WHO Reform

Need a global mobilization around the democratization of global health governance

David G Legge
People's Health Movement, Australia

Introduction

The role and reach of the World Health Organisation has been contested since it was created in 1948. The debate is commonly couched in terms of whether the organisation is 'fit for purpose' although whose purpose is not always explicated. There have been several attempts at WHO reform since its establishment, directed to making it fitter for a still contested purpose.

The current round of 'WHO reform' was launched in 2010 following a budget crisis and it continues as the new director-general settles into the job. The current reform program addresses: funds mobilisation, budgeting, evaluation, relationships with non-state actors, relationships within the secretariat (between headquarters, the regions and the country offices), WHO's role in global health governance (GHG), the emergency program and the management of the WHO's staff. All of these are discussed in more detail below.

The capacity, effectiveness and accountability of WHO is critical to the project of equitable health development globally. Nevertheless, there have been shortfalls. The delays in mounting an effective response to the 2014 Ebola outbreak in West Africa is an undisputed example. What is contested are the causes and how WHO should be reformed.

The root causes of WHO's disabilities include the freeze on WHO revenues, the dysfunctions associated with WHO's highly decentralised organisational structure, and the lack of accountability of member states for their contribution to WHO decision making and their implementation of WHO resolutions. However, the shortfalls and disabilities of WHO need to be understood in relation to the wider structures of global governance. How the structures of global power and the drivers of global benefit are understood will shape different analyses of global health governance.

In this paper we review the evolution of the current reform program and some of the major elements of the reform. In relation to each of these elements we review shortfalls, disabilities and reform options within the broader context of global health governance.

The argument developed in this paper is that the reform of WHO, to realise the vision of its Constitution, will require a global mobilization around the democratization of global health governance; not separate from, but as part of, a global mobilization for a convivial, equitable and sustainable world.

Background

The role, powers, and structures of WHO have been subject to debate since before it was established (World Health Organization 1958, Farley 2008). Criticism and debate continued after 1948 and there have been several rounds of structural reform before the present one,

notably under Dr Halfdan Mahler (Joint Inspection Unit 1993, para 22, Litsios 2002) and under Dr Gro Harlem Bruntland (Lerer and Matzopoulos 2001).

The present round of reform dates back to the deficit reported in WHO's financial reports for the biennium 2008/09. The Programme Budget and Administration Committee (PBAC, a committee of the Executive Board) reported to the World Health Assembly (WHA) in May 2010 that the deficit had been in part funded by reducing the carry forward from 2008/09 to 2010/11, in essence borrowing from the future to pay current bills (WHA63/REC3, p219).

The operating deficit was largely the consequence of WHO's dependence on unpredictable earmarked voluntary contributions (VCs) and the associated uncertainties of revenue budgeting, particularly in the aftermath of the global financial crisis. For the 2008/09 biennium only 19% of WHO's expenditure was met through assessed (or mandatory) contributions (ACs) (see A63/29). The bulk of the VCs were tightly earmarked to specific purposes (A63/ID4). The background to this high degree of donor dependency is discussed in more detail below.

The Director-General (DG), Dr Margaret Chan, commissioned an informal consultation in January 2010 (WHO_DGO_2010.1) to consider options for more predictable and flexible funding, and in January 2011 the Executive Board (EB) considered an item labelled 'The future of financing for WHO' (record of discussion here). The ideas outlined in this discussion eventually evolved into a far-reaching program of reform. The reform program took a clearer shape in November 2011 with a special meeting of the EB, focused solely on WHO reform and yielding a series of decisions dealing variously with priority setting, governance and management (and discussed in more detail below).

In reflecting on the evolution of WHO Reform it is important to keep in mind some parallel streams of deliberation and decision making within WHO which highlight the sharp contradictions between the rich donor countries and the low and middle income countries (L&MICs) regarding key issues in global health governance. These streams concern health and trade agreements, marketised (and privatised) models of health system development, and the need for regulatory strategies in relation to transnational corporations.

Contradictions between public health objectives and 'free trade', in particular, around extreme measures for the protection of intellectual property (IP), have been prominent globally since the Treatment Access Campaign in South Africa from 1997 (Heywood 2009). Debates around IP and medicines policies surface repeatedly in WHO's governing bodies. Typically the US leads the case for extreme IP protection and Brazil, India and Thailand lead the case for the use of TRIPS flexibilities to reduce drug prices and for arm's length regulation of the transnational pharmaceutical industry. However, there are other ignition points arising from trade agreements, including investor protection provisions as barriers to the regulation of tobacco, junk food and other hazardous products (McGrady 2012).

A second area which highlights deep differences of opinion between rich world and L&MIC governments, is the debate between publicly organised and funded health care versus health care markets based on competing private funders and providers. This debate surfaces repeatedly within WHO's governing bodies, with the US (delegates, foundations, think tanks and academics) leading the case for privatising health care delivery and for deploying market forces in health system design.

None of these debates are 'just about health'. They all touch closely upon the interests of powerful corporations and of the political leaders of countries which export IP and services.

In the context of these debates WHO's voice can be influential. Two stories told in Legge (2013) illustrate the importance for the US of seeking to control this voice. These episodes concern the WHO publications policy in 2005/06 (when the DG was disciplined for 'allowing' an apparently independent commission to authorise the publication of a discussion paper which the US didn't like) and the 2006 recall of Dr William Aldis from his posting in Bangkok (for publicly advising the Thais to make full use of the policy flexibilities provided for in the TRIPS agreement).

The freeze on WHO's assessed contributions, the tight earmarking of voluntary donations, and the periodic withholding of US assessed contributions (Bond 2003), are designed to discourage WHO from adopting or implementing policy positions in relation to global health governance issues, which run contrary to the interests of the US and the other big donors (including nation states, intergovernmental organisations and philanthropies).

Method

The data for this review come from three main sources: first, from a close review of the records of WHO's governing body meetings since before the present reform was initiated; second, from a range of publications dealing with history of WHO and global health since the first international sanitary conferences; and third, from some particular theoretical traditions (summarised briefly below) which have been deployed in the analysis of these data.

In the two sections following this note on methods I make brief references to the theoretical ideas underpinning my analysis and to some key historical passages which have framed this study.

I have structured my findings around the case for reform, the evolution of the reform plan and its implementation, and the main themes of reform.

My conclusions are framed by the questions outlined in the introduction to this paper: namely, the nature and root causes of WHO's disabilities and the significance of the reform program in terms of addressing these disabilities, and the kinds of policy and advocacy initiatives which might really strengthen WHO's capacity to address the challenges of equitable health development globally.

Theoretical resources

Three domains of theory have been particularly useful in framing the analysis presented in this chapter: governance theory, international political economy, and legitimation theory.

Governance theory

Governance provides a way of speaking about the power relations, decision processes and policing structures which goes beyond the formal institutions of government (Rhodes 1996, Rhodes 1997, Burris, Drahos et al. 2005, Rhodes, Murphy et al. 2011).

Governance is particularly useful in speaking about power, decision making and policing at the global level, where the formal structures of government (various intergovernmental

agreements and organisations) are generally relatively powerless (O'Brien, Goetz et al. 2000, Hettne and Odén 2002).

The actors engaging in global governance include nation states and nation state alliances; intergovernmental organisations; and transnational corporations and business associations. However, more dispersed constituencies also play a powerful role, such as the investors and institutions who police fiscal policy through their influence over share prices, bond prices, exchange rates and others financial drivers. Global governance is also mediated in some degree by ideological movements, such as neoliberalism, and the cultural players (such as the media and the academy) who serve as gate-keepers and entrepreneurs in shaping orthodoxy.

References to global *health* governance may therefore be taken as referring to the power relations, decision processes and policing structures operating at the global level which govern health care and the social and environmental conditions which shape population health. Some analysts (eg Ottersen and colleagues (2011)) reserve the term 'global governance *for health*' to refer to the conditions which shape population health, as distinct from health care. In this paper global health governance (GHG) is used to refer to both areas.

An important difference in usage is between those who treat global health governance as an autonomous domain of global governance rather than being rooted in the structures and dynamics of global governance more generally. Treating global health governance as somehow separate from global economic and political governance involves accepting as fixed the broader set of power relations, decision processes and policing structures within which health is explicitly considered. It has the effect of limiting description and analysis to 'technical' issues which are assumed to have no implications in the broader political or economic spheres. Contrariwise GHG in this paper is treated as a health policy lens through which the wider structures and dynamics of global governance may be viewed, critiqued and engaged.

The political economy of the global economy

Policy analysis in relation to global governance must make assumptions about how the global economy works and the structures and dynamics of global power relations. These are intensely contested fields.

For the purposes of this paper, the global economy is understood in broad historical terms along the lines of Wallerstein's world systems theory (2004). The contemporary global economy confronts a crisis of overproduction and under-consumption. Because fewer workers are needed to produce for wider markets, the flow of wages into consumption is choked, and profits flow increasingly into the financial system from whence they support corporate consolidation, speculation and debt funded consumption (Bello 2006, Kotz 2008). The consequences include unemployment, widening inequality, periodic economic crises and continuing environmental degradation.

The impact of the crisis of overproduction on health care and the conditions for population health is mediated in part by social policies (including privatisation and minimal social protection) which are rationalised by the ideology of neoliberalism (Harvey 2005, Labonté and Stuckler 2015). Neoliberalism also rationalises policies of free trade, economic

integration, and corporate deregulation which are driving the imbalance between productive capacity and consumer demand.

The dynamic of crisis is mitigated somewhat by faster economic development in China and the other 'emerging economies' but they are essentially locked into the same concentration of low-employment productive capacity which has led to the crisis in the 'advanced' economies.

Global power relations

In an earlier era of globalisation the dominant agent of governance was the nation state, including the colonial empires of Britain, France, Spain and the USA. With decolonisation, the imperial periphery was transformed into nation states (Wallerstein 2004). During the first half of the 20th century the US pioneered a new form of imperialism, exercising political and economic domination without imposing formal executive rule from Washington.

The rising number, size and power of transnational corporations (TNCs) during the last 60 years has led many commentators to suggest that the nation state is being displaced as the principal agent of global governance by the TNC (World Economic Forum 2010). It is undeniable that the control exercised by TNCs over investment, employment, trade and technology, constitutes a direct modality of global governance. The capacity of TNCs to extort tax and regulatory privileges from smaller nation states with promises or threats regarding investment, employment, technology transfer and access to markets epitomises this direct governance role.

However, this image of the TNC somehow taking over from the NS as the principal agent of governance ignores the powerful role played by the imperial powers, the US in particular, in progressing the political and commercial interests of the TNCs. Certainly TNCs are very powerful but their power is exercised in partnership with political elites in the imperial powers, in the 'emerging economies' and in other developing countries also.

The apparent tension between the TNC and the nation state as agents of governance can be resolved by recognising the emergent class structures associated with contemporary globalisation (Robinson 2004, Robinson 2012, Patterson 2013, Sklair and Struna 2013, Struna 2013). An older country-level configuration in which a capitalist class confronts a working class (and an ambivalent middle class) has been progressively subsumed into a globalised class structure in which a self-aware and well organised transnational capitalist class (TCC) confronts a dispersed, divergent, nationally identifying set of working classes, middle classes and marginalised classes.

The political and economic interests of the TCC are pursued through both the corporate elites (and the TNCs which they control) and the political elites (and the nation states which they control). The annual gatherings of the World Economic Forum at Davos symbolise the coherence of this class as well as the two sets of institutional structures through which its interests are pursued.

The picture is complicated further by the myriad of political, religious and social movements which constitute the broader constituency within which the TNCs and nation states discharge their governance functions. The concerns, consciousness, world views and relationships of these movements vary widely which enables the TCC (the 1%) to implement its political strategies and to envelop these different constituencies in the ideological fog of

neoliberalism. It is only too easy to pit different constituencies against each other by exploiting insecurities and distrust associated with religion, poverty, race and ethnicity. The persistence of patriarchal ideologies, institutions and practices plays a powerful role in obscuring the power relations of disadvantage and dispersing oppositional efforts.

This analysis of global power relations sets the scene within which the dynamics of global health governance are played out, including the role of WHO in global health governance.

Legitimation theory

In the context of global governance, contestation around regime legitimacy is an important modality of political engagement which can help to problematize the cover story of the global governors.

In the wake of the debt crisis during the 1980s the brutality of the structural adjustment policies (SAPs) imposed by the International Monetary Fund (IMF), as conditions for last resort lending, led to a certain fracturing of the perceived legitimacy of the prevailing regime of global economic governance. The 1987 UNICEF publication, Adjustment with a Human Face (Cornia, Jolly et al. 1987), summarised the human cost of the IMF's structural adjustment policies, including hunger, infant mortality and the destruction of health systems (Breman and Shelton 2001). The delegitimation of the prevailing regime was also expressed in the global Jubilee movement calling for the cancelling of 'odious debt' (Jubilee 2000 Coalition 1999, Mandel 2008, Ndikumana and Boyce 2011, Sehm Patomäki 2011).

In 1993 the World Bank released a major report on 'Investing in health' which argued that, with proper prioritisation and extensive use of the private sector, the structural adjustment programs could have a positive effect on population health. While *Investing in Health* did not restore global confidence in the health benefits of structural adjustment, it has served as the cornerstone of WB assistance for health in the succeeding decades.

In the late 1990s the legitimation crisis shifted to the World Trade Organisation with the protests in Seattle in 1999 and the Treatment Action Campaign in South Africa from 1997 to 2001. As the impact of the TRIPS agreement on access to medicines became more widely understood, opinion in the developing world regarding the WTO agreements became more sceptical and opposition to negotiating around the so-called 'Singapore issues' (investment protection, government procurement, trade facilitation and competition policy) hardened.

However, the massive increase in development assistance for health, in particular for medicines, in the first decade of the new millennium, has contributed to the relegitimation of the 'free trade agenda' including the continued strengthening of IP protection and the prosecution of the Singapore issues both through single focus agreements[1], or plurilateral comprehensive economic integration agreements[2].

---

1. Including a plethora of bilateral investment treaties (BITs), the failed ACTA (Anti Counterfeiting Taskforce Agreement), TISA (the proposed Trade in Services Agreement) and the Trade Facilitation agreement; more at www.bilaterals.org.
2. A forest of acronyms including the EPAs (Economic Partnership Agreements), NAFTA (North American Free Trade Agreement), the TPP (Transpacific Partnership Agreement), the TTIP (TransAtlantic Trade and Investment Partnership), CETA (Canada Europe Trade Agreement) and RCEP (Regional Comprehensive Economic Partnership) ; more at www.bilaterals.org.

The struggle over perceived legitimacy is an important dimension in policy making in WHO and GHG more broadly. For example, very few people would accept the claim that the freeze on assessed contributions and the donor chokehold are necessary disciplines to force WHO to become more efficient but this claim provides a smokescreen for a much more instrumental determination to prevent WHO from implementing policies adopted by the governing bodies which might cut across the interests of the global elite.

In the area of food and nutrition there has been much wringing of hands regarding NCDs (noncommunicable diseases - cancer, heart disease, diabetes, stroke, etc) but the donor countries (the US in particular) continue to push WHO towards 'working with industry' through 'multi-stakeholder partnerships', rather than contemplating regulatory and fiscal strategies which might make a real difference (Public Interest Civil Society Organizations 2014). Donor control of the WHO is of particular importance because of WHO's unique treaty making powers, as used in the Framework Convention on Tobacco Control.

History and context

Contemporary struggles over the soul of WHO are deeply rooted in history, in particular, the genealogy of WHO as an institution, the changing concerns and themes of global health policy, and the role of WHO (and its predecessors) in the governance of those issues.

These histories inform the analysis in this paper and in this section I briefly sketch some of this history and refer to sources for more detail.

The genealogy of WHO

WHO was created in 1948 as part of the establishment of the United Nations. It succeeded the Health Organisation of the League of Nations (LNHO) which had operated from 1922 to 1948 and had carried many of the functions now carried by WHO. These included notifiable diseases, standardisation of anti-diphtheria serum, the pharmacopoeia and the control of narcotic drugs.

Prior to the League of Nations, the Office Internationale de Hygiene Publique (OIHP), established in 1907 and based in Paris, carried some of these functions (how to prevent rats from accessing ships, compulsory disease notifications, drinking water standards)(World Health Organization 1958).

