting at the Top

WHO has exceptional people, sometimes trapped inside systems that prevent them from delivering. The job of its leadership is to free them to deliver.

I have spent my career building the things WHO exists to make possible: a national pediatric cancer service, a research institute, a charity that covers every child, a global knowledge platform, and networks that span continents. I built them in a small country affected by wars, with limited resources, where you learn quickly that the problem is rarely science. The problem is access, equity and delivery.

At 31 I was given the opportunity to consolidate Armenia's fragmented pediatric cancer services into one national center. We standardized care, started the country's first pediatric oncology fellowship, mentored a new generation of specialists, and survival rates rose to approximately 80%. With City of Smile, we made sure no family in Armenia pays for a child's cancer diagnosis or treatment. That is what "universal health coverage" looks like when it is real, and I know what it takes to get there.

I co-founded OncoDaily and built it from zero into one of the world's largest oncology communication platforms, reaching millions. I have led organizations across the public, private and non-profit sectors, and I know how to make impact visible, which WHO can do much better.

Internationally, I served as President of the International Society of Pediatric Oncology Asia Continental Branch (SIOP Asia) and of the POEM Group, which unites 110 centers across 28 countries. At SIOP Asia, we created around 45 country ambassador roles in two years. Engagement grew significantly across the continent, making SIOP Asia not only the largest but also one of the most active branches of SIOP. I currently serve as Co-Chair of the St. Jude Global Alliance European Regional Committee, which unites 13 European countries.

I have studied and worked in seven countries across Asia, Europe and North America, and I have worked on cancer care in conflict settings, including through the Institute of Cancer and Crisis, and I co-authored the 2024 manifesto on cancer care in conflict.

I am not an insider of Geneva, and I do not pretend to be. I have never tried to be the smartest person in the room. My job has always been to find the best people, empower them, and hold them accountable. That is the job of the Director-General. What I bring is the experience of a builder who has delivered results where the odds were against delivery, and who measures success by the lives changed, not the documents produced.

I have never run WHO. I have run the things WHO exists to make possible. I will pair that delivery experience with a leadership team combining deep WHO and UN executive knowledge, country experience and scientific authority.

Some ask why WHO needs a doctor and researcher at its head. My answer: because WHO needs a doctor's urgency to act and a scientist's rigor to defend the science.

You already have candidates who know WHO extraordinarily well. **My experience is different: I have built health services where the consequences of failure were immediate and personal for patients and families.**

I have read my fellow candidates' programmes and learned from them.

- **Dr. Hanan Al-Kuwari** is right to call for independent oversight of WHO's scientific advice, with the findings published in full. I have included this proposal in my programme.
- **Dr. Hanan Balkhy** has given a career to infection control and antimicrobial resistance; when WHO moves on AMR, hers is the first advice I would ask for.
- **Dr. Hans Kluge's** proposal for a coalition of heads of state against attacks on health workers and hospitals deserves to happen whoever wins this election.
- **Dr. María Neira** has championed prevention and environmental health for decades. Her proposal for an early-warning antenna to anticipate emerging risks, including microplastics, endocrine-disrupting chemicals and declining fertility, deserves a place in WHO's future.

- **Mr. Budi Gunadi Sadikin's** one costed national health plan per country, with the finance minister at the table, is the right model, and I have adopted it.
- **Dr. Li Song** led the programme that took hospital births for China's rural mothers from under half to nearly all; that is what delivery at scale looks like, and the world should learn from it.

If I am elected, the best ideas in this election will be implemented, and credited, whoever had them. A good idea does not need my name on it.

Here, I am proposing three areas of commitment, with signature examples, measurable results and timelines.

Some commitments I can deliver directly. Others require Member State decisions or national implementation. I will be transparent about all three, take responsibility for what is within my authority, and hold WHO accountable for its contribution.



I have enormous admiration for his leadership, vision, and, above all, his humanity. His candidacy fills me with pride, confidence, and hope.

Alejandra Mendez (Chile), President of Childhood Cancer International, mother of cancer survivor

I. WHO FOR PEOPLE

Noncommunicable diseases (NCDs) cause seven in ten deaths worldwide, including 18 million before age seventy. Four in five people with high blood pressure are not properly treated. Most of this is preventable, and prevention is the cheapest flagship WHO has. Tobacco control, clean air, clean water, safe food, less alcohol and sugar, more movement: these are prevention at scale, and WHO already knows what works.

We will report annually against the global target of reducing premature deaths by one-third by 2030, and we will report what each Member State has implemented of WHO's own best-buy interventions. The primary care that finds a child's cancer also finds a father's hypertension. The pharmacy that stocks chemotherapy must also have insulin.



1. Our Children First

If we are not taking care of our most precious - our children - what are we doing?