The OIHP was established in 1907 as a permanent secretariat for the periodic international sanitary conferences which were held from 1851. The first conference was convened by the French minister for agriculture and trade and its main business was to develop and adopt an agreed set of sanitary regulations, largely focused on controlling the international spread of cholera. The principal driver of this meeting were the tensions around the use of quarantine and border control in the event of a cholera outbreak. Countries hosting a cholera outbreak, were concerned not to have trade disrupted, while countries not yet affected might seek to gain commercial advantage by restricting trade in the name of protecting their population.

The concept of notifiable diseases (initially cholera, plague and yellow fever) and the International Sanitary Regulations created an agreed framework for managing these tensions.

These contradictions between trade and health have been reproduced many times since these early conferences, including recently in the context of SARS (severe acute respiratory

syndrome) in 2003 when both China and Canada were accused of covering up the severity of the epidemic in order to protect tourism and trade. Following the SARS outbreak a revised set of regulations were adopted, the International Health Regulations 2005. The IHRs (2005) signify a direct continuity between the early sanitary conferences, the OIHP, the LNHO and WHO. More recently, in the context of the 2014 West Africa Ebola outbreak, more than 40 countries imposed restrictions on traffic and trade which were in excess of those mandated through the WHO.

It is useful to locate the sanitary conferences, in the geopolitics of the 19th century, including rapid urbanisation in Europe and North America (and highly unsanitary urban infrastructure), active colonisation and imperial extension, and the increasing importance of international trade.

It is also important to recognise that the sanitary conferences, the OIHP and the LNHO were largely based on the European powers. It was only after the liberation struggles and the decolonisation which followed the Second World War that developing countries came to play a significant role in global health governance.

The establishment of the OIHP in 1907 followed a number of regional attempts to regulate quarantine. The Board of Health of Alexandria (later became Egyptian Quarantine Board) was established in 1831 and the Conseil Superior de Sante de Constantinople in 1838.

In the Western hemisphere the International Sanitary Bureau was formed in 1902, to become the Pan American Sanitary Organisation from 1923 and the Pan American Health Organisation from 1958. The Rockefeller Foundation was involved in supporting both the development of the Pan American Sanitary Organisation as well as the League of Nations Health Organisation. The cotton industry of the southern states of the US (pellagra and hookworm) and the construction of the Panama Canal (malaria and yellow fever) both played landmark roles in the development of public health during this period and both the Pan American Sanitary Bureau (PASB, the secretariat of PASO) and the Rockefeller Foundation played key roles in both episodes.

In 1948 when WHO was formed, the PASO was reluctant to cede its authority to a new international organisation (WHO) and its insistence on maintaining a high degree of autonomy ensured that the constitution of the newly formed WHO allowed for a high degree of decentralisation in the form of relatively autonomous regional committees and regional directors (EB136/INF./9).

This history is critical to an understanding of contemporary debates over WHO reform, partly because of the high level of regional autonomy but also because of WHO's unique regulation making power (as in the IHRs) and its treaty making power. The creation of the Framework Convention on Tobacco Control (FCTC) in 2005 was the first successful use of WHO's treaty making powers. What was adopted in 1981 as the (voluntary) Code on the Marketing of Breast-milk Substitutes was initially put forward as a binding treaty along the same lines as the FCTC. The US was opposed to both. In the context of debates over the need to regulate sugar, fat and salt as part of controlling noncommunicable diseases (NCDs) the US determination to maintain tight control over WHO is highly significant.

The North South divide in WHO debates

Two examples may serve to emphasise the embeddedness of WHO decision making in the wider tensions of macroeconomics and geopolitics. These concern WHO's guidance regarding health system development and regarding intellectual property rules and medicines access and regulation.

WHO was very late in providing systematic advice to member states regarding health system development. Farley (2008) tells of an incident during the early 1950s when Brock Chisholm, the first DG, was chastised by the US for allowing reference to health insurance in a WHO publication. It appears that the US was concerned to discourage any move to public funding or public provision of health care, apprehensive regarding the influence of the Soviet health care system and the new British NHS.

Litsios (2004) recalls that during the early 1970s many of newly independent member states urged the newly appointed Halfdan Mahler (third DG, 1973-1988) to give more attention to health services; a pressure which ultimately led to the Alma-Ata Declaration on Primary Health Care in 1978 (WHO and UNICEF 1978).

An important feature of the Alma-Ata Declaration, which is not widely appreciated, is the reference in Clause III to the proposed New International Economic Order (NIEO).

> *Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.*

Sneyd (2005) describes the NIEO in these terms:

> *The New International Economic Order (NIEO) was a comprehensive package of multilateral policy options that aimed to improve the position of Third World countries in the world economy relative to the richest states. It came together at the Non-Aligned Movement (NAM) Conference held at Algiers in September 1973. Subsequently, the leaders of the NAM requested a Special Session of the UN General Assembly to address issues associated with international trade in raw materials. At this Session in April 1974 the Group of 77 (G-77) secured the adoption of the Declaration and Programme of Action for a NIEO despite lacking the support of the United States and a small group of advanced industrialized countries.*
>
> *The NIEO's prescriptions for world trade were designed to stabilize and raise the prices of the commodities many G-77 members relied upon to earn foreign exchange, and to overcome long-term declines in their terms of trade. To improve the South's purchasing power a new institution was called for to govern the international commodity trade. A system to tie world commodity prices to trends in the prices G-77 countries paid for their imports of manufactured goods was a principal component of this proposed governance arrangement. As well, the South demanded that industrialized countries reduce tariffs and offer Southern exporters preferential access to their markets.*

The NIEO represents the highpoint of post-colonial optimism regarding the possibility of a world economy that might support economic development in the global South. However, just as the NIEO was finding a place in global health policy the interest rate hikes of 1980-81 were instituted which triggered the debt trap, structural adjustment and the tightening disciplines of neoliberal globalisation.

A second and more recent area of North South conflict within WHO concerns IP, access, and medicines regulation. The TRIPS agreement (Trade Related Intellectual Property) was conceived and largely driven by the international pharmaceutical industry, led by Pfizer (Drahos 2002). The full implications of the agreement were highlighted in the Treatment Access Campaign from 1997 to 2001 (Heywood 2009). In 2006 the World Health Assembly adopted a resolution on Trade and Health (WHA 2006) which amongst other provisions authorised the Secretariat to provide advice on using the full range of policy flexibilities provided for in the TRIPS agreement in order to reduce the prices of medicines (in particular through compulsory licensing and parallel importation). This is an area which clearly pits the friends of Big Pharma, in particular the IP exporters (Europe, Japan and the US), against the large majority of countries whose main objective in this space is to ensure access to treatment. In the years since TRIPS came into force the US has concluded trade agreements with many countries which preclude the use of the flexibilities provided for in the TRIPS agreement. See Legge (2013) for a more detailed account of the pressures on the WHO Secretariat to discourage the implementation of this resolution. This paper also provides some of the background to the controversy over the regulation of 'counterfeit' medicines.

The inclusion of the NIEO in the Alma-Ata Declaration, the struggles over the legitimacy of the TRIPS flexibilities, and debates over regulatory and fiscal strategies to address NCDs symbolise the ubiquity of geopolitics in the deliberations of WHO and the untenable character of commentary which assumes GHG operates in some kind of autonomous space, distant from wider conflicts over macroeconomics and geopolitics.

The evolving themes of WHO reform

The case for reform

The impetus for a new round of reform arose initially from the budget crisis of 2008/09 and the need to borrow from the planned carry forward to fund concurrent operations. The reform was initially conceived as focusing on how to ensure predictable, flexible and adequate funding to implement the decisions of the governing bodies. However, within a short while the canvas had been expanded to address governance and management issues as well as budgeting, planning and funds mobilisation.

It has been clear from the beginning that the barriers to flexible and predictable funding arise from the freeze on ACs and the tight earmarking and unpredictability of donor contributions. However, most of the rich countries refuse to acknowledge the extent to which these policies are damaging WHO and the emerging economies have shown no enthusiasm for to stepping into the breech.

The underlying narrative from the rich countries is that WHO is inefficient and that until the weaknesses in governance and management are addressed they have no intention of providing more flexible and predictable funding. What this narrative glosses over are first, the extent to which the management weaknesses of WHO are actually a consequence of the

ACs freeze and the tight earmarking of donor funds; and second, the strategic purpose for the rich countries of shackling WHO.

Among the management weaknesses commonly cited are opaque priority setting and budgeting, weak evaluation practices and weak accountability for organisational performance. However, in an environment where regions, clusters and departments depend entirely on donor funds for any new initiatives and are constantly competing with each other for donor attention such problems are inevitable. Competition for donor attention leads to fragmentation and programmatic incoherence; where managers are accountable to donors for programmatic outcomes it is inevitable that their accountability through the formal hierarchy will be weakened. One of the key themes of reform concerns staffing rigidities; too many permanent staff facing fluctuating and unpredictable donor preferences. It is unfortunate that staffing strategies must be tailored to accommodate the donors' preference for flexibility in terms of timing and commitment of funds.

Not all management weaknesses can be attributed to donor dependency. The radical decentralisation of WHO has contributed to failures in accountability; most notably in the area of direct financial cooperation (DFC) which refers to small grants provided from WHO regional and country offices to local ministries of health. Flaws in the management of DFC have been compounded by failures to act on negative audit findings. These problems appear to have been addressed through the current management reforms.

Different views contend regarding the causes of management weaknesses within WHO. The donor states (and their supporters within the global health commentariat) suggest that such weaknesses reflect neglect and incompetence evoking more than an echo of the neoliberal distrust of public sector bureaucrats. On the other hand, many commentators recognise the fragmenting impact of donor dependency as a major contributor.

More controversial is the contribution of WHO's decentralised structure to opaque budgeting and attenuated accountability. A kind of co-dependency between regional directors and ministers has evolved in some regions which weakens the accountability of both the regional office and the ministry and greatly limits the effectiveness of the country office (discussed in more detail below).

A structural disability which is not commonly mentioned in the governing bodies is the lack of accountability of the member states themselves, both for their contribution to decision making and their implementation of WHO policy recommendations. The discourse of the governing bodies places a strong emphasis on WHO as a 'member state driven organisation' and this is appropriate. However, the accountability of regional offices, country offices and ministries of health to civil society is in some places very weak. The 2014 guide for developing country cooperation strategies (WHO 2014) makes no provision for any consultation with civil society, either in the development of the strategy or in its evaluation. This is consistent with Article 71 of the WHO Constitution which explicitly prohibits WHO from engaging with civil society at the national level without government approval.

The lack of direct civil society engagement with WHO at the regional and country level is in part a reflection of more immediate priorities associated with more direct 'development assistance'. In countries infested by 'development assistance agencies' many NGOs tend to be preoccupied with project funding and vertical disease specific programs and it can be hard to put the required effort into more coherent and long term policies for health development.

The evolution of the reform program

The current round of reform commenced with the DG's informal consultation in January 2010 (WHO_DGO_2010.1). It has been shaped by periodic discussions in governing body meetings but its reach was broadly settled in the special session of the Executive Board held in November 2011 (EBSS/2/2011/REC/1) which adopted three decisions (dealing respectively with priority setting, governance and managerial reform) which have largely guided the reform from that time.

A major new element of the reform program, focusing on WHO's capacity to prepare for and respond to outbreaks and emergencies, was added following the special session of the EB held in Jan 2015 to review the lessons from the 2014 Ebola epidemic. The decision adopted in that meeting (EBSS3.R1) addresses a range of issues concerning funding, human resources and product development as well as the need for a major reform of WHO arrangements for dealing with emergencies (discussed below).

The reform program has been steered from within the DG's office, subject to reports and decisions taken in the governing bodies. An evaluation framework has been put in place to monitor the implementation of the various governing body decisions (here). A useful chronology of reform can be found here.

Predictable, flexible, adequate funding for WHO

WHO's most basic disability, the lack of predictable, flexible and adequate funding has not been effectively addressed in the current reform program. Tightly earmarked voluntary contributions comprised close to 80% of WHO's revenues in the last biennium (EBSS/2/INF.DOC./2). There is little enthusiasm among member state representatives to increase assessed contributions and most donor states have shown no intention to untie their voluntary contributions (VCs) (Norway is a signal exception).

Only the most obtuse delegates would not acknowledge privately the donor chokehold as the principal cause of 'inefficiencies' (competitive fundraising, conflicted accountability, long term staff but short term, unpredictable project funding) and would not recognise the 'efficiency case' for reform as double speak.

However, instead of real financing reform WHO has developed the *funding dialogue*. This involves adopting an unfunded biennial budget (within a fixed budget ceiling) in the May WHA before the biennium commences and then embarking on a dialogue, bilateral and multilateral, with possible funders. The broad purpose of the dialogue is to persuade donors to commit to various budget lines, up to and not beyond the budget provision. Donors who wish to give to particular lines which have already been funded are asked to divert their funds to line items which are looking less healthy.

In this context the DG has attempted to curtail the entrepreneurial approach of clusters, departments and regions dealing directly with donors through the establishment in the DG's office of a coordinator of funds mobilisation. It is not clear how successful this initiative has been.

The funding dialogue is represented by the Secretariat as protecting member state sovereignty in that the budget is adopted before the funding dialogue commences. However, the Secretariat is very aware of the predispositions of the donors and to suggest

that the budget as submitted to the Assembly pays no attention to the donor wishes would be fanciful.

The funding dialogue is extremely expensive in terms of the time of senior officials. It may have addressed in small degree the problems of rigid and unpredictable donor funding. The move to centralised coordination of funds mobilisation may help to reduce the problems of internal competition for donor attention. However, the power of the donor veto over WHO's work plan is as tight as ever.

The DG has called for financing which is predictable, flexible *and adequate*. WHO's annual budget is now around $2,200 million. This is around 30% of the annual budget of US CDC; 4% of Pfizer's turnover; and 3% of Unilever's turnover in 2015; and around 10% of Big Pharma's annual advertising in the US. It is simply not enough for WHO to properly fulfil its responsibilities in global health.

Priority setting, resource allocation, evaluation, accountability

Priority setting, resource allocation, evaluation and accountability have been recurring themes in discussions of the WHO Reform Program.

Member states have questioned whether the distribution of WHO resources across programs and units correspond to perceived priorities. They have questioned the allocative efficiency of WHO expenditure; is it the case that each dollar yields comparable health benefits no matter where it is spent. In both cases the answer is 'probably not'.

Undoubtedly WHO's dependency on donor preferences has seriously distorted resource allocation and has distorted the logic of 'budgeting'. However, with the introduction of the funding dialogue and the separation of expenditure budgeting from funds mobilisation there has been scope for developing a more systematic approach to expenditure budgeting. This has involved a number of linked management reforms:

- closer attention to the program logic underlying priority setting and evaluation, expressed in terms of a revised 'results chain';
- increased attention to the development of country cooperation strategies (CCS) and the role of CCS in priority setting;
- promoting a culture of evaluation and organisational learning; and
- implementing new methods for the allocation of budget 'space' ('space' referring here to the fact that an empty expenditure budget is adopted before funding has been secured).

WHO's mid to long term planning is based on the global program of work (GPW) which encompasses three biennia. The twelfth global program of work 2014-2019 (GPW12) includes a newly conceived 'results chain' (A66/6, para 148 et seq) which flows from Inputs to Activities, to Outputs (deliverables),to Outcomes and finally to Impacts. Unfortunately credibility of the program logic underpinning this chain varies across programmes; the indicators for measuring performance across these domains are generally quite soft; and the protocols for collecting such data are of variable quality. The work that WHO does is unique and complex and there are real limits to indicator based evaluation. On the other hand there have been some very useful mixed methods evaluations and some moves towards action learning. WHO's revised evaluation policy was initially vested in the Office of

the Internal Auditor. It was moved to the DG's Office in 2015 and the orientation is being changed from an audit orientation to one of organisational learning.

The initial focus of the Reform Program was on priority setting out of which emerged six high level programmatic categories and six leadership priorities (as articulated in the 12th Global Program of Work (GPW12), adopted (in A66/6) in May 2013). The categories are:

- communicable diseases,
- noncommunicable diseases,
- promoting health through the life-course,
- health systems,
- preparedness, surveillance and response, and
- corporate services/enabling functions.

The leadership priorities articulated in GPW12 were:

- advancing universal health coverage,
- health-related Millennium Development Goals,
- addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities;
- implementing the provisions of the International Health Regulations (2005),
- increasing access to essential, high-quality and affordable medical products, and
- addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries.