A child's survival begins with the mother's. Maternal, newborn, adolescent and reproductive health remain at the top of WHO's agenda, and WHO's guidance in these areas will stay what it has always been – based on science.

Childhood cancer survival is the litmus test of the whole system.

A child with leukemia needs primary care to notice, a lab to diagnose, a pathologist, a blood bank, a pharmacy that never runs empty and a nurse trained to follow up: whoever builds that has built a health system.

It is our shame that in the 21st century we still talk about survival of 20%, while 30 years ago survival was already above 70% in rich countries, with very cheap medications. And survival is not the finish line. Our responsibility is that children survive and then thrive.

What we will do

We will accelerate WHO's existing childhood cancer initiatives, bringing together Ministries of Health, treatment centers, professional associations, foundations, civil society, industry and partners. Every participating country will have a nationally owned, financed implementation plan.

I will appoint a dedicated **Special Envoy for Childhood Cancer** to coordinate delivery, including survivorship and the meaningful participation of survivor and family organizations, and ensure results are reported publicly, country by country, every year.

What we will measure

By 2028, participating countries will establish baselines for diagnosis, treatment abandonment, medicine availability and survival.

By 2032: At least 90% of expected childhood cancer cases diagnosed, treatment abandonment below 10%, uninterrupted core medicines, sufficient trained personnel and independently validated, publicly reported survival outcomes, and, in countries ready for it, follow-up with survivors' return to school and work and families' financial protection reported alongside survival.

We will accelerate WHO's existing goal of at least 60% childhood cancer survival by 2030 and aim for 80% five-year survival by 2037 in participating countries.

How It Will Be Financed

Build on WHO's existing childhood cancer initiatives, strengthen sustainable financing through Ministries of Health and national pediatric cancer foundations, and mobilize partners and the WHO Foundation to close gaps.

These are country outcomes, not something a Director-General can deliver alone. **My commitment is to work with every country to make them happen.**

2. No Miracle Drug Without Access: On the Shelf in Every Country, Made in Every Region

In 2021, science delivered vaccines at extraordinary speed. But access was profoundly unequal, and billions of people waited. That must never happen again.

The Global South must not remain only a recipient of innovation. It must also become a creator, manufacturer and supplier.

Not every country builds a plant; every region has one, at a scale that makes economic sense. No one is left waiting for someone else's plant.

Innovation matters. But without access, it means nothing. The essential basket addresses medicine shortages, not the price of innovative treatments. A family should not have to sell its house to buy a medicine.

What we will do

In the first year, WHO and Member States will agree on a priority basket of approximately 30 essential medicines and accompanying diagnostic tests. Availability will be measured according to each facility's level of care: a rural clinic does not need everything a specialized hospital stocks, but both must have what they need.

With each WHO region, we will develop manufacturing compacts for vaccines and 10–15 priority medicines, building on, not duplicating, existing institutions such as Africa CDC, the African Medicines Agency, PAHO's Revolving Fund, and ASEAN and Gulf regulatory networks.

These compacts will connect technology transfer, stronger regulation, WHO prequalification, pooled procurement and predictable demand. WHO provides standards, expertise and convening power; Member States, manufacturers and development banks make investment and purchasing decisions, ensuring economically viable production. And every region will have a strong clinical trial network, so that the Global South produces science, not only receives it.

WHO will also publish the prices countries pay for every medicine in the basket, as it already does for vaccines; support pooled negotiations, as PAHO does; and work with the Medicines Patent Pool to expand access.

What we will measure

2028: Medicine basket, baselines, price transparency, regional priority lists and financing gaps.

2030: Manufacturing compacts operational in all six regions. Each region with a clinical trial network.

2032: Regional vaccine and medicine production, 80% availability at designated facilities, public stock-out reporting where possible, and pooled negotiation for high-cost medicines available to participating countries.

How It Will Be Financed

WHO convenes and provides standards; governments, development banks, manufacturers and other partners finance investment and purchasing.

3. Keep Care Going in a Crisis: Preparedness Before Panic

A person should not die from diabetes because an earthquake interrupted insulin supplies. A child should not stop chemotherapy because a war has begun. And an outbreak should not spread for weeks before the world recognizes it.

> **We need to prepare before the panic starts.**

The world has amended the International Health Regulations and adopted the Pandemic Agreement. The remaining piece is the annex on pathogen access and benefit-sharing. My job is not to write a third instrument. It is to complete the existing ones and make them work, so that the country sharing a pathogen is never the last to receive the vaccine.

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Remarkable commitment to global health, equity and stronger health systems.

African Organisation for Research and Training on Cancer

What we will do

- **Detect outbreaks faster.** Expand the 7-1-7 framework, the standard WHO already endorses: detect suspected outbreaks within seven days, notify authorities within one, and complete essential early response actions within seven.
- **Keep care going through every crisis.** Protect treatment for cancer, diabetes, cardiovascular and renal diseases, HIV, tuberculosis, mental health and other conditions, alongside maternal, newborn and primary care. Continuity of care will be integrated into participating countries' IHR preparedness self-assessments through agreed reporting mechanisms. Plans will be tested against conflict and climate shocks. Heat kills, floods close clinics, and care must continue.
- **Protect healthcare in conflict.** Care cannot continue where the hospital is a target. WHO will publish verified attacks on health care within days, as it already records them. The same verification standard will apply to every party to every conflict, with published criteria for how an incident is verified and how sources are rated, and the data open to independent audit with a formal way to correct errors. WHO will work with all parties so that patients and health workers can reach each other, as international humanitarian law provides. And WHO will convene a coalition of heads of state and government against attacks on health care *(as proposed in Dr. Hans Kluge's program)*, because hospitals stop being targets when the people who command armies say so.
- **Confront existing and emerging threats.** Antimicrobial resistance is the slow pandemic. Working through the Quadripartite with FAO, WOAH and UNEP, we will pursue the UN's target of reducing deaths from resistant infections by 10% by 2030. A small foresight team, potentially at WHO's existing Berlin Hub, will publish annually from 2028 **the ten risks the world is not yet counting** *(building on Dr. Maria Neira's proposal for a risk antenna)*.
- **Keep essential supplies moving.** WHO sets the standard for what every emergency kit must contain and the trigger for release. Partners already equipped to store and transport supplies should lead those operations. WHO does not build a second logistics system.

What we will measure

By 2028: Publish standardized 7-1-7 and continuity-of-care indicators, with country baselines. Independently review major emergencies and publish lessons and corrective actions.

By 2032:

- Every WHO region publishes annual 7-1-7 results, with most assessed outbreaks meeting the standard.
- Every participating country has a continuity-of-care plan, exercised at least every two years against conflict and climate shocks.
- Participating countries annually report IHR core capacities, with continuity-of-care readiness assessed alongside them.
- Verified attacks on health care are publicly reported within days.

How It Will Be Financed

We will build on WHO's existing emergency functions, national preparedness budgets, multilateral financing, the Contingency Fund for Emergencies where eligible, emergency appeals and partners, while identifying and addressing remaining funding gaps.

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Genuine Humility, Integrity, and a Deep Commitment to Improving Patients’ Lives.

Prof. Piotr Wysocki (Poland), Former President
of the Polish Society of Clinical Oncology



II. WHO FOR COUNTRIES

> **Our responsibility is to empower countries and the people who serve them.**

Geography creates inequality inside countries too. A herder's child in Mongolia, a family in the Sahel or on a Pacific island should not be beyond the reach of the health system. Reaching rural and remote populations will be a stated element of every costed national plan WHO supports.

4. Strong Countries, Strong Regions

One size does not fit all. Countries need different levels and types of WHO support, from health systems strengthening, surveillance and emergency response to specialized technical expertise and policy cooperation. WHO's country offices must have the authority, expertise and resources to deliver what each country needs.

And the regions must be empowered. I see the elected Regional Directors as a strength of WHO, not a weakness to be overcome.

The ultimate ambition is for WHO's expertise and functions to be distributed much more widely across its Member States, with every country able to contribute to, and benefit from, the Organization's global work.

You have my 100% vote!

Dr. Patrick Soon-Shiong (USA), inventor of Abraxane, Chair of Los Angeles Times



What we will do

- In the first year, working with Regional Directors and Member States, we will review WHO's functions, decentralize decisions and expertise, and make headquarters leaner without weakening its core scientific and coordination roles. A smaller headquarters with the best experts in the world is not a weaker one; it is one where the world's best advice is a phone call away for every region and every country. Member States will have transparent opportunities to host WHO technical functions, with every relocation supported by a published business case assessing costs, staff implications, benefits and risks.

- **WHO in every country that wants it.** Today 19 Member States are served from five multi-country offices. Being served from another capital and having someone in your Ministry of Health every day are different things. No Member State that asks for a WHO presence will be told no because it is too small. A state of ten thousand people is still a state; its people still face outbreaks, medicine shortages and a child with cancer. Presence does not always mean a building. It may begin with one WHO liaison officer inside the ministry, funded jointly with the host, drawing on regional expertise rather than duplicating it. The arrangement can differ. The commitment cannot. WHO was built by countries, for countries. It should live in them.

- **Small Island Developing States will be among the first, not last, in our functional review.** Nearly forty Member States face recurring cyclones and hurricanes, often with just one WHO representative. We will strengthen their support and make sure emergency supplies are pre-positioned in every island region, through the partners who hold them.