The six categories help to give more coherence to WHO's work at all three levels and the leadership priorities provide guidance in terms of staff effort and budgeting. Country cooperation strategies (CCS) provide a further input to priority setting. As part of the reform there have been promises of improved recruitment and more professional development for country office positions and for a more systematic approach to CCS development (WHO 2014).

In addition to these initiatives the Executive Board, through a working group (WG), has developed a revised methodology for 'strategic budget space allocation' (EB136/35 and WHA69/47) which was adopted by the Assembly in May 2016 (WHA69(16)).

The WG recommended a number of principles which would inform expenditure budgeting. It should be based on needs and evidence regarding achievable impact. It should reflect bottom up planning (in particular the CCS) but be aligned with organisation wide priorities. It should be informed by realistic costing of outputs and clarity regarding the roles and functions at the three levels of the organisation. It should reward performance and support accountability.

The WG identified four 'operational segments' with different resource allocation methodologies for each segment. The segments are:

1. technical cooperation at the country level,
2. provision of global and regional goods,
3. administration and management,
4. response to emergency events, outbreaks and crises.

For Segment 1 the relative regional allocations are first calculated on a needs basis, corrected for population. In a second step, country by country allocations within each region

are determined, having regard to relative needs, the activities foreshadowed in the various CCSs, the priorities articulated in the GPW and the 'comparative advantage of WHO'.

The allocation of funds within Segment 2 is based on the relative needs associated with different programs; is aligned with the priorities articulated in the GPW and other resolutions of the governing bodies having regard to the comparative advantage of WHO in global health. It is to be informed by a 'realistic costing' of outputs and clarity regarding the different roles and functions of the three levels of the organisation. Resources will be managed in accordance with a project management approach.

The allocation of funds to and within Segment 3, governance and management, is based on the input costs of the various governance and management functions, subject to continuing pressure for improvements in efficiency.

Segment 4 includes the Polio Eradication and Endgame Strategic Plan 2013-18 for which an allocation methodology has already been adopted. In relation to other humanitarian emergencies and outbreaks the WG proposed a global revolving fund. This is further considered below in relation to emergency management reform.

The WG did not report on the allocation choices between segments. Presumably this is at a sufficiently high level to be determined by the EB and the Assembly and adjusted incrementally over time.

Some of these managerial reforms, such as the more structured approach to evaluation, represent marginal improvements on what has gone before.

However, the meaningfulness of bottom up budgeting is uncertain in view of the exclusion of civil society from the process, the co-dependency relationship between some RDs and their MOHs, and the general lack of MS accountability for their contribution to WHO and their implementation of WHO guidelines. The mantra of the 'realistic costing' of outputs assumes a Lego model of program implementation, with each program comprising a set of planned outputs each of which comprises a known number of prescribed activities all of which have known costs. It appears that there is no provision for complexity, negotiation or flexibility in implementation. In fact, fixed performance indicators have dubious validity or reliability in mediating 'accountability for outcomes' in a complex and dynamic environment where outcomes are a function of the broad program logic and the strategic choices made during implementation including engagement with external forces.

Governance

The reforms which have been discussed under the rubric of 'governance' include four different streams, dealing respectively with:

- the method of work of the governing bodies;
- WHO's relationships with various 'non-state actors' (other IGOs, philanthropies, corporations and business associations, academia and civil society);
- the 'alignment of governance' across all three levels of WHO (headquarters and regional and country offices);
- WHO's role in global health governance.

These different streams were all included under 'governance' during the initial years of the reform discussion. However, from 2015 the discussion separated into two different processes and fora. In February 2015 (in EB136(16)) the EB established the member state

consultative process (comprising a working group and two open member state meetings) to consider, first, the methods of work of the governing bodies and second, how to improve the alignment of the governance of all three levels of the organization.

At the same meeting (Feb 2015) the EB commissioned (in EB136(3)) a separate consultative process involving first the regional committees and then three open-ended intergovernmental meetings (in July 2015 and April 2016) to finalise the new 'framework for engagement with non-state actors' (FENSA). This proved highly contentious but a finalised version was finally agreed and adopted at WHA69 (May 2016) in WHA69.10.

Method of work of governing bodies (GBs)

This has been a recurring item on the EB agenda, since well before the launch of the new WHO Reform Program but has been subsumed within WHO reform as part of the governance reform. Under this heading a range of quite practical issues has been discussed including:

- controlling the agendas of the Executive Board and the Assembly;
- developing guidelines of 'best practice' in governance work;
- restricting the number of items on GB agendas;
- imposing new criteria for new items to be included on the agendas; and
- using modern information and communications technology to support GB meetings.

The reforms in this stream (WHA69(8)) are generally sensible although it is unfortunate that there has been no open discussion of the underlying causes of agenda overload. These include: lack of accountability of member state delegates; strategies by units within the Secretariat to attract donor attention; and strategies by special interests (including private sector entities) to promote or defend their interests.

Lack of delegate accountability is evident when delegates' interventions are demonstrably irrelevant to the substantive issues under consideration. Because the mantra of nation state sovereignty is so strong within the organization, delegate accountability is not discussed in formal sessions.

Another contribution to agenda overload are the efforts of various networks to get their issues onto the WHO agenda. Many of these instances are completely legitimate and deal with important issues where WHO can make a difference; but not always.

Common pathways for getting items on the GB agendas typically involve: sponsoring glossy publications; organizing side meetings during the Assembly; getting regional committee support; getting onto the EB agenda; and finally inclusion on the WHA agenda.

In many cases the item is important and the actions recommended by consequent resolutions will make a significant contribution to global health. However, not in all cases. In some cases the initiative is driven by a unit within the Secretariat which is looking to boost its donor visibility, often in consultation with a special interest NGOs. Often such special interest organisations have collaborative relationships, including financial links, with corporations who produce relevant products or services. It is not always clear why certain governments are willing to carry the flag for particular items.

Some of these dynamics were evident in the consideration by the EB133 (May 2013) of a draft resolution submitted by Panama seeking to publicise World Psoriasis Day and commissioning a 'global report on psoriasis' from WHO. In a comment on this item the

People's Health Movement (WHO Watch 2014) drew attention to the huge market for modern psoriasis drugs and the involvement of a 'patients' organisation' which was strongly supported by the pharmaceutical industry and questioned whether conflict of interest implications had been considered. While Panama was the original sponsor, the resolution was supported by 25 countries from across the regions many of whom spoke warmly in support of its adoption. The cost of organising this level of support from across the regions would have been significant but presumably Panama was supported in its efforts by the pharma-funded Psoriasis Association.

The Board had before it a note on the financial and administrative implications of the draft resolution (here) which indicated that the cost of implementation in the present biennium was estimated at around $200,000 and that no such provision had been included in the Programme Budget. In answer to the proforma question, 'How would this resolution contribute to the achievement of the Organization-wide expected result(s)?', the Board was advised, by the Secretariat, that, '*World Psoriasis Day will help to raise public awareness of psoriasis and its shared risks factors, and will provide an opportunity for education on the disease, and greater understanding of it as a consequence. This will contribute to reducing disease, disability and premature death from noncommunicable diseases.*'

At the same meeting the Board had before it a report on the challenges of managing the EB agenda (EB133/3) and the draft FENSA (the proposed framework of engagement with non-state actors EB133/16) but none of the member states speaking to this draft resolution thought it appropriate to refer to these items in voicing their support for Panama and World Psoriasis Day.

This episode points to some of the less salubrious challenges of WHO reform, in particular, the lack of accountability of member states for their use of the Organisation. It is not clear how closely the Secretariat was involved in the development and progress of this resolution, nor which donors might have volunteered to support the production of the global report on psoriasis called for in the resolution (and adopted as WHA67.9 in May 2014).

A World Health Forum, partnerships and conflicts of interest

A range of different concerns and purposes have animated the debates regarding WHO's relationships with various external stakeholders. These include: different views regarding WHO's role in GHG; pressures for WHO to shape its programmes in accordance with the 'multi-stakeholder partnership' model; and concerns regarding WHO's relationships with private sector entities.

In 2008 Silberschmidt, Matheson and Kickbusch published proposals for a new Committee C running in parallel to existing Committees A and B within the World Health Assembly. In addition to member states, Committee C would include other intergovernmental organisations, global health partnerships, philanthropies, and national development assistance donors. Essentially Silberschmidt and colleagues were seeking to strengthen the role of WHO in the coordination of the many different actors in global health. The assumption was that the WHA provided a safe space in which different global health bodies could negotiate boundaries and cooperation. The presence of the member states might be expected to give more weight to the global South than the Development Assistance Committee (DAC) of the OECD. Silberschmidt and colleagues argued that:

"WHO has not been proactive enough in searching for mechanisms that allow for better exchange and transparency between the many global-health organisations and the member states. The challenge is to find a workable mechanism to improve consistency of global-health action and coordination between many partners while respecting their independence and decision-making structure."

This proposal resurfaced in the first iteration of the DG's proposal for a new round of WHO reform in January 2011. At this stage the reform plan included three elements, the first of which was:

A plan for strengthening WHO's central role in global health governance, comprising a proposal to hold a regular multi-stakeholder forum (the first in May 2012, subject to the guidance of the World Health Assembly); a proposed process for addressing other aspects of global health governance, possibly also including an overall framework for engagement in global health (EB128/INF.DOC./3).

At WHA64 (May 2011) the Secretariat advised (A64/4 para 86) that "WHO will convene a multi-stakeholder forum for global health". In Resolution WHA64.2 the Assembly requested a concept paper on the proposed WHF but negative feedback in the lead up to the Special Session of the EB in Nov 2011 led to the World Health Forum being dropped.

Some of the opposition to the WHF was in reaction to the term 'multi-stakeholder' which has been recognised as code for involving private sector entities. The case for the WHF had a certain logic and spoke to the role of WHO in exercising leadership over the 'crowded field of global health governance'. However, it came soon after the controversy over WHO's hosting of IMPACT (the International Medical Products Anti-Counterfeiting Taskforce) without any reference to the governing bodies (described in more detail below) and was clearly consonant with the World Economic Forum's global governance 'Redesign Initiative' (described below).

The DG accepted that the WHF was not going to fly but was still keen to advance WHO's role in GHG. As reported in EBSS/2/INF.DOC./11 the DG advised the Special Session as follows:

Now turning to WHO's role in global health governance, the proposals address two main issues: engagement and coherence. The aim is to have WHO play a greater leadership role in global health governance.

As I said before, we will not pursue the option of a World Health Forum.

Let me mention some other specific proposals.

First, set out a series of principles, in paragraph 87 of the document [EBSS2/2], governing the engagement of a wider range of players, while also ensuring the primacy of the intergovernmental nature of the Organization.

Second, convene multi-stakeholder forums on key health issues, conduct separate consultations with different groups of stakeholders, and invite comments through face-to-face meetings or web-based forums, with the full engagement of governing bodies in these processes. […]

Third, strengthen coordination within the United Nations system, and with coalitions, alliances and partnerships, to achieve greater coherence and complementarity in public health policies and strategies.

This intervention marks a move from multilateral coordination in a single forum to separate streams of 'engagement' and partnerships.

Partnerships had been on the agenda since EB107 in May 2001. In Jan 2008 (EB122) the Secretariat tabled a comprehensive overview report regarding partnerships and WHO's role (EB122/19) and was asked to draft guidelines governing WHO's involvement in global health partnerships. A report conveying draft guidelines (EB124/23) was considered by the Board in Jan 2009 and referred to WHA62 in May 2009 but deferred to WHA63 because of the H1N1 influenza pandemic.

During this same period the controversy around the definition of 'counterfeit' and WHO's role in hosting the International Medical Products Anti Counterfeit Taskforce (IMPACT) broke. Concern regarding IMPACT was exacerbated by the concurrent actions of the European Commission in seizing drugs in transit from India to Brazil (legal in both countries) on the grounds that they might be in breach of patent laws in Europe.

When the draft guidelines on partnerships were considered again in 2010 at WHA63 (as A63/44 as corrected in A63/44 Corr.1) they were adopted (in A63.10) and the Secretariat was asked to prepare an operational framework for *hosted* partnerships. While the guidelines were adopted concerns were expressed by Thailand and in the subsequent EB (in May 2010) May 2010 by India (EB127/2010/REC/1) regarding partnerships and conflicts of interest.

There were concrete grounds for this kind of scepticism.

The Moscow Declaration (April 2011) commits signatory governments to engage *"the private sector in order to strengthen its contribution to NCD prevention and control according to international and national NCD priorities"*.

Clause 54 of the Political Declaration of the High level meeting of the UN General Assembly on the prevention and control of NCDs (Sept 2011) commits governments to: *"Engage non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors, including through building community capacity in promoting healthy diets and lifestyles"*.

Clause 64 requests *"the Secretary-General in close collaboration with the Director-General of WHO, and in consultations with Member States, United Nations funds and programmes and other relevant international organizations, to submit by the end of 2012 to the General Assembly, at its sixty-seventh session, for consideration by Member States, options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership"*.

B130.R7 adopted by EB130 (Jan 2012) requests the DG

> *"to develop, in a consultative manner, WHO's input, called for in paragraph 64 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, concerning options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective and transparent partnership, while safeguarding public health from any potential conflict of interest, and submit it to the Secretary-General by the end of 2012"*

and

"to build on work from the 2008–2013 action plan, which, inter alia, called for WHO to provide support to countries in enhancing access to essential medicines, to facilitate engagement by governments and, as appropriate, civil society and the private sector with appropriate safeguards against conflict of interest, in accordance with relevant paragraphs of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, for improved access to medicines".

In May 2012, in the follow up to the UNGA high level meeting on NCDs and the Moscow ministerial conference on NCDs, an item appeared on the WHA65 agenda concerning the need for 'multisectoral action through partnerships' (A65/7) to address NCDs. The Secretariat's report was noted although Thailand commented (A65/2012/REC/3) that many of the proposed 'partners' had conflicts of interest in such partnerships: '*Experience had shown, however, that in some cases the private sector had opposed proven and effective interventions, and it was therefore essential to safeguard health from any potential conflict of interest involving, for example, the tobacco and alcohol industries.*'

The Rome Declaration on Nutrition (adopted at the Second International Conference on Nutrition in November 2014) has its signatories recognising (in 14(c)) that *"collective action is instrumental to improve nutrition, requiring collaboration between governments, the private sector, civil society and communities"*.

The May 2012 assembly, in an omnibus resolution regarding WHO reform (A65(9)), asked the Secretariat to produce draft policy papers on WHO's engagement with NGOs and private commercial entities and for a report on WHO's arrangements for hosting global health partnerships. EB132 (Jan 2013) considered a number of reports (EB132/5, EB132/5 Add.1 and EB132/INF./2) which together provided an overview of the eight global health partnerships currently hosted by WHO (no longer including IMPACT). Further updates were provided to EB134 (Jan 2014) in EB134/42 and to EB138 (Jan 2016) in EB138/47, EB138/47 Add.1 (reporting on the Global Health Workforce Alliance) and EB138/47 Add.2 (reporting on the Partnership for Maternal, Newborn and Child Health).

There is a superficial logic to the idea of intergovernmental organisations working with private sector entities, for example, working with vaccine manufacturers on the complexities of vaccine production. However, some degree of scepticism is required given the many instances of private sector entities seeking to subvert public health objectives.

The IMPACT story tells of a deliberate strategy by Big Pharma to encourage WHO to adopt a definition of 'counterfeit' which would facilitate harnessing the authority of WHO and the regulatory powers of national drug regulatory agencies in policing alleged patent breaches. The Taskforce, which included medicines regulators, various intergovernmental organisations, the International Federation of Pharmaceutical Manufacturers and Associations, 30-40 member states was launched in 2006 and hosted by WHO. Funding came from the European Commission, the governments of Australia, Germany, Italy and the Netherlands, the IFPMA and from the WHO budget (A62/14). The first time the existence of IMPACT, and WHO's role in hosting, came before the Executive Board or the Assembly was in January 2009 with a report on 'counterfeit medical products' (EB124/14).

It was perhaps ill-timed that IMPACT was announced to the EB just days after a series of seizures of medicines being transhipped from India through Europe to Brazil, Colombia, and

Peru (SpicyIP). A statement by the EU defended the seizure on the grounds of a suspicion that these goods infringed an intellectual property right (in the European market).