- **Africa first in delivery, not last in line.** Nowhere is the donor exit hitting harder, and more than thirty African countries now spend more on debt service than on health. Africa has already defined the answer in the Lusaka Agenda and the Accra Reset: fewer parallel programmes, domestic financing that donors align behind, institutions led from the continent. WHO's part is specific. "One costed plan, one budget, one report" starts in the African countries that ask for it.

- The African manufacturing compact is built with Africa CDC and the African Medicines Agency leading, at the scale where production is viable, because a plant that needs permanent subsidy is not sovereignty. We will work with AMA, national regulators and WHO prequalification to strengthen regulatory reliance, avoid unnecessary duplication and accelerate access to quality-assured medicines, so a medicine approved once is not reviewed six times. And Africa must be where innovation is born, not only where it is delivered: the continent that hosts the world's largest trials in malaria and HIV should design and lead them, which is why fostering an African clinical trial network will be a priority. I was nominated by an African country that looked across regions. The obligation is not to speak for Africa. It is to make WHO deliver for it - and to make the world learn from it.
- Donor funding is leaving faster than domestic financing is arriving. WHO will stand beside health ministers where budgets are decided, bringing finance ministries, development banks and partners behind one nationally owned plan. **One country, one costed plan, one budget, one report** *(as Mr. Budi Gunadi Sadikin and the Accra Reset have proposed)*. The health minister should never have to make that case alone.



His candidacy transcends borders and regions.

The Mexican Association of Pediatric Onco-Hematology

What we will measure

By 2028, we will publish a functional review, decentralization plan, cost assessment and accountability framework for Member State consideration.

By 2032, our ambition is that every Member State that has requested a WHO presence has one, in a form agreed with it; more Member States host a WHO function, unit or hub where justified; and every participating country has one costed national health plan that WHO and partners fund through, not around.

Success will not be measured by offices opened, but by the speed and quality of country support and access to expertise.

We will introduce an independent annual Member State satisfaction survey, publicly reporting results and corrective actions, **targeting at least 80% positive satisfaction by 2032.**

5. No Health Without Health Workers

Without health workers, nothing else in this document will happen. A new hospital without staff is not progress.

WHO will make national workforce planning central to its country support, working with professional and training institutions to strengthen education, distribution, retention, working conditions and leadership, especially for nurses, midwives and community health workers. We will also promote ethical international recruitment, respecting workers' mobility and protecting vulnerable health systems.

By 2028, WHO will report how its support aligns with national workforce priorities. By 2032, participating countries will have measurable workforce plans covering availability, distribution, training and retention, integrated into universal health coverage strategies.

6. Universality Means Keeping Everyone at the Table

The world must have WHO. I will work to bring the United States and Argentina back to WHO, by making its impact visible and rebuilding trust.

I cannot promise that another government will change its decision. But I can promise that the door will remain open and that I will do everything I can to make it happen.



III. A WHO ACCOUNTABLE FOR RESULTS

> **Empower countries. Empower regions. Hold the entire Organization accountable for results.**

This is accountable delivery, not disruption. WHO will measure outcomes, publish performance, identify who is responsible for correcting failure, and support those responsible to solve problems early. Accountability must be a management tool for delivery, not a retrospective exercise in blame.

7. No Empty Desks

I know of important, fully funded WHO positions left vacant for years. Someone was named "in charge," the vacancy was covered on paper, and one person carried two jobs. The work suffered. This should not happen again.

My commitment: no funded post vacant for more than 60 days. Recruitment will begin when a departure is known, and acting appointments will still count as vacancies. Delays will be tracked and escalated, with justified exceptions documented and reported. Every quarter, WHO will publish a vacancy dashboard by department, region and recruitment performance.

Technical decisions will belong to qualified technical leads, with **no clearance chain longer than two steps**, except where legal or ethical safeguards require more.

The objective is not to bypass fair competition, scientific review or accountability. It is to make them work.

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For all that he has done for us, for the confidence he has inspired, and for the doors he has opened, we offer our sincere and heartfelt support for his candidacy.

Hope4Kids Albania

He is a servant leader with the unique gift of bringing people together.

Prof. Leo Mascarenhas (USA),
Renowned oncologist, Cedars-Sinai

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8. The Best Place to Work, and a New Generation in Leadership

My ambition is for WHO to become **the world's best place to work in global health**.

We will conduct independent staff surveys, publish results and management actions, and ensure fair, merit-based recruitment, career development and real leadership opportunities for young professionals.

By 2032: 90% of staff recommend WHO as a workplace, 80% trust senior leadership, at least 5% are under 30 (from an estimated below 1%), with more young professionals in meaningful leadership roles.

We will publish annual workforce data on recruitment, promotion, retention and diversity. Gender balance at every leadership level, including Assistant Directors-General and country representatives, will be reported by level and post.

We will not confuse experience with age or youth with inexperience. We need the best people, working together.

9. Zero Tolerance Must Be Measurable

> **A safe workplace is not a slogan.**

Zero tolerance for sexual exploitation, abuse, harassment, retaliation and other misconduct requires independent investigations, whistleblower protection, survivor support, timely decisions and consequences for wrongdoing.

We will strengthen WHO's existing safeguards and publish anonymized data on investigation timelines, outcomes, disciplinary actions and implementation of recommendations.

No one should fear losing their career because they reported misconduct. No one should be protected because they are powerful.

> **Zero tolerance must be measurable and it will be.**

10. Financing WHO

WHO's financing crisis will not be solved by one mechanism. Member State contributions remain fundamental. I will uphold the agreed path to 50% of WHO's base budget from assessed contributions by 2030–31.

When we founded City of Smile in Armenia, many doubted public donations could sustain childhood cancer treatment. We proved otherwise. St. Jude has demonstrated the power of public giving at scale. Why not WHO?

> **Ten million people. One billion dollars. Every year. Just $100 per person annually.**

I will propose a mass-giving strategy with the independent WHO Foundation, respecting its governance:

- By 2028: A published fundraising plan covering donor acquisition, retention, costs and safeguards.
- By 2032: More than $250 million annually.
- By 2037: $1 billion annually, aiming for ten million individual donors.

This must provide flexible, non-earmarked funding, alongside, never instead of, Member State contributions, with transparent reporting of fundraising costs and funds transferred to WHO. Our success should not be judged by the amount we announce that we have raised, but by the resources WHO can actually use and the health impact they help achieve.

11. WHO Focused on What Only WHO Can Do

Fewer things, done fully.

In the first year, we will conduct a transparent functional review, identifying what WHO should retain, strengthen, consolidate or transfer to capable partners, including its more than 800 Collaborating Centers and other institutions.

Every transfer will respect WHO's mandate, Member State oversight, scientific independence and legal responsibilities.

Stop doing does not mean stop caring. It means focusing WHO's resources where they can make the greatest difference.

What WHO will stop doing (a few examples):

- Producing separate headquarters and regional guidelines on the same question;
- Publishing dozens of separate global status reports every year, each read mainly by the programme that wrote it. WHO will move to one consolidated annual report on the state of the world's health, with the data behind every chapter open to all;
- Running its own routine procurement and logistics where UNICEF, WFP and the Global Fund's pooled mechanisms already do it, and expanding PAHO's Revolving Fund model to other regions instead;
- WHO as event-organiser. WHO convenes; it should not be the production company. Months of staff time go into venues, visas, badges and catering. The agenda and the science are ours. The logistics belong to host countries, partners and professional organisers.

12. Radical Transparency, Starting at the Top

Every year, the Director-General, Assistant Directors-General and Regional Directors will publicly report to the Executive Board on promises and results. **Senior leadership will meet monthly, with public agendas and minutes** documenting decisions, responsible leaders and deadlines, while protecting legitimate personnel, legal, security and sensitive country matters.

When something is delayed, the reason will be visible. When something fails, we will learn from it. When something succeeds, those who delivered it will receive the credit.

We will distinguish WHO's responsibilities from Member State decisions and national implementation. WHO must neither claim credit for outcomes it cannot demonstrate it helped achieve nor use complexity to avoid accountability.

WHO must also speak to people, not only to ministries. Most of what WHO publishes is written for experts, and most of the world never hears it. Every major WHO result, guideline and warning will be explained in plain language, in the languages people speak, where people actually are: on their phones, in their communities, through their own doctors and nurses. Trust in WHO is built one person at a time. If people do not understand what WHO does for them, they will not defend it when it is needed.



For years he is proving that even with limited access, world class medicine is possible.

Prof. Dilyara Kaidarova (Kazakhstan),
President of Kazakhstan Cancer Society



A PLEDGE TO DELIVER



I do not want another vision forgotten after an election. Every commitment will have an owner, baseline, deadline, financing plan and public measure. This is not a new bureaucracy. It is a discipline for making the existing system work.

A stronger WHO is not measured by what it asks from countries, but by what it helps countries deliver for their people.

My First 100 Days

Reform will not begin with another report; it will begin with listening, decisions and people empowered to act. I will listen to Member States, WHO staff, Regional Directors, country offices, health workers and communities, and act first on what can make an immediate difference.