A vigorous debate ensued in the EB (EB124/2009/REC/2) during which the defenders of IMPACT spoke about the importance of regulating the medicines market to get rid of substandard, spurious, falsified and falsely labelled medical products. The critics of IMPACT challenged the use of 'counterfeit' (a legal term referring to trade mark violations) to refer to substandard medicines and thereby harness real concern about quality of medicines in the cause of policing intellectual property. Kenya adopted a new Patent Act in 2008 which made the manufacturing, import or sale of 'counterfeit goods' a criminal matter rather than a matter for civil proceedings. In April 2012 the Kenya High Court ruled that the Act was invalid because it was too broad and vague with respect to counterfeit and generic medicines (IP-Watch 2012).

At the time of writing WHO has still not adopted a single term to refer to substandard, spurious, falsified or falsely labelled medical products which does not conflate quality and efficacy with IP status.

Shashikant (2010) has compiled a series of reports on the IMPACT controversy which provide a compelling case for the view that the IFPMA deliberately encouraged WHO to adopt the 1992 definition of 'counterfeit medicine' which was worded in such a way as to include both substandard products and generics. This meeting took place towards the end of the Uruguay Round during which the TRIPS agreement was being debated with the IFPMA central among the drivers of TRIPS (Drahos 2002). The creation of IMPACT took place at the same time as a small group of countries led by the USA and Japan were negotiating the proposed Anti-Counterfeiting Trade Agreement (ACTA) (Legge, Gleeson et al. 2014).

Another famous case illustrating the tensions which can arise between transnational food corporations (Nestlé in this case) and public health objectives concerns the WHO Code on the Marketing of Breast-milk Substitutes. Richter (2002) provides a detailed account of the role of the infant food industry in opposing the development and undermining the implementation of the WHO Code.

Three more recent instances of corporate prosecution of special interests in engaging with WHO include: the psoriasis resolution proposed by Panama in the EB133 (May 2013) and adopted in May 2014 in WHA67.9 (PHM comment here); the Italian intervention on behalf of the sugar/chocolate industry in EB137 (May 2015) (PHM comment here); and regarding road safety (PHM comment here).

The 'multi-stakeholder partnership' as a vehicle for a corporate take-over of global governance is spelled out in detail in the World Economic Forum's Global [governance] Redesign Initiative (GRI) (World Economic Forum 2010) which articulates very clearly the business case for transferring the business of government to the transnational corporations.

Gleckman (2012) has assembled a 'readers' guide' to the GRI. The Overview is worth reading in full:

> *WEF's diagnosis of the current ills in global governance and WEF's prescriptions for treatment of these maladies are important contributions to the debate on the future of global governance.*

WEF acknowledges that neither the US, nor the EU, nor any grouping of G7/G8 countries can still be counted on to make and implement crucial global economic decisions. In their view, the realities of globalization have eclipsed the post-WWII hierarchy of nation-states and the existing architecture of international organizations. […]

In WEF's view, multinational corporations, international civil society organizations, and larger developing countries have entered the space formerly held by the major Northern nation-states and the UN system. This transformation has not occurred overnight. Rather, over the past decades all these Actors have in different ways built global or regional governance systems that exist in parallel to the existing formal system of international organizations and bilateral relations. In the case of the MNCs, their effective reach as de facto global governance institutions has long surpassed the functioning of the UN system. International civil society organizations have a created a separate people-to-people sphere in governance with the other Actors in global governance. These three institutional governing forces sometime intersect tumultuously with each other, sometimes engage each other with a profound understanding of the independent role of the other governing system and sometimes join together on a common project. In WEF's view this alignment has evolved into something new in governance history - something that WEF seeks to capture in the phrase "geography of cooperation."

The implication of this is four-fold. First, MNCs and international CSOs need to be recognized in their own right as full Actors in the global governance system, not just as lobbyists to nation-states or international proponents of specific positions or solutions. Second, governments of selected 'emerging economies' should also be formally acknowledged as significant players in global governance, not just one amongst equals in the developing world. Third, only by embracing these new Actors formally and in a constructive manner can one meaningfully attempt to manage globalization. And fourth, corporate executives and international CSO leaders need to be self-conscious of their new global Actor role and not try to pretend or minimize, as they have done in the past, their leadership role in global governance. WEF's position is that a realignment of these three categories of Actors – MNCs, civil society leaders, and nation-states - has the best shot at managing globalization.

In its view, the World Economic Forum is the body best suited to develop a new framework for a post-United Nations-based system of international governance. It has fifty years' experience convening leading stakeholders from the political, economic, cultural, civil society, religious, and other communities to discuss the way forward in global affairs. It has built a reputation as an innovative thought center. It has played a role in global conflict resolution. WEF openly recognizes that economic inequalities and global governance failures are inhibiting the adaptability of the current economic system to continue to grow and prosper. As the three co-chairs observed in their introduction to this report: "The time has come for a new stakeholder paradigm of international governance analogous to that embodied in the stakeholder theory of corporate governance on which the World Economic Forum itself was founded.

The record of Big Tobacco, Big Asbestos, Big Food and Big Pharma in health; of Big Oil in relation to global warming; and of Big Arms in profiteering from political instability all cast doubt on the WEF claims that a stronger representation of the corporate perspective in global governance would solve the problems of inequality and global governance failure.

The food, nutrition and agriculture field provides a case study regarding the risks of conflicting purposes and multi-stakeholder partnerships. Valente (2015) has provided a

useful overview of the structures and strategies involved in the struggle for control of the global governance of food and nutrition and in particular the tension between various expressions of the multi-stakeholder partnership model and the principle of intergovernmental nation state sovereignty.

For the large corporations the issues are huge, including protecting the junk food industry from regulation and defending industrial agriculture and 'free trade' in agricultural commodities (including dumping) as the preferred model for achieving food security.

Arrayed against the pressure for the multi-stakeholder partnership are a loose alliance of civil society organisations and social movements ranging from those with a public health orientation (concerned about both under-nutrition and the role of food systems in non-communicable diseases) to the international small farmers' movement, Via Campesina.

In relation to hunger the free trade lobby argues that industrial (high input) agriculture in a small number of agricultural exporters should be the principal policy strategy for addressing under-nutrition. On the other hand the impact of dumped agricultural product (under-priced or provided as 'aid') on small farmers' livelihoods has been devastating in many developing countries.

A key demand from the civil society side is for agriculture and food policies to have regard to food sovereignty as well as food security. The food sovereignty movement highlights the social, cultural and environmental context of growing, processing, procuring, preparing and sharing food and the need for farmers and communities to have the choice to retain and shape food systems which are valued for social, cultural and ecological reasons as well as the provision of adequate nutrition. Choices with regard to food systems have important gender implications also.

Government positions on these issues vary widely, ranging from the US and other G8 governments, who have provided powerful political support to the corporate lobby, to the governments of countries who are persuaded of the need to regulate junk food for public health and who are concerned to protect the interests of small farmers.

Key players on the business side are the World Economic Forum (and its Global Redesign Initiative), the Bill and Melinda Gates Foundation and various sectoral business associations.

Between the WEF and Via Campesina is a complex mix of intergovernmental organisations within and beyond the UN system, including the Food and Agricultural Organisation, the WHO, the World Trade Organisation, the World Bank, the World Food Program and UNICEF. A range of organisational vehicles have been developed to carry the corporate program, among which SUN (Scaling Up Nutrition), is one of the most prominent.

In some degree the tensions in this field are about specific policy issues; Valente discusses the debates over the use by UNICEF of ready-to-use-foods (RTUF) in addressing under nutrition. In relation to the structures of governance one of the main tensions has been between the UN Standing Committee on Nutrition (SCN) and the UN Committee on Food Security (CFS) on one side and the various initiatives of the Bill and Melinda Gates Foundation, the World Bank, the G7, and the WEF; all directed in various ways to shore up the Big Ag / free trade model and to secure a central position for the business lobby in global food governance.

Valente describes the WEF sponsored Global Food, Agriculture and Nutrition Redesign Initiative, the goal of which is to "*guide the development of food and agriculture policy and supportive multi-stakeholder institutional arrangements that will address current and future food and nutrition requirements within the realm of environmentally sustainable development.*" The initiative combines a range of existing vehicles and programs including SUN.

The role of Ann Venemin illustrates some of these connections. Valente (2015) writes:

> *However, the SCN's functioning as the UN harmonizing body of global nutrition programming was severely constrained from 2008 onwards under the chairpersonship of Ann Veneman. She was also Executive Director of UNICEF at the time. In FIAN's view, this appointment was part of a broader strategy to replace the normative, transparent, and broadly representative institutions with those easily controlled by the private sector. Veneman was at the right place at the right time to move things in this direction. Prior to being selected by George W. Bush to lead UNICEF as its Executive Director, Veneman was one of the negotiators of the North American Free Trade Agreement (NAFTA). She also worked for Calgene, the first company to register a genetically modified seed, and was secretary of the US Department of Agriculture (USDA) under George W. Bush. Veneman presently is a member of Nestlé's Board of Directors. She also had the full support of the World Bank and the World Food Programme (WFP)—both of which have their governance, as UNICEF, defined by the US—to severely curtail SCN's working methods.*
>
> *From 2008 onwards the inclusive annual SCN sessions have been cancelled and the technical working groups have been dormant. In 2010 the Steering Committee, in which civil society representatives were active, was eradicated. Instead the only 'members' of the SCN are now high-level staff from four UN organizations who were to meet quarterly. However, such meetings ended after taking place only twice. In the meantime the Secretariat serves only the needs of the Scaling Up Nutrition (SUN) initiative, as discussed below.*

The UN Secretariat, under Secretary-General Ban Ki Moon, has been a strong supporter of the multi-stakeholder partnership, under the flag of the UN Global Impact (Gregoratti 2011, United Nations Global Impact 2016). Adams and Martens (2015) link the SG's support for the Global Compact and the multi-stakeholder partnership model to the continued freeze of assessed contributions to the UN and its increasing dependence on donor funding.

The FENSA debate

In the early presentations of the WHO reform program the proposed World Health Forum figured prominently as a mechanism through which WHO might encourage closer coordination between the various agencies (public, private and mixed) involved in global health. The WHF was rejected by the member states, some, because they were concerned about providing a platform for private sector entities within the Assembly, others, because they were determined to restrict WHO's role in global health to standard setting and health security.

Member state concerns about closer engagement with private sector entities undermining the inter-governmental nature of WHO decision making was not focused solely on the WHF proposal but arose also in relation to the funding dialogue and the continuing pressure to

reshape WHO's programmatic work in accordance with the multi-stakeholder partnership model.

Since the Treatment Access Campaign from the late 1990s the issue of IP and access to medicines has been a recurring cleavage in the Assembly including: the deliberate conflation of quality and efficacy with IP status (and the IMPACT scandal); the US harassment of the DG over the William Aldis incident and the legitimacy of deploying TRIPS flexibilities to promote access; the failures of monopoly price funded R&D in driving innovation for antibiotics and for Type 2 diseases; US bullying of the DG over a publication produced for the supposedly independent Commission on Public Health Innovation and Intellectual Property; the increasing levels of protection of IP through regional trade agreements; and more recently the astronomical prices for biologicals.

In many discussions regarding non-communicable disease similar conflicts of interest have been apparent, including in the Moscow ministerial meeting and the second International Conference on Nutrition. The transnational food companies, supported by the US and like-minded governments, lobbied strongly in and around these events to prevent firm commitments to regulation and fiscal and taxation measures to promote healthy diets.

Against this background it is not surprising that there has been widespread concern that private sector 'partners' might face conflicts of interest in multi-stakeholder global health initiatives and that robust protocols might be needed to manage risks to WHO's integrity.

In both the access to medicines field and across nutrition and agriculture there are many civil society organisations and social movements which have been very active in highlighting the risks to good governance associated with corporate conflicts of interest. Many of these networks are particularly strong in the global South (associated with AIDS/HIV constituencies and small farmers) and have brought their concerns clearly to developing country governments.

With the defeat of the plan for a WHF in 2011, the focus of the discussion regarding WHO's role in GHG moved to 'engagement'. In Nov 2011 the special session of the EB requested the DG to provide "further analysis of proposals to promote engagement with other stakeholders". This analysis was provided to the Board in Jan 2012 but required further discussion (see). It was considered again by the Assembly in May 2012 which in A65(9) requested the Director-General:

> *(a) to present a draft policy paper on WHO's engagement with nongovernmental organizations to the Executive Board at its 132nd session in January 2013;*
>
> *(b) to present a draft policy paper on the relationships with private commercial entities to the Executive Board at its 133rd session in May 2013; and*
>
> *(c) to present a report on WHO's hosting arrangements of health partnerships and proposals for harmonizing work with hosted partnerships to the Executive Board at its 132nd session.*

EB132 (Jan 2013) decided to pull these different strands together and in EB132(11) requested the DG

> *(1) to submit, for the consideration of the Executive Board at its 133rd session in May 2013, overarching principles for WHO's engagement with non-State actors, defining*

separate operational procedures for both nongovernmental organizations and private commercial entities;

(2) to harmonize the development of the draft policy for engagement with nongovernmental organizations with the draft policy on WHO's relations with private commercial entities, such development being guided by the principles stated by the Sixty-fifth World Health Assembly in decision WHA65(9), subparagraphs (9)(i)–(v);

(3) to work further on the draft policy of engagement with nongovernmental organizations, proceeding with the revision of accreditation procedures for nongovernmental organizations for WHO's governing bodies (i.e. authorization to participate therein) and incorporating those procedures in the draft; including updated terms of reference and operational procedures of the standing committee on nongovernmental organizations; and incorporating the inputs provided during the deliberations of the Board at its 132nd session;

(4) to conduct public web-based consultations on the draft principles and policies of engagement with non-State actors; and convene two separate consultations, one with Member States and nongovernmental organizations, and one with Member States and the private commercial sector, to support the development of the respective draft policies;

(5) to report on the development of the two draft policies to the Board at its 134th session in January 2014.

The first integrated draft 'framework of engagement with non-state actors' (FENSA) was considered by EB134 (Jan 2014) in EB134/8 and the Board committed to further consultations.

It was considered again in May 2014 at WHA67 (in A67/6) and the assembly committed, in WHA67(14), to further consultation including a web-based platform and regional consultations.

It was considered again in Jan 2015 at EB136 (in EB136/5) with the results of those consultations and in EB136(3) the Board decided to collect more inputs and hold an open ended intergovernmental meeting (OEIGM) at the end of March 2015 with a view to finalising and adopting the framework at the WHA68 in May 2015.

A further revision was submitted in May 2015 to WHA68 (in A68/5) but there were extended passages still under debate. The Assembly decided, in WHA68.9, to hold a further OEIGM (held in July 2015) to finalise the framework.

Results of the July OEIGM were provided to the EB in Jan 2016 in EB138/7 and following a long debate committed (in EB138(3))to yet another OEIGM in April 2016 with a view to adopting in WHA69.

The third OEIGM was still not able to finalise the framework (text forwarded to WHA69, May 2016, in A69/6) but in a marathon run of closed meetings during the 69th Assembly a consensus version was finally achieved and in WHA69.10 the Assembly adopted the framework and commissioned a number of further steps for implementation and monitoring and evaluation.

The finalised FENSA is a long and complex document which traverses some highly contested territory and it should be no surprise that it required three EB debates, three Assembly

debates, three separate OEIG meetings and extended closed negotiating sessions to be finalised. Some of the sharpest debates dealt with:

- the precise wording regarding 'conflict of interest', 'due diligence', and 'risk management' and whether distinctions should be made between different kinds of non-state actors in relation to these issues;
- whether to include an explicit prohibition of secondments to the Secretariat from private sector entities (included in final version, see Clause 47);
- provisions regarding pooled funding mechanisms through which private sector entities (PSEs) could contribute financially to the work of the Secretariat (included, but in quite restrictive terms in the final version).

The provisions regarding conflict of interest were the subject of vigorous lobbying from civil society groups from both the access to medicines and nutrition areas who had experience with corporate entities in those fields. One of the early debates was whether the framework should set out different provisions for different types of stakeholders. For example, in the debate at EB130 (Jan 2012) the highly influential Dr Silberschmidt (Switzerland) 'commented that increased stakeholder engagement was also welcome, but given the specific characteristics, roles and interests of nongovernmental, private-sector and other organizations, WHO should avoid differentiating between categories of stakeholders.' Along the same lines and in the same debate Dr Daulaire (US) 'urged caution about differentiating between the various types of nongovernmental and civil society organizations, given the danger of excluding certain stakeholders or not appropriately acknowledging their specific spheres of interest or activities as part of a transparent consultative process'. The view that COI provisions regarding NGOs might be the same as for PSEs was not supported in subsequent discussion.