In my first 100 days I will:

- Build an executive team capable of governing from day one. Appoint a leadership team combining WHO and UN executive experience, country delivery, scientific authority and regional diversity. Establish clear portfolios, decision rights and collective responsibility for results. I will not learn the building alone.
- Travel to the Democratic Republic of the Congo, then to Washington and Buenos Aires: first to where WHO's work is hardest and matters most, then to ask the United States and Argentina, in person, to come back.
- Ask every WHO country office one question: **what is the one thing blocking your work that headquarters or the regional office could fix now?** Then fix the ones that can be fixed. A signature, a post, a shipment. Where WHO can make an immediate difference, we will not wait for the reform to be finished.

- Go to the September 2027 UN High-Level Meeting on Universal Health Coverage with one ask: one costed national health plan per country, with WHO beside health ministers when they take it to finance ministers.
- Launch a review of WHO's delivery barriers. Examine vacancies, approvals and technical clearance chains; begin implementation of the 60-day vacancy standard and two-step technical-clearance principle, with justified exceptions documented.
- Open a public Commitment Register. Publish what WHO has promised, who is responsible, what is funded, what requires Member State or partner action, what will be measured and when. The register will distinguish WHO-controlled actions from country-led outcomes.
- Start monthly senior leadership meetings with public agendas and minutes. The people responsible for each priority will come to the table. We will review what is on track and what is not, resolve stalled decisions, and assign corrective actions to named individuals with clear deadlines.
- Begin a "measure what matters" review: every unit asked one question - which of your measures tell us whether people's health is improving? Measures of activity cut; measures of outcome kept. A meeting, report or resolution is not itself a health result. WHO's current strategy carries close to two hundred indicators. By 2028 it will carry fewer, and better.
- Begin consultations with Regional Directors and Member States on decentralization; establish the Childhood Cancer Special Envoy with a clear mandate; and open discussions on mass giving with the independent WHO Foundation.

By the End of 2028

We will have:

- Costed flagship plans, baselines and financing gaps; country-by-country childhood cancer reports; the essential medicines basket, stock data and regional manufacturing plans.

- Completed the functional and country-support review and agreed on a presence model with Small Island Developing States. Functions identified for transfer to capable partners will have clear transition plans, with results publicly tracked.
- Institutional accountability mechanisms into operation, including independent staff and Member State surveys, vacancy dashboards, monthly leadership records, annual reporting to the Executive Board and the first independently reviewed progress assessment.
- Assessed primary health care delivery country by country for the fiftieth anniversary of Alma-Ata, showing where access, quality and financial protection are improving, where gaps remain, and what WHO and Member States need to do differently.
- Strengthened scientific independence and the use of evidence, with independent oversight mechanisms operating, their first findings published, and updated standards for health-data interoperability and AI safety in clinical care available to countries.
- Reduced duplication in WHO's global reporting, building on existing publications to establish a consolidated annual assessment of the world's health, replacing dozens of separate global status reports, with underlying data openly accessible where legally and ethically appropriate.
- Advanced the protection of health care and preparedness for emerging risks, with the first heads-of-state coalition meeting against attacks on health care convened and concrete follow-up actions agreed. A scientific foresight function, drawing on WHO's existing expertise, including the Berlin Hub, will be operational and will have issued an assessment of ten emerging health risks requiring international attention.

By 2030

An independent review will assess organizational reforms and WHO's contribution to country outcomes, publishing corrective actions, responsible leaders and deadlines.

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Truly Significant Recognition for Your Leadership and Commitment to Global Health

HRH Princess Dina Mired of Jordan,
Humanitarian and Global Health Leader

Dr. Tamamyan is the man for the job!

Prof. Robert Peter Gale (USA), Humanitarian and Renowned Doctor; Led the Medical Relief Efforts following the Chernobyl disaster.