The proposal for 'a mechanism to pool funds from the private sector' had been part of the Secretariat reform agenda since May 2011 (in A64/INF.DOC./5). Some forewarning of opposition to this proposal was provided by Brazil in the debate over this item at WHA64 (May 2011).

One of the issues which attracted much criticism from civil society but remained in the final version was the provision for PSEs (typically business associations) to be accepted as in 'official relations' with WHO. Part of the arrangement is that organisations in 'official relations' with WHO are required to negotiate explicit 'programs of cooperation' with WHO. It is unclear what kind of programs of cooperation the various business associations will undertake.

The finalised FENSA is long and complex and it remains to be seen how it will work in practice (indeed whether it can be fully operationalised in practical terms). The finalised text represent something of a truce between the proponents and opponents of the private sector having a 'seat at the table' of global health governance.

One of the biggest weaknesses of the finalised FENSA is that it is solely about the Secretariat and leaves member states free to advance the interests of private sector entities through the governing bodies and the financing dialogue with no provisions for public accountability (recalling IMPACT, sugar and psoriasis).

The FENSA discussion started with a focus on WHO playing a more proactive role in global health governance, and in particular, helping to coordinate the anarchy of multiple 'global

health initiatives' providing 'development assistance for health'. This vision has been completely lost as the focus of debate narrowed to the Secretariat's relationship with private sector entities.

Alignment and harmonization; delegation and accountability

The status of regional offices (regional committees and regional directors) has been controversial since before WHO was established. During the negotiation of WHO's Constitution there was a fierce debate between those who argued that regional offices should be subordinate to the centre and those who were determine that the Pan American Sanitary Bureau would not cede its autonomy to the yet-to-be-established WHO (Farley 2008). The defence of the continuing autonomy of the PASB was led by Thomas Parran, the US Surgeon General and by Hugh Cuming, the director of the PASB and prior to that the US Surgeon General. It appears that the US demands for the continued autonomy of the PASB reflected the Monroe Doctrine (regarding US hegemony in Latin America) applied to public health.

In fact the WHO Constitution as adopted makes it clear that the regional office operates under the general direction of the DG and the regional directors are to be appointed by the EB "in agreement with the regional committee".

Nevertheless the degree of regional autonomy and the operational effectiveness of the regional structures have continued controversial to the present day. In the context of the present Reform Program much of this debate has been about recognising (or otherwise) that some of WHO's disabilities arise from the way its decentralised design presently works.

Debate around regional structures was initially treated as part of 'governance reform' with quite general references in the Secretariat documents and little substantive debate. This changed in early 2015 when the failures in the Secretariat response to the 2014 Ebola outbreak were discussed in the special session of the EB on the response to the Ebola epidemic.

In the routine EB136 which followed the special session on the Ebola response there was dissatisfaction at the lack of progress on governance reform, part as a consequence of the Ebola discussions but also triggered by the report of the Independent Expert Oversight Advisory Committee (EBPBAC21/2) which stated that slow progress on governance reform could impede the overall WHO reform agenda. Accordingly, in EB136(16) the Board decided: '*to establish an inclusive Member States consultative process on governance reform, to complete its work by the Sixty-ninth World Health Assembly, providing recommendations through the Executive Board on how to improve WHO governance efficiency*'.

At the time of writing the Member States Consultative Process on Governance Reform (MSCPGR) is in deadlock over essentially the same issues over which Brock Chisholm and Hugh Cuming clashed in 1947. We return to the MSCPGR below but before doing so we will trace the chronology of this debate during the current reform program.

A key part of the pre-history of the debate is the 1993 report by the United Nations Joint Inspection Unit (JIU) regarding WHO's decentralised structures (JIU/REP/93/2).

The JIU referred to previous reviews of decentralisation (see footnote 1 on page 8) which recognised significant shortcomings in the functioning of decentralisation. The inspectors reported:

14. Some of the key issues concern, for example, the depth of commitment by individual Member States to programme policies and managerial principles adopted collectively within the governing bodies; the effectiveness of the Constitutional role of the Regional Committees and of the correlation of that role with the roles of the Executive Board and the World Health Assembly; the potential and instances of management tension between the Director-General and Regional Directors who are all elected by the same Member States, etc.

The inspectors concluded:

122. The Inspectors conclude that because WHO's decentralized structure is currently handicapped by many problems identified in this report, it is not functioning as efficiently and effectively in the nineties as it did in the early decades of its existence.

The inspectors offered a suite of structural reforms of which Recommendation 3(a) is the most critical: *The Director-General should be empowered to select and nominate RDs for confirmation by the Executive Board, following consultations and in agreement with the Regional Committees concerned or their Bureaux, as appropriate.*

This was never acted upon. At the time of writing nominees for the RD position are selected by regional committees (through a range of different procedures with varying degrees of probity) and the selected nominee is submitted as a sole nomination to the DG for presentation to the EB and formal appointment by the EB. We shall return to the 1993 JIU report shortly.

Relations between the regional offices and headquarters were not emphasised in the initial presentations of the reform program. In her concluding remarks after the debate at EB128 (Jan 2011) the DG referred in general terms to the need for 'corporate approaches to shared functions such as resource mobilization and communications' (EB128/INF.DOC./3).

In May 2011 the DG's major statement on reform (A64/4) announced (para 61) that

the Global Policy Group (GPG) has therefore decided, as a first step towards increasing transparency, coherence and accountability across the Organization, to ask the Director-General to assume responsibility for monitoring performance across the whole of WHO. This process will be reinforced by the new results based planning and accountability framework.

In November 2011 the EB held its special session on WHO Reform (EBSS2). The secretariat paper on governance reform (EBSS/2/2) was quite forthright.

77. Regional Committees have different arrangements with respect to their subsidiary bodies and for dealing with specific agenda items and preparing their sessions. Regional Committees' practices and methods of work also vary considerably; greater standardization could be attained.

78. Linkages between global and regional levels of governance are weak, and strategic alignment between regional and global governing bodies is needed. Outcomes of the Health Assembly and the Board are incorporated into Regional Committee discussions, however Regional Committee discussions are not adequately reflected in the agenda and discussions of the Board.

The paper suggested (para 81) that regional committees should

(1) adopt uniform procedures to consider the credentials of Member States through credentials committees;
(2) adopt uniform processes for Regional Director nominations (criteria, interviews);
(3) agree on a unified approach in relation to attendance by observers;
(4) standardize intersessional work.

The reaction of MS was mixed and the Board decided (in EBSS2(2)) that: *the linkage between the work of the Regional Committees and that of the Executive Board and the Health Assembly should be enhanced and strengthened* and requested the Director-General to undertake *further analysis of ways to increase linkages and alignment between Regional Committees, the Executive Board and the Health Assembly as well as of proposals to harmonize the practices of Regional Committees*.

The Board also asked the Joint Inspection Unit (JIU) to review and update its 1993 report on decentralization in WHO, referred to above, and its 2001 report on management and administration in the WHO (JIU/REP/2001/5).

JIU's updated report on decentralisation (JIU/REP/2012/6) was submitted to the EB132 in EB132/5 Add.6. The following extracts are sharp in their critique and revealing regarding the ongoing disabilities of WHO.

34. A review of the Regional Committees' agendas for the last two years shows that no decision was taken to bring issues to the attention of the World Health Assembly and EB. Instead, all Regional Committees dedicate an agenda item to the World Health Assembly and EB resolutions of interest to the region and other issues proposed by headquarters. The interaction between global and regional governing bodies works only one way. The voice of the regions is not well articulated and insufficient space is created to have issues discussed first at the regional level and then tabled at the global level.

35. There is little oversight of the work of regional offices by Regional Committees as required by article 50 (b) of the Constitution. A review of the agenda, decisions and reports of the meetings of the Regional Committees for the last two years shows that management reports are not systematically listed for consideration, and if tabled they generate limited interest and action.

62. Article 52 of the Constitution provides that the "head of the regional office shall be the Regional Director appointed by the Board in agreement with the regional committee". As such, Regional Directors are elected officials like the Director-General. However, in the organizational chain of command, they are under his/her authority as per article 31 of the Constitution, which stipulates that the Director-General is the chief technical and administrative officer of the Organization, and article 51, which indicates that the regional offices are subject to his/her general authority.

63. The two previous JIU reports on WHO examined this issue and its implications in detail. Particularly, JIU/REP/93/2 highlights that accountability is better exercised when based on a single, pyramidal chain of command and not with seven "executive heads". It proposes to change the procedures for nominating Regional Directors – without changing the Constitution – to empower the Director-General to select them and nominate them for confirmation by the Executive Board, following consultations

and in agreement with the Regional Committees. While the Inspectors concur with this analysis, they are of the opinion that the involvement of the Director-General in the selection process of the Regional Directors is not the only way to improve the chain of command and enhance accountability and ensure coherence.

69. The delegation of authority to Regional Directors states that they are accountable to the Regional Committees for the effective and efficient operation of the regional offices and to the World Health Assembly through the Director-General for the efficient and effective use of resources in implementing the programme budget within the region under their responsibility. They have therefore a dual accountability to Member States and to the Director-General.

70. The delegation order also indicates that compliance will be monitored systematically and withdrawal of the authority delegated will be considered in the case of non-compliance. It also announces some work to establish an accountability framework for monitoring and harmonizing delegation of authority across the Organization, of which the Inspectors did not find any evidence.

The inspectors cite an earlier report on accountability frameworks in the United Nations system (JIU/REP/2011/5) which identifies work plans and performance assessment as the principal accountability tools.

73. At WHO, both accountability tools exist, but Regional Directors are not subject to a formal performance assessment. The Director-General indicated that she is not the first-level supervisor of Regional Directors by means of the Constitution, but she provides feedback to them on their performance. The Inspectors are not aware of any performance appraisal of Regional Directors done by Regional Committees either.

74. The Inspectors encourage the Director-General to establish monitoring and accountability mechanisms for Regional Directors to monitor compliance with the authority delegated to them and to assess their performance. As chief technical and administrative officer of the Organization, the Director-General has the constitutional authority and duty to do so, regardless of the dual reporting line of Regional Directors.

90. The relationship between the CCS and other WHO planning instruments is weak, as acknowledged in the different reform documents. While the CCSs can provide an indication of individual country priorities, "the development process is imperfect and the link with the WHO managerial framework and country programme budgets in particular, is weak"; and "there is no systematic link between the priorities identified in the country cooperation strategies and the categories around which the programme budget is organized. As a result, there is a mismatch between the country cooperation needs that are expressed in the country cooperation strategy and the programme budget that is approved".

91. The JIU review of a sample of CCSs confirmed the lack of linkage with major WHO strategic planning instruments. In addition, more corporate branding, consistency and regularity in their preparation is required. Their layout differs, including within some regions, even if they follow to a certain extent the structure proposed in the guidelines, and in content their quality is uneven. More importantly, in some

instances there is a gap (which may range from one to five years) between the two generations of CCSs.

93. Finally, a major weakness of the CCSs themselves is that their implementation is not monitored and reported on properly. The revised CCS Guide developed in 2010 includes for the first time guidance to review WHO performance in countries. This review should in principle be conducted during the second half of the CCS cycle and used in the development of the revised CCS for the next cycle.

This material did not come to the EB until EB132 in Jan 2013. Meanwhile the EB130 (in Jan 2012) considered EB130/5 Add.3 which articulated for the first time (in this reform program) the challenges of closer alignment between the different levels of the organisation and of harmonisation of governance practices across the regions. The Board decided to circulate a summary of the governance discussion and seek written input before the Secretariat prepares a further report for the WHA65 in May 2012.

In May 2012 WHA65 considered a consolidated report on WHO reform (A65/5) which included a more detailed section on the 'scheduling, alignment and harmonization of governance processes'.

The reference to rescheduling was part of a discussion about the WHO calendar and whether a different sequence of meetings might strengthen the linkages between the regions and the centre. In the end the decision was to stay with the existing arrangements.

The reference to alignment was largely about RC input to global decision making and reports to the EB regarding RC work.

Harmonization was discussed in terms of the process for nominating Regional Directors (#30); the review of MS credentials for participation at RCs (#31-32); and the rules governing the participation of observers (#33).

In A65(9) the Assembly decided to adopt some process changes designed to better link the discussions in the regional committees and those in the Geneva meetings.

In relation to the nomination of regional directors, the Assembly decided:

(a) that regional committees that have not yet done so, in line with principles of fairness, accountability and transparency, establish:

(i) criteria for the selection of candidates; and

(ii) a process for assessment of all candidates' qualifications;

Regarding the participation of observers in regional committee meetings the Assembly decided *that regional committees that have not yet done so, ensure that there are relevant rules within their Rules of Procedure that enable them to invite observers to attend their sessions, including as appropriate, Member States from other regions, intergovernmental and nongovernmental organizations*.

The 'alignment and harmonisation' issues returned to the fore in EB136 (Jan 2015), in part as a consequence of the Ebola discussion, but also triggered by the report of the Independent Expert Oversight Advisory Committee (EBPBAC21/2) commenting on the lack of progress with governance reform. The Board, in EB136(16), decided: '*to establish an inclusive Member States consultative process on governance reform, to complete its work by*

the Sixty-ninth World Health Assembly, providing recommendations through the Executive Board on how to improve WHO governance efficiency'.

The member state consultative process on governance reform (MSCPGR) involved a working group and an open member state meeting (OMSMGR) which met three times. The sequence of meetings and the evolving character of the recommendations is worth clarifying.

The WG met face to face and by internet following the adoption of EB136(16) in Jan 2015 and submitted its first report (EB/OMSMGR/1/2) to the first session of the OMSMGR in early May 2015. This first report described the WG's initial approach and sketched an agenda.

The WG met again following that first session, undertook further research and in its second report (EB/OMSMGR/2/2) submitted a more detailed set of recommendations to the second session of the OMSMGR on 10-11 December 2015. These recommendations addressed both the working methods of governing bodies and the alignment of the governance across all three levels of the Organization. It was accompanied by a more detailed analysis of the problems being addressed with reference to previous recommendations, including those of the JIU.

The recommendations of the WG were supported by a library of documentation assembled and, at the time of writing, still available on the MSCPGR website.

The OMSM in Dec 2015 was not able to agree on very much, partly because of shortage of time. A report of the meeting (EB138/6) 'issued at the sole responsibility' of the chairperson was considered by the EB138 in Jan 2016. The chairperson's report provided a revised version of the WG's recommendations. In decision EB138(1) the EB authorised further sittings of the OMSM to pick up where the December meeting had left off and to agree on a set of recommendations for WHA69 in May 2016.

The OMSM met again in March and in April and submitted its report to WHA69 in A69/5. The OMSM identified the recommendations on which agreement had been possible and noted that there was no consensus on the way forward. In WH69(8) the Assembly adopted the agreed recommendations.

Before exploring the implications of the conflict around the internal governance of WHO we need to review a separate stream of discussion which is highly relevant to MS accountability and RC functioning. This concerns 'national reporting'.

This issue first arose during the Nov 2011 special session of the EB on WHO reform. In the context of the discussion about the overloaded agenda several MS criticized the tendency of some delegates to take up time, during technical debates, by reporting at length on what their country was doing rather than engaging with the substantive issues. However, it was recognized that countries should not be discouraged from reporting on what they were doing.

As a consequence, in decision EBSS2(2) the Board decided to ask the DG to bring forward proposals 'on how to streamline national reporting in accordance with Articles 61 to 65 of the Constitution of the World Health Organization, using modern tools'.

The DG responded to this request in Jan 2012 in EB130/5 Add.3 which listed the current reporting practices in relation to articles 61-65 and offered to undertake further analysis and develop specific proposals.

Further work was reported to the EB132 in Jan 2013 in EB132/5 Add.4. The paper identified three different streams of reporting:

- statistical data reporting (on health status, epidemiology, health financing and health infrastructure);
- health policy reporting (on national health policies and health-related laws, regulations and reports); and
- reporting on implementation of resolutions and decisions by the governing bodies.

An overview of current practices under each of these headings was provided. The report noted that '*there is no established practice concerning reports by Member States in response to WHO governing body resolutions*' and that '*Member States do not have a clearly defined, formal reporting channel to WHO on national developments in health*'. The report promised further analysis and more detailed proposals.

In Jan 2014 the EB134 considered EB134/7 which dealt further with national reporting and communications with MSs. The report noted that

> *7. The Secretariat has published on its website the results of a study on the actions urged on Member States by the Health Assembly over the past 10 years. During the period 2004–2013 the Health Assembly adopted 248 resolutions, of which 144 contained operative paragraphs urging Member States to action. Although subparagraphs within those 144 resolutions contained some 1059 specific recommendations, some of the actions urged were duplicated, others were not applicable to all Member States and yet others were conditional in their language. Exclusion of those texts leaves a total of 756 firm, unique actions urged by the Health Assembly on all Member States.*

Unfortunately the report provided no data or analysis on actual reports regarding those commitments.

EB134/7 listed a number of projects directed to streamlining the collection of statistical and policy data and commented loosely on the reporting of implementation action.

Perhaps the most striking finding in the report was in para 17 which noted that

> *In the course of the preparatory work for this part of WHO reform, the Secretariat identified the need for an Organization-wide information management strategy. On the basis of a detailed analysis of the current information management policies, practices and tools, the Secretariat will elaborate an overall information management strategy and new, more streamlined systems and methods.*

The report promised a further report for EB136 but it has yet to appear. In EB138/5 considered by the Board in Jan 2016 the Secretariat advise that work on 'streamlined national reporting' had been put on hold during the Ebola outbreak response owing to resource constraints but work in this area was being reactivated. This advice was repeated in A69/4 submitted to the Assembly in May 2016.

The material we have reviewed in this section can be summarized as follows:

The effective governance of the WHO is compromised by the lack of accountability of the regional directors and regional committees.

The relative autonomy of WHO regional offices was a consequence of necessary compromises in the drafting of the WHO constitution associated with the inclusion of the

PASB, later to become PAHO. However, the Constitution includes provisions which could be used to require much tighter accountability of both regional directors and regional committees than is presently the case.

Regional directors are only loosely accountable to the DG and to their RC. RCs are only loosely accountable to the Assembly and to the member states of their regions. While the regional office has direct responsibility for country offices the accountability of regional directors and committees for the quality and implementation of CCSs is quite loose.

Member states are not accountable for implementing (or failing to implement) the many actions which are urged upon them through WHA resolutions. The findings of the Ebola Interim Assessment Panel (final report) on the failures associated with the IHRs in the Ebola response illustrate this: "*(i) Member States have largely failed to implement the core capacities, particularly under surveillance and data collection, which are required under the International Health Regulations (2005); (ii) in violation of the Regulations, nearly a quarter of WHO's Member States instituted travel bans and other additional measures not called for by WHO, which significantly interfered with international travel, causing negative political, economic and social consequences for the affected countries*".

Practical steps towards tighter accountability and more effective governance (as recommend by the JIU and by the WG of the OMSGR) are being resisted by many member states.

Part of the problem appears to be a kind of co-dependency between some regional directors and their regional committees. In certain regions ministers for health may stand to benefit from having a close working relationship with their regional director. In return, the regional committee may provide the regional director with some degree of protection from being held fully accountable to the Director-General, while the regional committee itself requires only loose accountability from the regional director (Joint Inspection Unit 1993, PricewaterhouseCoopers 2013).

In these circumstances the country office and the head of the country office would be constrained to have close regard to the interests of both the minister of health nationally and the regional director. Such constraints could place limits on how effectively the country office operates. In these circumstances moves to improve the quality, implementation and accountability of country cooperation strategies might not be enthusiastically supported.

The provision of Article 71 in the WHO Constitution which prevents the CO from communicating with national NGOs without the approval of the national government is a further restriction on the accountability of national ministers.

The lack of member state accountability in WHO stands in stark contrast to the trade review process of the WTO, the national hearings processes of the Human Rights Council and the national reports of both the OECD and the IMF.

Many commentators are reluctant to acknowledge the co-dependency syndrome or the case for strengthening the hierarchical coherence of WHO because of their concerns regarding increasing corporate influence over the Secretariat in Geneva.

WHO's role in GHG

In the first major document of the WHO Reform Program (EB128/21) WHO's role in GHG was discussed in terms of:

- health security (in particular, outbreak preparedness, surveillance and response);
- guidelines, norms and standards (eg custody of the International Classification of Diseases);
- codes, treaties and regulations (FCTC, IHRs);
- coordination of development assistance; and
- leadership in global health policy.

WHO's role in 'development assistance' was discussed in terms of the 'proliferation of global health initiatives', conflicting advice, duplication of efforts, fragmented channels of funding, high transaction costs, burdensome reporting requirements and the lack of effective institutional architecture at the global level. The need for global coordination was identified but WHO's role was reduced to that of providing advice to ministers at the country level. The role of monitoring and disciplining the myriad of global health initiatives was displaced to the donor countries.

In relation to global health policy the paper argued for the importance of the growing range of stakeholders, from the public, private and voluntary sectors, to be heard in WHO (through the proposed but since dumped World Health Forum). 'Being more inclusive can contribute to a stronger leadership role for WHO by gathering broader-based support.' Coming from a supposed 'evidence-based' organization this proposition is breath-taking.

In the debate around this paper, the US warned against WHO undertaking 'policy advocacy' in fields where others were better informed (EB128/2011/REC/2, p128) whereas Brazil highlighted the need for WHO to project global leadership in addressing the social determinants of health (EB128/2011/REC/2, p130).

A more robust defence of WHO's role in GHG was annunciated in A64/4 (May 2011).

> *7. Other overarching priorities will be health initiatives that contribute to poverty reduction; reducing the costs of health care, especially those related to pharmaceutical expenditures, in all countries; and standards that continue to ensure the safety of water, food, urban air, pharmaceutical products, and industrial chemicals. […]*
>
> *8. As many major threats to health arise in other sectors, WHO will continue to argue for a whole-of-society approach that analyses the consequences and the costs for health of policies made in other sectors. Recommendations from the Commission on Social Determinants of Health will guide this process and underscore its urgency.*
>
> *9. WHO will use its convening power to ensure that health needs in the developing world get due attention and a square deal during international negotiations on trade, agriculture, climate change, and other issues where health might otherwise be neglected in favour of other priorities.*

By the time of the special session of the EB on WHO reform (in Nov 2011) the title of the lead paper (EBSS/2/2) was more ambitious ('WHO reforms for a healthy future') notwithstanding the demise of the WHF proposal. Chapter 2 of the paper discusses WHO's leadership role in global health, 'both in terms of engagement with other stakeholders and

how WHO can promote greater coherence and coordination among the many actors involved in global health at global and country level'.

Among the proposals submitted by the Secretariat to the EB regarding WHO's role in GHG (from page 17) were:

- multi-stakeholder forums on key issues in global health;
- consultations with different groups of stakeholders to provide input on specific issues under consideration;
- strengthening coordination across the UN system both at the global and country levels;
- strengthening coordination through coalitions, alliances and partnerships: and a
- 'framework to guide stakeholder interaction' (apparently focused on development assistance for health).

By Dec 2011 (EB130/5 Add.4) the focus was on promoting engagement with other stakeholders and involvement with and oversight of partnerships.

By May 2012 (A65/5) WHO's role in GHG has been reduced to a set of rules for engaging with NSAs, the FENSA discussed above.

It is difficult to make sense of the shrinking scope of WHO's role in GHG partly because of the ambiguity of the slogans about 'stakeholders' and 'partnerships'. The continued use of the term 'stakeholders' (and the bundling of NGOs, PSEs and philanthropies) appears to endow all of these 'stakeholders' as having a kind of right to be heard, a right to have a 'seat at the table' with only the tobacco and arms industries declared beyond the pale. Such 'rights' stand in sharp contrast to the rights enshrined in the various HR instruments which are about the rights of real people including the right to health.

The language of 'multi-stakeholder partnerships' (again bundling NGOs, PSEs and philanthropies) goes beyond the right to be heard to posit the (unspecified) stakeholders as 'part of the solution'. What is missing from this discourse is any robust analysis of the root causes of the preventable global disease burden which might provide clear criteria regarding which stakeholders are part of the problem and which stakeholders are part of the solution and which stakeholders can be trusted to have a seat at the table. Human rights principles provide such criteria; likewise the concept of social and political determinants of health.

The stark gap in this discussion is any serious reference to WHO's treaty making power (Articles 19 and 20). This is a unique asset of direct relevance to WHO's role in GHG. In the context of globalization the corpus of international law has been progressively expanded through trade agreements with binding provisions, arbitration structures and meaningful sanctions. However, much of this body of law is designed to facilitate economic integration, privatize knowledge and technique as intellectual property with increasing levels of protection for IP owners and to protect investors. There are certain contradictions between the effects of such laws and the objectives of international public health. In this context WHO's treaty making powers could play a powerful role, first in setting standards which are binding for those countries who accede; and second, providing a defence of national laws which are challenged in trade arbitration.

A similar argument holds in relation to WHO's regulation making power (Article 21) which to this time has been only used to regulate health security. There is wide scope to use Article

21 to give teeth to various codes (for example, on the marketing of breast-milk) and non-binding standards, including for example, food labelling.

The significance of WHO's treaty making and regulatory powers was highlighted in various statements from the DG in the early stages of the reform program (see for example her speech to the Informal Consultation of Jan 2010 (WHO/DGO/2010.1). The control of the donors is nowhere more evident than in keeping these possibilities off the agenda; epitomized by the progressive reduction in ambition regarding WHO reform in relation to WHO's role in GHG.

A second area which has been flagged by the DG but clearly needs more attention is the challenge of donor coordination in relation to development assistance for health (DAH). The problems were recognized in EB128/21 with its references to the 'proliferation of global health initiatives, conflicting advice, duplication of efforts, fragmented channels of funding, high transaction costs, and burdensome reporting requirements'. However, the Secretariat papers have failed to articulate the basic problem which is that the donors are not accountable for their compliance with the excellent principles adopted in Rome, Paris, Accra and Busan (OECD 2016). WHO would be showing real leadership in the DAH space if it were documenting and publishing the development assistance practices which run counter to those principles.

More fundamental is to question the architecture of global economic governance which locks a billion people into continuing poverty. While economics is not WHO's core expertise the impact of such poverty on population health justifies WHO working with other agencies within the UN system to focus attention on these questions.

In relation to more specific global health policies, such as climate change, asbestos, NCDs, and action on the social determinants of health, WHO will be showing real leadership when it starts forging partnerships and alliances which are based on a clear analysis of threats and possibilities, rights and wrongs and of barriers and pathways at the global, regional and national levels.

Human resources

The reform of human resource management (HRM) has been a key part of the wider WHO Reform Program since the financial crisis of 2008/2009. In fact the budget crisis precipitated a staffing crisis as almost 600 staff were sacked in 2011 in order to address the deficit and the staffing cuts in turn contributed to further failures in organisational performance, most notoriously, the failures in the management of the Ebola outbreak in 2014. See paras 88 and 124 of the report of the Review Committee on the role of the IHRs in the Ebola crisis submitted to the EB138 (Jan 2016) in A69/21. An earlier review of management and administration, undertaken by the UN Joint Inspection Unit in 2012, had commented that "*The drastic budget reductions for training and staff development in recent years are an issue of serious concern in a "knowledge-based organization*" (EB132/5 Add.6 (Jan 2013)).

The underlying problem facing WHO in the HR arena was the mismatch between rigid, unpredictable, and short term funding (consequent upon its dependence on tightly earmarked voluntary contributions) and a staffing profile dominated by staff on continuing or fixed term (long term) contracts. On Dec 31 2009 80% of staff were on either continuing or fixed term contracts; the remaining 20% were temporary, A63/40). (The proportion of

long term staff had increased by 20% over the past year, largely because of a decision in the Africa region to convert around 800 temporary positions into fixed term.)

A key factor which had contributed to the growth in longer term contracts was the provision in the staff regulations to the effect that staff members who had reached five years of uninterrupted service with a satisfactory performance were normally granted a continuing appointment (JIU/REP/2012/6).

Once it became clear that the member states were not going to increase assessed contributions and that the donors were not going to untie their earmarked funds the challenge became one of adapting the staffing structure to the dysfunctional funding arrangements.

The staffing funding mismatch was not the only weakness in WHO's human resource management. Other frequently mentioned weaknesses included:

- widely varying, but generally long drawn out, recruitment practices across the clusters and levels;
- weak and ineffective performance assessment and performance management;
- neglect of training and staff development.

The most obvious impact of the HR crisis has been on the quality of country office work with criticisms variously directed towards staff competence, the meaningfulness of the country cooperation strategies and the mismatch between the priorities in country cooperation strategies and the programme budget. There has been nothing in the reform discussions which might help to distinguish, in terms of the causes of shortfalls in country office function, between the funding crisis, dysfunctional decentralisation (the co-dependency syndrome discussed above) or intrinsic weaknesses in human resource management.

As far as HRM is concerned the reform process has been largely planned in-house with member state involvement limited to the EB and the PBAC. The staff associations complained early on that they were not being consulted but latterly there was greater involvement of the Global Staff Management Council.

The content of the reforms have been informed by the updated Joint Inspection Unit reports (JIU/REP/2012/6 and JIU/REP/2012/7, both included in EB132/5 Add.6, and the Second Stage Evaluation of WHO Reform undertaken by PricewaterhouseCoopers (EB134/39).

A revised HR strategy was presented to the EB in Jan 2014 but at the time of writing important subordinate documents, in particular, the mobility policy, had not been shared with the governing bodies.

The reform process began with the retrenchments of 2010 and 2011 which were clearly devastating to the individuals and disruptive to the organization. The staff associations' statement to EB128 in Jan 2011 (EB128/INF.DOC./1) spoke about the work pressures staff were under, claiming that 60-70 hours per week were now the norm and that experienced employees were leaving because of work pressures.

Following the initial retrenchments more systematic work began on a number of separate components of the reform:

- contract reform, seeking to greatly reduce the proportion of long term staff to provide for greater staffing flexibility in the face of funding uncertainty;

- mobility strategy, seeking to mandate and facilitate greater geographic mobility of staff, ostensibly to promote staff development but also providing for more management flexibility with respect to staff deployment;
- recruitment reform, seeking to systematise and harmonise recruitment practices and reduce the excessive time involved;
- staff development reform, reinvesting in staff development capability and establishing a more systematic platform to support staff development and learning (including management development);
- performance management reform, seeking to systematise and harmonise across the organisation; strengthening performance assessment and strengthening management capacity to act upon it;

One of the main elements of contract reform has been the elimination of the right of short term employees to achieve fixed term status once they have served for five years. The capacity to promote staff whilst remaining in their appointed position has also been made much more difficult. A further change has been increasing reliance on national professional officers in country offices because they can be employed on local salaries. The staff associations were particularly critical of this latter move, in their contribution to the EBSS2 debate, on the grounds that it undermined the international character of the organisation.

The new 'mobility policy' has been much spoken about but took a long time to be finalised. Management has spoken about increased geographic mobility purely in terms of staff development. The human resources annual report to WHA66 in May 2013 (A66/36) speaks about "a more mobile workforce for whom rotation and mobility are part of an integrated approach to career development that includes tools, such as a skills inventory and an online career path mapping tool". While the second stage evaluation (EB134/39) reports considerable staff support for a more systematic approach to mobility and rotation, the staff associations were apprehensive that references to mandatory mobility might be applied universally, including to staff in highly specialized roles (see the staff associations' statement to EB135 in May 2014 (in EB135/Inf./1).

In an update on the mobility framework in Jan 2016 (in EB138/51) it was made clear that the scheme would only apply to "professional and higher categories whose positions are designated as rotational". However, EB138/51 also makes it clear that while "incumbents of non-rotational positions will be able to stay in the same position and in the same duty station without time limit" … "after 10 years at the same duty station, in order to rise to higher-level positions, they will have to apply and be selected for ad hoc vacancies in other duty stations."

It is unfortunate that in the public discussion of contract reform and the mobility framework there has been no analysis of the balance between experience and corporate memory in relation to particular functions or places versus a continuing refreshment of generic officers.

A66/36 (May 2013) makes it clear that the purpose of contract reform is "a more flexible workforce and appointments policy covering recruitment, management of staffing levels and effective use of non-staff members that will allow the Organization to respond quickly to staffing needs". The reference to non-staff members applies to individuals commissioned to undertake a particular task, consultants, interns and secondments. The secretariat does not report on the extent to which it depends on secondments.

A66/36 also speaks of "a more mobile workforce for whom rotation and mobility are part of an integrated approach to career development". While there are clearly career benefits associated with a more systematic approach to mobility, the driver is clearly the need for management flexibility in the face of uncertain funding.