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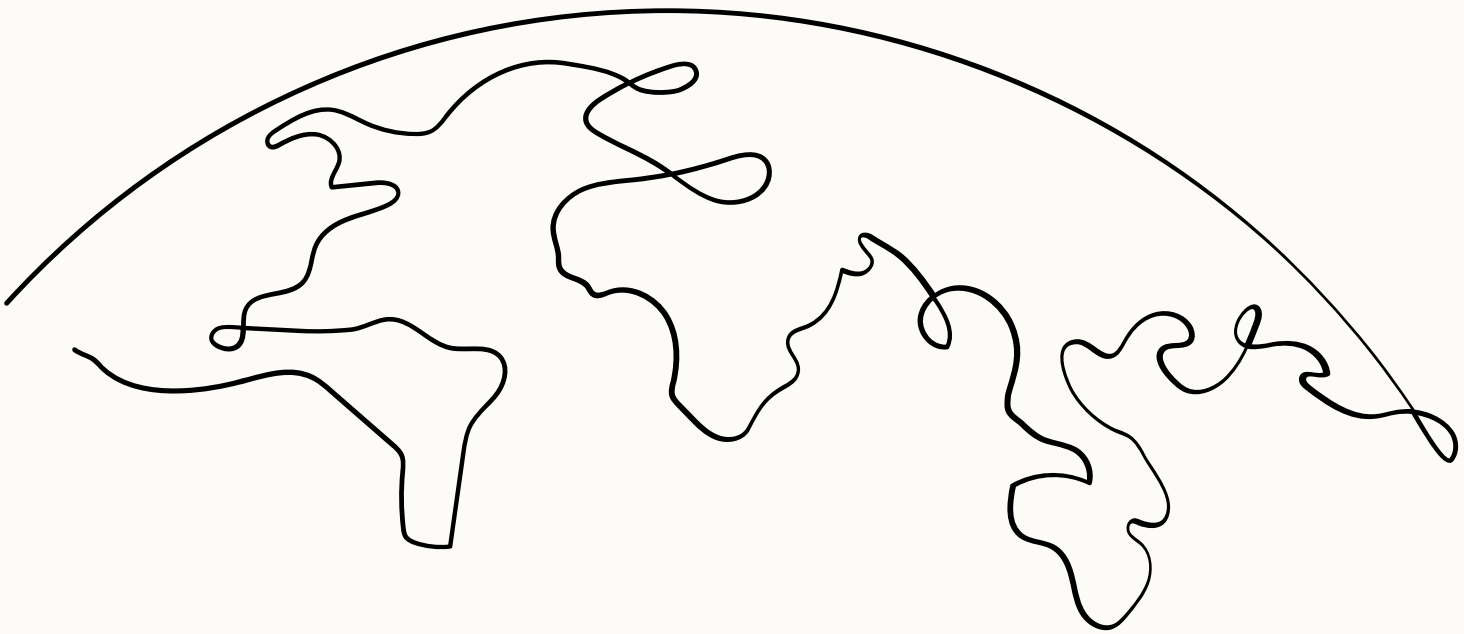
OUR 2032 SCORECARD

Selected measurable commitments

Commitment	Indicator	Target
Childhood cancer	Expected cases diagnosed	≥90%
Childhood cancer	Treatment abandonment	<10%
Essential medicines	Availability at designated facilities	≥80%
Outbreak preparedness	Regional 7-1-7 reporting	Annually
Continuity of care	Emergency preparedness plans tested	Every 2 years
WHO country presence	Proportion of requesting Member States with an agreed WHO presence	100%
Member State satisfaction	Positive satisfaction responses	≥80%
WHO recruitment	Maximum duration of funded vacancies	≤60 days
WHO workplace	Staff recommending WHO	≥90%
Leadership trust	Staff expressing trust	≥80%
Young professionals	Staff under 30	≥5%
WHO Foundation	Annual fundraising	>$250 million

The scorecard highlights selected measurable targets. Our public reporting will cover all 12 commitments, including:

- **For people:** Uninterrupted access to essential childhood cancer medicines; quality-assured regional vaccine and medicine production; annual IHR capacity assessments; and timely, transparent reporting of verified attacks on health care.
- **For countries:** Stronger national health workforce planning; one costed national health plan per participating country; more Member States hosting WHO functions; and a country-presence model agreed with Small Island Developing States.
- **For WHO:** Faster technical decisions, with no more than two clearance steps except where safeguards require more; transparent investigation and disciplinary reporting; monthly public leadership records; annual independent assessments of delivery and institutional integrity; and reduced duplication of WHO functions.



MY PERSONAL ACCOUNTABILITY

Leadership is not about promising that everything will work. It is about doing everything within our power to make it work, and taking responsibility for the results.

So here is mine. **If less than 80% of the commitments due by the end of my first term have been delivered, I will not seek a second term.**

The rules will be set at the start, not at the end: which commitments are due before my first term ends, how much each one weighs, and which depend on me rather than on others. Independent assessors, appointed by the Executive Board rather than by me, will apply them. I will not change the rules of assessment to make failure look like success.

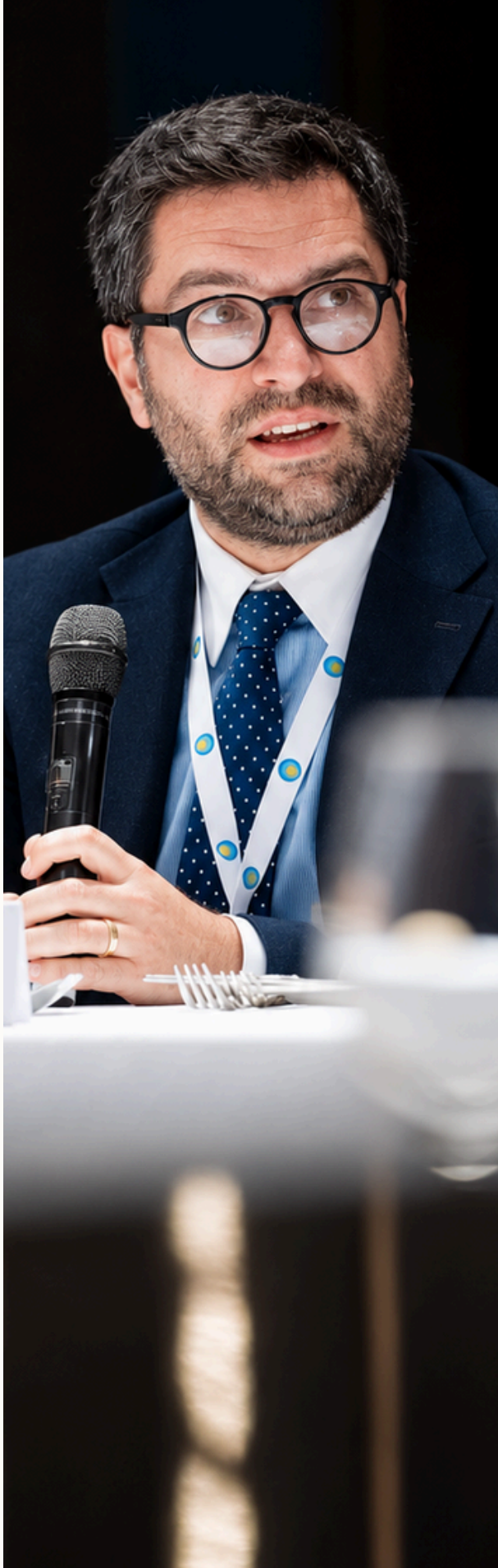
I have worked with children and families for whom time matters. Global health cannot be an endless process. WHO must deliver.

Geography must not decide who lives. The world must have WHO. WHO for U.

Dr. Gevorg Tamamyan

Candidate for Director-General of the World Health Organization

Nominated by the Republic of Botswana, whose decision to look beyotnd national borders reflects a simple conviction: geography must not decide who leads global health, just as it must not decide who lives.







Gevorg Tamamyan

MD, MSc, PhD, DSc, FASCO

Candidate for the post of Director-General of the World Health Organization, nominated by the Republic of Botswana.

He is a global leader in oncology, health systems strengthening, and international health cooperation, recognized for building bridges between countries and advancing equitable cancer care in resource-limited settings.

Dr. Tamamyan is Professor and Chairman of the Department of Pediatric Oncology and Hematology at Yerevan State Medical University and CEO of the Immune Oncology Research Institute (IMMONC).

He is the Co-Founder and Editor-in-Chief of OncoDaily, one of the world's largest oncology media platforms, created to democratize access to reliable, independent, and evidence-based cancer information globally.

Dr. Tamamyan was elected and served as President of two major international pediatric oncology organizations: the International Society of Pediatric Oncology (SIOP) Asia Continental Branch, representing pediatric oncology professionals across Asia, and the Pediatric Oncology East and Mediterranean (POEM) Group, uniting 28 countries and 110 cancer centers. He also serves as Co-Chair of the St. Jude EURO Regional Advisory Committee, encompassing 13 European countries.

At the age of 31, Dr. Tamamyan was appointed Head of the Pediatric Cancer and Blood Disorders Center of Armenia, where he led the consolidation of previously fragmented pediatric oncology and hematology services into a single national center. Under his leadership, the Center evolved into a regional reference point, with survival rates reaching up to 80%.

He also co-founded City of Smile, a national pediatric cancer charity that helps ensure universal coverage for the diagnosis and treatment of every child and young adult with cancer in Armenia.

Dr. Tamamyan is Chairman of the Board of the Institute of Cancer and Crisis and an adviser to the Rector of Yerevan State Medical University. He previously served as President of the Harvard Club of Armenia.

Educated and trained across seven countries in Europe, North America, and Asia, his professional journey spans frontline clinical practice, research, academic leadership, national cancer center management, global health diplomacy, and institution building.

He is the recipient of numerous international awards and distinctions, including Fellow of the American Society of Clinical Oncology (FASCO); ASCO LIFe and IDEA Awards; 2015 UICC and IARC Young Leader Awards; the 40 Under 40 in Cancer Award; the Latin American and Caribbean Society of Medical Oncology (SLACOM) Award for Global Oncology Leadership; and the Global Health Catalyst Distinguished Leader Award.

He is married and has two daughters, Charlize and Letizia.