While clearly there will be benefits to the organization from reforms in the areas of recruitment, performance management and staff development there is a serious risk the in the implementation of contract reform and mandatory mobility the value of deep expertise, long experience and corporate memory is being discounted, notwithstanding the stark lessons of the Ebola crisis.

The Emergency program

Strengthening WHO's work in outbreaks and other health emergencies and on the health side of humanitarian emergencies was added to the broader reform program in the aftermath of the West African Ebola outbreak of 2014. As it emerged the reform of WHO's emergency preparedness comprised three main components: the contingency fund, provisions for a more systematic approach to deploying an emergency workforce, and a new health emergencies program within WHO.

The Ebola epidemic commenced in late 2013. The first diagnosed cases were in late March in Guinea. By 23 June 2014 MSF had around 300 international and national staff working in Guinea, Sierra Leone, and Liberia and had sent more than 40 tons of equipment and supplies to the region to help fight the epidemic.

WHO was slow to build its response to the Ebola outbreak. The shortfalls in WHO's management of the Ebola outbreak pointed to specific problems in the implementation of the International Health Regulations (IHRs) and WHO's emergency management capability. However, the shortfalls in the management of Ebola also reflected all of the disabilities discussed earlier in this paper including the funding crisis, weaknesses in budgeting, evaluation and accountability, dysfunctional relationships between levels, and deficiencies in human resources management.

In WHA68/26 the secretariat notes:

> *When Ebola virus disease was first confirmed in West Africa, WHO's only sources of financing for an early, rapid response were regular budget lines and the modest bridge financing already in place for emergency responses. WHO issued its first appeal to underwrite its Ebola response on 27 March 2014, and a second on 10 April 2014. In response, donors contributed US$ 7 006 230, although processing requirements meant that funds were available on 5 June 2014. Additionally concerning is that most of the funds were highly specified, which inhibited the ability to match funding to need as the crisis evolved.*

In August 2014 the DG declared a public health emergency of international concern (PHEIC) under the IHRs and appointed an emergency committee and WHO released its 'Ebola response roadmap'.

The first substantive consideration of the EVD outbreak by the governing bodies was in a special session of the EB held in early January 2015 (EBSS3). The purpose of the special session was to ensure the international Ebola response, including that of WHO, was on track and second, to identify the lessons and reforms needed to do better next time. The agenda

of the special session included a range of issues specific to Ebola including the fast tracking of preventive, diagnostic and therapeutic products, building resilient health systems in Ebola affected countries, and planning for 'getting to zero'. The Board's consideration of the implications of Ebola outbreak for WHO's work in health emergencies was informed by two main documents:

EBSS/3/INF./4 provided a brief overview of the development of the IHRs and their application in the context of the Ebola outbreak. The paper includes some particularly sharp comments on three areas:

- the need to ensure all countries had established national preparedness capabilities as prescribed by the IHRs;
- the need to ensure the timely sharing of information in such emergencies (something which had not happened in this case), and
- concern regarding 'additional measures', referring to the 40 states parties who had imposed restrictive measures on traffic and trade beyond those prescribed by the emergency committee (in contravention of the IHRs).

EBSS/3/3 considered how to ensure WHO's capacity to prepare for, and respond to, future large-scale and sustained outbreaks and emergencies. The paper was structured around five proposals:

1. affirming WHO's mandate and role in outbreak, humanitarian and emergency response and preparedness;
2. reforming WHO's crisis management mechanisms:

   17. As a first step, the outbreak and humanitarian/emergency response activities will be merged. Such a unified all hazards, global emergency response entity would maximize efficiencies and effectiveness, facilitate appropriate accountability and position the Organization to take on the leadership role for which it is poised.

   18. To genuinely leverage WHO's expertise, strengths and resources, the emergency response programme would be merged across all three levels of the Organization, with departments or units in each WHO office. The structure would be headed by a lead, or incident command during a response, with substantial delegated authority, giving the programme both singular leadership and direct reporting lines.

3. expanding WHO capacities, networks and partnerships, including an adequate standing cadre of emergency staff plus a surge capacity;
4. establishing funding mechanisms for the emergency response, including a special fund for emergencies; and
5. improving performance management and accountability.

The debate around these documents was fairly general with several delegates denouncing the failures of some states parties (largely the poorest countries in the world) to ensure full implementation of the capacity standards of the IHRs.

One of two standouts in the debate was the intervention of Ms Matsoso of South Africa who commented that "*Member States should create an enabling environment that allowed the Organization to respond swiftly in times of crisis, rather than adopting resolutions that tied its hands*". It is not clear what resolutions she was referring to.

A second standout was the intervention of Mr Oberreit (for MSF International) who described the work that MSF had been doing and warned the Board that although the number of cases of Ebola virus disease had decreased substantially, the epidemic was not under control. He went on:

> "*Major gaps remained: there was almost no sharing of information for cross-border contact tracing, surveillance teams lacked basic resources for active case finding, and safe access to health care for non-Ebola cases remained largely neglected. It was necessary to accelerate the development of vaccines, treatments and diagnostic tools and establish an implementation plan. Cases might keep emerging, and health systems therefore had to learn to cope with Ebola. Public health engagement and strong leadership were needed. Thousands had died because of international negligence and because there was no functioning global mechanism to deal with a potential pandemic in countries with fragile health systems. A clear gap remained between commitments made and actions taken."*

The Board adopted an omnibus resolution (EBSS3.R1) which included commitments in a range of areas, including health systems (and IHR capabilities), emergency preparedness globally, information flows and funding for emergencies.

These commitments were further advanced in May 2015 at WHA68 which considered discussion papers on a contingency fund for emergencies (A68/26) and provisions for an emergency workforce (A68/27). The proposal for a $100m contingency fund for emergencies arose first in the report of the review committee on the functioning of the IHRs in the H1N1 2009 outbreak (A64/10) but was not supported by the governing bodies. The proposal resurfaced in 2012 (in EB130/5 Add.6) as part of the DG's early reform proposals but again was not taken forward by the member states.

A68/26 explored the options for a contingency fund in the light of the Ebola outbreak; including size, scope, sustainability, operations, sources of financing and accountability mechanisms. In decision WHA68(10) the assembly endorsed the proposed fund, and:

> *2. Decided to create a specific, replenishable contingency fund to rapidly scale up WHO's initial response to outbreaks and emergencies with health consequences, that merges the existing two WHO funds, with a target capitalization of US$ 100 million fully funded by voluntary contributions, flexible within the fund's scope;*
>
> *3. Agreed that the contingency fund will reliably and transparently, including with regard to financial reporting and accountability, provide financing, for a period of up to three months, emphasizing predictability, timeliness, and country ownership; humanitarian principles of neutrality, humanity, impartiality, and independence; and practices of good humanitarian donorship;*
>
> *4. Decided that the contingency fund would be under the authority of the Director-General, with disbursement at his or her discretion;*
>
> *9. Requested the Director-General to prioritize in-field operations in affected countries when using the contingency fund.*

A68/27 reviewed the kind of workforce likely to be needed for future health emergencies and explored the systems involved in scaling up (and deploying and decommissioning) a global emergency workforce. The first responders would be national. WHO would have both a standing and a surge capacity from existing staff. In addition the paper reviewed the international sources on which further surge capacity would be based. The paper reviewed the resources and systems already operating within the UN and how WHO might work more efficiently with those resources. The paper described how the emergency workforce would function and outlines governance and financing arrangements. In decision WHA68(10) the assembly endorsed the broad framework outlined in A68/27 and looked forward to further details in future governing body meetings.

The third element of the health emergencies reform was introduced in EB138 (in Jan 2016) with EB138/55 which outlined plans for a new WHO health emergencies program. (The design of this proposed new program was informed by the first and second reports of an advisory group on emergency reform.)

A more advanced version of the proposed new health emergencies program was submitted to the WHA69 in May 2016 in A69/30. The key elements of the new program include:

- a single programme, with a common structure across headquarters and all regional offices;
- functions of the programme to include:
    - infectious hazards management (including high threat pathogens, expert networks, etc);
    - country health emergency preparedness and the IHRs, including monitoring and evaluation of national preparedness, planning and capacity building for critical capacities;
    - health emergency information and risk assessments, including event detection and verification, health emergency operations monitoring, and data management and analytics; and
    - emergency operations, including incident management, operational partnerships and readiness, and operations support and logistics.
- a single executive director would be responsible for technical oversight and standards, all strategic and operational planning, risk and performance monitoring, budget and staff planning, and interagency and partner relations;
- the executive director would be supported by regional emergency directors, who will have delegated authority for emergency activities in their regions, and will form part of the global management team of the new programme;
- day-to-day oversight and management of major outbreaks and health emergencies will be delegated to the executive director who will have direct executive control over regional and country office involvement;
- a revised WHO emergency preparedness framework
- a new emergencies oversight and advisory committee to advise the DG and the governing bodies.

In WHA69(9) WHA69 decided:

> *(1) to welcome the progress made in the development of the new Health Emergencies Programme [..] and the establishment of the Emergencies Oversight and Advisory Committee;*

(2) to encourage ongoing collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to enhance humanitarian system-wide coordination of the response to large-scale infectious hazards in the future;

(3) to note that the overall budget for the Health Emergencies Programme and its new operational capacities will be US$ 494 million for the biennium 2016−2017, representing a US$ 160 million increase over the current budget for WHO's primarily normative and technical work in health emergency management;

(4) to approve an increase of US$ 160 million for the Programme budget 2016−2017 to initiate the implementation plan for the new Health Emergencies Programme, and to authorize the Director-General to mobilize additional voluntary contributions to meet this financial need for the biennium 2016−2017;

The Ebola outbreak raised many issues, including weaknesses in WHO's emergency response capacity. The reforms to WHO's emergency program, including the contingency fund and the provisions for an emergency workforce, are all sensible and likely to make a difference in the future.

However, the flaws in WHO's response to the Ebola crisis also reflected the underlying weaknesses in WHO's funding and operations which have been referred to earlier. These include: the distortions arising from the AC freeze, the budget ceiling, the tight earmarking of donations and the dysfunctional relations between headquarters, regional offices and country offices. The impunity of those countries who imposed 'additional measures', beyond those authorized by the emergency committee, reflects the weak accountability of individual countries to the wider international community, of member states to the WHA.

In several respects the emergency program reforms seek to bypass these underlying weaknesses with separate funding and much stronger central control of the emergency function.

However, the West Africa Ebola outbreak also points to a wider set of issues including: the social and economic roots of the epidemic; barriers to health systems strengthening; and the failures of profit-dependent medical products development.

In relation to the social and economic roots of the epidemic, the Secretariat notes (EB136/26, para 3) that:

All three countries were suffering economically, following years of civil war and unrest, and in spite of determined efforts, their health systems remained weak, including with regard to surveillance and laboratory capacity. Populations of interconnected families and communities living close to porous borders moved easily and regularly between countries. Timber harvesting and mining over the previous decades had changed the ecology of densely forested areas. Fruit bats, which are thought to be the natural reservoir of the virus, moved closer to human settlements. Collectively, this presented a favourable context for a virus like Ebola to spread.

In a more extended analysis People's Health Movement (2014) points to land grabbing, the impact of the global trade regime on local farmers, and the role of mining companies in stoking civil war.

WHO has policies on addressing the social determinants of health and on human rights. The DG claims these are 'cross cutting principles' in WHO's global program of work. However,

WHO's record in documenting, analyzing and publishing around the issues which contributed to the severity of the 2014 Ebola outbreak is bleak.

In EBSS/3/INF./2 the WHO secretariat recognized the role of weak health systems in amplifying the severity of the epidemic.

> *Ebola became epidemic in Guinea, Liberia, and Sierra Leone in large part because of their weak health systems.*
>
> *Despite the acknowledged health systems challenges pre-existing in the affected countries, their pre-EVD performance on many indicators mirrors many other countries in the subregion and this raises both the opportunity and the need for a broader cross-country and regional approaches to building robust and resilient health systems.*

The key principles (para 9) adopted in the December 2014 meeting of various national and intergovernmental bodies (see EB136/INF./5) are of critical importance. In particular:

> *Instead of creating yet another vertical programme for a specific health condition or to respond to a crisis, investments should be used to build systems that are grounded in primary health care and universal health coverage principles and capable of responding to diverse and unexpected challenges that might arise in the future.*

This is a reference to the ways in which various disease focused 'global health initiatives' have contributed to health system fragmentation, have overburdened local health officials with reporting requirements and have weakened health systems through internal brain drain. However, in the discussions regarding WHO's role in global health governance (discussed above) there has been no support for WHO holding such donors to account. In fact it is the same donors who are preventing WHO from fulfilling its mandate in these respects through the donor chokehold.

Rowden (2014) has highlighted the role of IMF imposed austerity programs in West African couintries in limiting their capacity to respond to the outbreak. Land grabbing, corporate extortion, theft, bribery and tax evasion (Health Poverty Action, Jubilee Debt Campaign et al. 2014) all combine to keep public revenues low and constrain health systems development. Despite WHO's highly decentralized structures the political and economic determinants of health system (under)development appear to have been largely neglected.

The Ebola crisis also highlights the failure of the profit driven model for the funding of research and development. This is an issue which has been the focus of a prolonged North South stand-off within WHO's governing bodies.

EBSS/3/INF./1 describes the impressive progress that has been made during 2014 in relation to the development and roll out of vaccines, blood therapies, drugs and diagnostics. It is also an indictment of the profit driven model for research and development regarding vaccines, drugs and diagnostics, which has ensured the neglect of Ebola since the isolation of the virus in 1976 (Olliaro, Horby et al. 2015).

Since the report of the WHO Commission on Public Health, Innovation and Intellectual Property in 2006 (Commission on Intellectual Property Rights Innovation and Public Health 2006) the US and like-minded countries have stalled proposals directed to delinking research and development funding from the market opportunities associated with monopoly pricing.

Not just WHO

Before leaving this review of some of the key issues facing WHO it is important to note that the treatment of WHO by the rich countries is part of a wider onslaught on the UN system generally.

A recent report by the UN JIU on the resource mobilization function within the United Nations system (JIU/REP/2014/1) documents the degree to which the whole UN system is held hostage to short term, unpredictable, tightly earmarked donor funding. The report demonstrates the increasing reliance on increasingly tightly earmarked voluntary contributions. The inspector urges chief executive officers of UN agencies to take action to control 'in-house' competition, programmatic fragmentation and fraud and misconduct.

Adams and Martens (2015) have described how all of the same strategies of control have been applied across the UN system generally: freezing of assessed contributions, tightly earmarked voluntary contributions, dependence on private philanthropy, periodic withholding of assessed contributions and the continuing pressure to adopt the multi-stakeholder partnership model of program design and implementation, giving global corporations 'a seat at the table' (Martens 2014).

Conclusions

We have reviewed the case for reform, the evolution of the current reforms and some of the key issues being addressed (or not) in the reform program. In this final section we summarise three the key themes of the argument presented in this paper:

- the problems facing WHO should be understood in relation to the wider structures of global governance;
- the struggle over the effectiveness and accountability of WHO remains critical to the project of equitable health development globally;
- the reform of WHO, to realise the vision of its Constitution, will require a global mobilization around the democratization of global health governance; not separate from, but part of, a global mobilization for a convivial , equitable and sustainable world.

The problems facing WHO should be understood in relation to the wider structures of global governance

To treat WHO as a purely technical agency in which political choice has no role, or to treat global health governance as somehow independent of global economic and political governance, would be absurd. Nonetheless such assumptions play an important political role in that they help to obscure the vested interests and power relations at play in the shackling of WHO and in the debates around WHO 'reform'.

However, it is not sufficient to simply recognise that global health governance is embedded in global economic and political governance because different models for understanding the economic drivers and power relations of global governance can make a big difference to how we understand the donor chokehold, the 'multi-stakeholder partnership' and the current trajectory of 'reform'. In particular, it is necessary to hold a view about the interplay of geopolitics (or nation state imperialism) and the power of global corporations in a time of economic globalisation. The image of the TNC *replacing* the nation state as the principal

agent of governance fails to account for the close collaboration between the imperial powers (in particular the US and Europe) and the leading global corporations (a collaboration epitomised by their annual gathering at the World Economic Forum in Davos). However, the inclusion of a global class analysis (with a self-aware and coherent transnational capitalist class (the global 1%) confronting a melange of dispersed and nationally / ethnically identified working classes, middle classes and marginalised classes) offers a framework for understanding the interplay of the TNC and the nation state in contemporary global power relations.

This kind of structural analysis – corporation, empire and class – is necessary but not sufficient because it is more or less silent about the economic drivers which motivate the transnational capitalist class and the core political choices regarding the future of humanity which express themselves in the more specific debates about global health governance. To make sense of these economic drivers and political choices it is necessary to have a view of the dynamics of the global economy in a period of anthropogenic global warming. The understanding which has framed the analysis in this paper recognises several different dynamics at play in the global economy; including the post-Fordist crisis of over-production and under-consumption on the one hand and the dynamic of Fordist growth in the relatively protected 'emerging economies'. In this context the neoliberal ideology of materialism, privatisation, 'free' trade and corporate impunity reflects the determination of the TCC to preserve its privileges even while trashing the environment and widening inequality.

Against this background the continued freeze on ACs, the tight earmarking of VCs, the periodic discipline of withholding ACs and the pressure on WHO to adopt the multi-stakeholder partnership as its preferred model for program design all make perfect sense.

The substantive work of WHO in relation to health system development represents a real threat to the privatisation agenda. The substantive vision of creating the social conditions for population health and health equity represents a real threat to the unsustainable exploitation of farmers, workers, consumers and the human environment by transnational banks and corporations.

Decent health care and good living are deeply human aspirations and exercise a powerful pull for families, communities, public health professionals, and many government officials and politicians. Accordingly the defence of the neoliberal project must be cloaked in the rhetoric of health care and population health. Slogans such as 'universal health cover', 'development assistance' and public private 'partnerships' project a common agenda which is nevertheless still consistent with the program of the 1%.

The preceding analysis explains the position adopted by the US and like-minded states within and behind the scenes of the WHO but the analysis does not posit devious or Machiavellian subterfuge. The public health experts and foreign affairs officials who speak for the US do so from within a world view which accepts as natural and unchanging the global inequalities, the environmental degradation and the beneficence of private enterprise.

However, the wider neglect of WHO by the governments of the 'developing countries' is not so straightforward. While their delegates generally support progressive resolutions in the Assembly, relatively few speak clearly about the damage being done to WHO by the donor chokehold. We may speculate that this reflects in some degree the power of the neoliberal agenda, and Thatcher's TINA ('there is no alternative'). It may simply reflect the stronger

case for other claims on limited public revenues. It may reflect in part the weakness of health ministries, vis a vis finance ministries and the lack of a strong public constituency for global health.

The struggle over the effectiveness and accountability of WHO remains critical to the project of equitable health development

The struggle to improve the capacity, effectiveness and accountability of WHO (including through the current 'reform' debates) remains critical to the project of equitable health development, particularly, in particular in the context of neoliberal globalisation.

Notwithstanding its limited financial resources WHO is a unique producer of global public goods (norms and guidelines, technical assistance, policy analysis, and surveillance and emergency response). It is a significant forum within which important decisions are made and through which important programs are implemented which have a significant impact on the possibilities for equitable health development. It has a constitutional mandate to negotiate treaties and to issue binding regulations to protect global health.

WHO decision making and program implementation will always be subject to vested interest advocacy exemplified at the present time by the pressures around the regulation of medical products, the delinking of drug development from the patent monopoly, threats regarding WHO's advice regarding trade agreements and health and the dance of diplomacy around the regulation of junk food. Even where WHO is just a bystander it provides a window into health development issues within the wider global governance context (eg farming, hazardous waste, 'development assistance for health').

It is because of the potential power of WHO around these kinds of questions that it is being deliberately shackled by donor control.

While it does have design flaws and dysfunctions, in particular, associated with its highly decentralised structure, it is not a lost cause and the costs of allowing it to be eviscerated would be huge. Any replacement body would face all of the same pressures which now bear down on WHO without any guarantee that the strengths of WHO, such as they are, would be reproduced in such an agency body.

Need for a global mobilisation directed to democratising global health governance

Real reform of WHO, to empower it to realise the vision of its Constitution, will require a global mobilization, not just around WHO but around the democratization of global health governance generally; not separate from, but part of, a global mobilization for a convivial, equitable and sustainable world.

The corporation, empire and class model of global power points towards the huge transformation which would be possible if there was some coming together of the dispersed and divergent working, middle and marginalised classes around the world: richer communications and sharing; stronger sense of shared identity and solidarity.

The network model of governance highlights how power is mobilised through nodes and links and how new or changed relationships can alter the distribution of power. This is the logic of the social movement approach to political change.

The dynamics of legitimation – delegitimation, relegitimation – highlight the degree to which political domination depends on a perception of legitimacy. The massive growth in funding for disease focused global health initiatives from the turn of the century was in part a response to the growing opposition to, delegitimation of, the TRIPS regime and the associated denial of treatment for people living with AIDS/HIV.

It is apparent that progress towards global health equity will require a global mobilisation directed to empowering WHO as part of democratising GHG more generally. This will include closer civil society engagement with WHO processes at local, national, regional and global levels, directed to making national governments more accountable for the various roles they play in global health governance and specifically in WHO decision making and the implementation of WHO resolutions. Closer civil society engagement with WHO will find and create opportunities to develop a broader community understanding of the links between local health problems and global decision making and to build practical people-to-people solidarity around public health issues.

References

Adams, B. and J. Martens (2015). Fit for whose purpose? Private funding and corporate influence in the United Nations. New York and Bonn, Global Policy Watch. from https://www.globalpolicy.org/images/pdfs/GPFEurope/Fit_for_whose_purpose_-_final_final_draft_24-07-2015_US.pdf.

Bello, W. (2006). "The capitalist conjuncture: over-accumulation, financial crises, and the retreat from globalisation." Third World Quarterly **27**(8): 1345-1367.

Bond, A. (2003). "US funding of the United Nations: arrears payment as an index of multilateralism." Berkeley J Int'l Law **21**: 703.

Breman, A. and C. Shelton (2001). Structural Adjustment and Health: A literature review of the debate, its role-players and presented empirical evidence, CMH Working Paper Series (Paper No. WG6 : 6). Retrieved 11 Nov, 2014 from http://www.whoindia.org/LinkFiles/Commision_on_Macroeconomic_and_Health_06_06.pdf.

Burris, S., P. Drahos and C. Shearing (2005). "Nodal Governance." Australian Journal of Legal Philosophy **30**: 30-58.

Commission on Intellectual Property Rights Innovation and Public Health (2006). Public health, innovation and intellectual property rights. Geneva, WHO. from http://www.who.int/intellectualproperty/en/.

Cornia, G., R. Jolly and F. Stewart (1987). Adjustment with a human face : protecting the vulnerable and promoting growth. Oxford, Clarendon Press.

Drahos, P. (2002). Developing countries and international intellectual property standard-setting, UK Commission on Intellectual Property Rights. from http://www.anu.edu.au/fellows/pdrahos/articles/pdfs/2002devcountriesandipstandards.pdf.

Farley, J. (2008). Brock Chisholm, the World Health Organisation and the Cold War. Vancouver, Toronto, UBC Press.

Gleckman, H. (2012). Readers' guide: Global Redesign Initiative An overview of WEF's perspective. from http://wphna.org/wp-content/uploads/2015/11/2012-Global-Redesign-Initiative-Readers-Guide.pdf.

Gregoratti, C. (2011). The United Nations Global Compact and development. Business regulation and non-state actors: Whose standards? Whose development? P. Utting, D. Reed and A. M. Reed. New York, NY, Routledge: 95-108.

Harvey, D. (2005). A brief history of neoliberalism. Oxford, Oxford University Press.

Health Poverty Action, Jubilee Debt Campaign, World Development Movement, African Forum and Network on Debt and Development (AFRODAD), Friends of the Earth Africa, Tax Justice Network, People's Health Movement Kenya Zimbabwe and UK, War on Want, Community Working Group on Health Zimbabwe, Medact, Healthworkers4All Coalition, groundWork, Friends of the Earth South Africa and JA!Justica Ambiental/Friends of the Earth Mozambique (2014). Honest accounts? The true story of Africa's billion dollar losses. Retrieved 11 Nov 2014 from http://www.healthpovertyaction.org/wp-content/uploads/downloads/2014/07/Honest-Accounts-report-v4-web.pdf.

Hettne, B. and B. Odén, Eds. (2002). Global Governance in the 21st Century: Alternative Perspectives on World Order. Studia Latina Stockholmiensia No. 48. Stockholm, Almqvist & Wiksell International.

Heywood, M. (2009). "South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health." J Human Rights Practice **1**(1): 14-36.

IP-Watch. (2012, 21 April 2012). "Kenyan High Court's Overturning Of Anti-Counterfeit Law Hailed." Retrieved 24 August, 2013, from http://www.ip-watch.org/2012/04/21/kenyan-high-courts-overturning-of-anti-counterfeit-law-hailed/.

Joint Inspection Unit (1993). Decentralization of organizations within the United Nations system: Part III: The World Health Organization (JIU/REP/93/2). Geneva, UN. from https://www.unjiu.org/en/reports-notes/JIU%20Products/JIU_REP_1993_2_ENGLISH.pdf.

Jubilee 2000 Coalition. (1999). "IMF takes $1 billion in two years from Africa as official report reveals five new reasons to drop the debt." Retrieved 5 March, 2013, from http://archives.econ.utah.edu/archives/pen-l/1999m04/msg00561.html.

Kotz, D. M. (2008). "Contradictions of economic growth in the neoliberal era: Accumulation and crisis in the contemporary U.S. economy." Review of Radical Political Economics **40**(2): 174-188.

Labonté, R. and D. Stuckler (2015). "The rise of neoliberalism: how bad economics imperils health and what to do about it." J Epidemiol Community Health **0**: 1-7.

Legge, D. G. (2013). Trade and Health: An Enquiry into the Role of the World Health Organisation in promoting Policy Coherence across the fields of Trade and Health and in particular, the Origins, Implementation and Effectiveness of World Health Assembly Resolution 59.26 on International Trade and Health. Oslo, Lancet & University of Oslo Commission on Global Governance for Health. Retrieved March 6, 2014 from https://www.med.uio.no/helsam/english/research/global-governance-health/background-papers/who-trade.pdf.

Legge, D. G., D. H. Gleeson, H. Lofgren and B. Townsend (2014). "Australia's position on medicines policy in international forums: Intellectual property protection and public health " Journal of Australian Political Economy(73): 103-131.

Lerer, L. and R. Matzopoulos (2001). ""The worst of both worlds": the management reform of the World Health Organization." International Journal of Health Services **31**(2): 415-438.

Litsios, S. (2002). "The long and difficult road to Alma-Ata: a personal reflection." International Journal of Health Services **32**(4): 709-732.

Litsios, S. (2004). "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach." American Journal of Public Health **94**(11): 1884-1893.

Mandel, S. (2008). Debt relief as if justice mattered. London, New Economics Foundation. from http://www.jubileeresearch.org/news/debt%20relief%20as%20if%20justice%20mattered.pdf.

Martens, J. (2014). Corporate Influence on the Business and Human Rights Agenda of the United Nations, Working papers, Misereor, GPF, Brot fur die welt. from http://www.globalpolicy.org/images/pdfs/GPFEurope/Corporate_Influence_on_the_Business_and_Human_Rights_Agenda.pdf.

McGrady, B. (2012). Confronting the tobacco epidemic in a new era of trade and investment liberalization. Geneva, WHO.

Ndikumana, L. and J. K. Boyce (2011). Africa's odious debts: how foreign loans and capital flight bled a continent. London Zed Books (in association with International African Institute, Royal African Society and Social Science Research Council).

O'Brien, R., A. M. Goetz, J. A. Scholte and M. Williams (2000). Contesting Global Governance: Multilateral Economic Institutions and Global Social Movements. Cambridge, NY, Melbourne, Madrid, Cape Town, Cambridge University Press.

OECD. (2016). "The high level fora on aid effectiveness: a history." Retrieved 10 Oct, 2016, from http://www.oecd.org/dac/effectiveness/thehighlevelforaonaideffectivenessahistory.htm.

Olliaro, P. L., P. Horby and E. Torreele (2015). "Health security and rights in times of emerging health threats: towards a new way of doing essential health research and development." Lancet **385**(9980): 1892-1893.

Ottersen, P., J. Frenk and R. Horton (2011). "The Lancet–University of Oslo Commission on Global Governance for Health, in collaboration with the Harvard Global Health Institute." Lancet **378**.

Patterson, R. (2013). "Transnational Capitalist Class: What's Race Got to Do With It? Everything!" Globalizations **10**(5): 673-690.

People's Health Movement. (2014). "Ebola epidemic exposes the pathology of the global economic and political system." Retrieved 9 November, 2014, from http://www.phmovement.org/sites/www.phmovement.org/files/phm_ebola_23_09_2014final_0.pdf.

PricewaterhouseCoopers (2013). WHO reform Stage 2 evaluation: final report. Geneva, WHO. from http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_39-en.pdf.

Public Interest Civil Society Organizations (2014). Vision statement on nutrition. Rome, FAO and WHO. from http://www.fao.org/fileadmin/user_upload/faoweb/ICN2/documents/CSO_Vision_Statement_-_Final.pdf.

Rhodes, M. L., J. Murphy, J. Muir and J. A. Murray (2011). Public Management and Complexity Theory: Richer Decision-making in Public Services. Oxon, Routledge.

Rhodes, R. A. W. (1996). "The new governance: governing without government." Political Studies **44**: 652-667.

Rhodes, R. A. W. (1997). Understanding governance: policy networks, governance, reflexivity and accountability. Bristol Pa, Open University Press.

Richter, J. (2002). Codes in Context: TNC Regulation in an Era of Dialogues and Partnerships, Corner House Briefing 26. from http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/26codes.pdf.

Robinson, W. I. (2004). A Theory of Global Capitalism: Production, Class, and State in a Transnational World. Baltimore, MD, Johns Hopkins University Press.

Robinson, W. I. (2012). "Global Capitalism Theory and the Emergence of Transnational Elites." Critical Sociology **38**(3): 349-363.

Rowden, R. (2014). "West Africa's financial immune deficiency." Foreign Policy.

Sehm Patomäki, K. (2011). "Towards Global Equity: Disentangling Odious Debt from Sovereign Economic Insolvency." Global Society **25**(4): 491-512.

Shashikant, S. (2010). "The IMPACT counterfeit taskforce, intellectual property rights enforcement and seizure of medicines." TWN Intellectual Property Rights Series Retrieved 13, from http://www.twn.my/title2/IPR/pdf/ipr13.pdf.

Silberschmidt, G., D. Matheson and I. Kickbusch (2008). "Creating a committee C of the World Health Assembly." The Lancet **371**(9623): 1483-1486.

Sklair, L. and J. Struna (2013). "The Icon Project: The Transnational Capitalist Class in Action." Globalizations **10**(5): 747-763.

Sneyd, A. (2005). New International Economic Order. Globalization and Autonomy Online Compendium. W. D. Coleman and N. Johnson.

Struna, J. (2013). "Global Capitalism and Transnational Class Formation." Globalizations **10**(5): 651-657.

United Nations Global Impact. (2016). "UN Global Impact." Retrieved 25 Sept, 2016, from https://www.unglobalcompact.org/.

Valente, F. L. S. (2015). The Corporate Capture of Food and Nutrition Governance: A Threat to Human Rights

and Peoples' Sovereignty. Peoples' nutrition is not a business. R. t. F. a. N. Watch: 15-23.

Wallerstein, I. (2004). World-systems analysis : an introduction. Durham, Duke University Press.

WHA (2006). WHA Resolution on International Trade and Health (WHA59.26). Geneva, World Health Organization. Retrieved 1 July 2012 from http://apps.who.int/gb/ebwha/pdf_files/WHA59-REC1/e/Resolutions-en.pdf.

WHO (2014). Guide for the formulation of a WHO country cooperation strategy (WHO/CCU/15.02). Geneva, WHO. from http://apps.who.int/iris/bitstream/10665/181038/1/ccs_guide_2014.pdf?ua=1&ua=1&ua=1.

WHO and UNICEF (1978). Alma-Ata 1978. Primary Health Care. Geneva, World Health Organisation. Retrieved 29 March 2010 from http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

WHO Watch. (2014). "Psoriasis." Retrieved 6 March, 2014, from http://www.ghwatch.org/who-watch/topics/psoriasis.

World Economic Forum (2010). Everybody's business: Strengthening international cooperation in a more interdependent world. Report of the Global Redesign Initiative. from http://www3.weforum.org/docs/WEF_GRI_EverybodysBusiness_Report_2010.pdf.

World Health Organization (1958). The first ten years of the World Health Organization. Geneva, WHO.