

Save WHO!

Background to Current WHO Reform Initiatives and Possible Advocacy Messages

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Introduction

WHO is in crisis. It is in debt and its agenda is increasingly dictated by donors rather than member states. The Director General has initiated a reform process which will come to a head in November 2011. There are powerful pressures at work which are directed to restricting WHO to a purely technical role and towards closer relationships ('partnerships') with private corporations and private foundations (in particular the Gates Foundation).

This paper is designed to provide a background to the WHO Reform process and a starting point for consideration of possible advocacy messages.

Background to the WHO Reform Initiative

The issue of WHO Reform was opened for official discussion at the May 2009 World Health Assembly (WHA) when the focus of concern was WHO's increasing dependence on earmarked funds from donor countries and foundations. Since then the range of issues at stake has been widened to encompass a broad approach to WHO reform. Further decisions were taken in Geneva in May 2011 with a commitment to further consultation and decision making over the next twelve months.

A broad background to the reform plans can be found on the [DG's pages on the WHO website](#). Following the May 2011 World Health Assembly the WHO Secretariat has produced three concept papers on:

- [WHO Governance](#);
- A proposed [Independent Evaluation](#) (focusing on health systems strengthening); and
- A proposal for a new structure, a [World Health Forum](#) (as outlined in [Resolution WHA64.2](#)).

The first draft concept papers do not say very much but they are currently under consultation and presumably will be bulked up through this process. The concept papers plus the [WHO background page](#) are essential reading. They are currently subject of member state consultation

in the lead up to a dedicated meeting in Geneva in November. The consultation has involved a web platform (restricted to member state representatives); a briefing in Geneva and discussions at the six regional committees scheduled to meet from August through to October. Finally the reforms will be discussed at a special meeting of member states in November. Following this November meeting a set of reform proposals will be prepared for consideration by the Executive Board at its meeting in January 2012 and for final decision at the World Health Assembly in May 2012. In addition to the formal discussions there has been intense informal discussion at various venues, including the NCDs meeting in New York in September and the conference on SDH in Rio in October.

Further comment on the Reform Initiative can be found indexed on the pages of the [WHO Watch website](#), see in particular, [WHO Reform](#).

A note on global health governance

The wider context of this discussion of WHO Reform is the prevailing configuration of institutions and power around global health governance generally. The position that people adopt in relation to WHO Reform are closely related to their views regarding the wider debates around global health governance.

The field of GHG has been the subject of extensive commentary from a range of different perspectives. In many such commentaries the field is taken as bounded by identified global institutions such as the WHO and the Global Fund. Some commentaries take a wider view and include the big power dimension. The following account takes a broader political economic view.

The present global health crisis has many faces: food insecurity, preventable child and maternal deaths, price barriers to accessing medicines, collapsing health systems. It is clear that there are more than enough resources on the planet to provide for 'health for all' but the necessary resources flow instead to overconsumption, military expenditure and obscene wealth for a small elite. How is this situation stabilised and reproduced?

Resources could be made available for resolving the global health crisis. The fact that they are not so deployed is a consequence of the prevailing governance structures. Public health advocates need to understand the structures and dynamics of global governance, including the global governance of health, in order to direct their efforts most strategically. Global health governance (GHG) encompasses the social determinants of health and health system development both of which are increasingly driven by policy paradigms, donor practices and corporate power which are themselves part of neoliberal globalisation.

There is no simple way of representing the structures of global governance. It is necessary to look at it from a range of different but overlapping perspectives: nation states, intergovernmental institutions,

the corporate sector, the market place, civil society and social movements and knowledge, information and ideology. The dynamics of global governance involve the purposes, world views, strategies and engagements of the different parties over particular issues and general directions.

It is useful (although not sufficient) to recognise global governance as the interplay of nation states, including the US as the global superpower, the G8 as the leading group of rich countries, the BRIC countries as the 'newly emerging economies' and so on. The nation state perspective highlights the projection of national power through military and other means. The role of US trade law (Super 301) and the US trade representative (USTR) in pressuring small countries to adopt restrictive intellectual property (IP) policies provides a case where this perspective is particularly useful.

We must recognise also the formal institutions of global governance and regulation: organisations such as the UN, the WHO, the World Bank and the IMF; laws and agreements such as the Universal Declaration on Human Rights or the 23 enforceable trade agreements administered through the WTO. The role of the WTO's Agreement on Agriculture in sanctioning dumping of subsidised foods into low and middle income country (L&MIC) markets, destroying small farmers' livelihoods provides a case which illustrates the usefulness of this perspective. Behind the World Bank and the IMF are the big powers, particularly the USA and Europe and behind them are the US and European transnationals who expect 'their' governments to do their bidding. Behind the WTO are the nation states (and their farmers) and transnational agribusiness corporations which have the power to impose an unfair and unbalanced agricultural trade regime.

Also within this group of intergovernmental structures are the various global public private partnerships (GPPs) which disburse aid and advice, mainly to poor countries. These include the Global Fund for AIDS, TB and Malaria (GFATM), Global Alliance for Vaccines and Immunisation (GAVI) and over 100 others. Many of these are hybrid structures including private foundations (such as the Bill and Melinda Gates Foundation) and intergovernmental organisations such as the World Bank. The role of the GPPs varies according to the play. In terms of the immediate needs of sick people and poor countries, the funds mobilised are life-saving. In the context of the politics of intergovernmental organisations, the separation of these GPPs from WHO reflects the ongoing project of the rich countries to contain the influence and reach of WHO; the one country one vote constitution is seen as giving too loud a voice to poor countries. From a more critical perspective, the role of the GPPs is to shore up the legitimacy of the regime of global governance which reproduces inequality, exclusion and marginalisation.

We need to recognise also the corporate sector, in particular the transnational corporations (TNCs) and their various peak bodies and their

links with nation state sponsors. In particular we recognise the power of the financial corporations which are 'too big to fail'; the pharmaceutical giants and others who shape US trade policy; and the global food corporations who destroy indigenous food systems and force junk foods onto global markets. The freedom of the TNCs and their lack of accountability is a consequence of their nation state sponsors ensuring that the global regulatory environment is TNC friendly. The levers which harness the nation state in the interests of the transnationals also need to be explored. In some circumstances this is electoral leverage (eg the influence of the US auto industry on Capitol Hill); sometimes it involves the purchase of influence (eg campaign contributions by big insurance in the US to prevent health care reform and by big oil to prevent action on global warming); and sometimes reflects a confluence of interests between the corporation and its nation state host (eg highly protected intellectual property enables big pharma to inflate profits through monopoly pricing and helps to maintain US export revenues and reduce the trade deficit).

The market place is one of the key structures of global health governance; separately from the power of the big corporations. The parameters of a myriad of market places shape the processes of innovation through investment choices and shape what is offered for sale (or not offered for sale) through production costs, prices and consumer demand. This is well illustrated in current debates about the need for a carbon tax so as to encourage innovation in green energy. The 'invisible hand' must be recognised as one of the core structures of GHG even if we are unconvinced regarding its eternal benevolence. However, markets operate within regulatory frameworks which are erected through national governments and intergovernmental structures. The environment within which the invisible hand operates is created through deliberate policy. For example corporations may be able to externalise certain costs, to the environment (eg coal fired power generators), to government (eg clean up costs of nuclear accidents) or to their workers (illicit coal mines in China) and continue to profit from damaging processes and products. While individual companies may lobby to be exempt from regulation, equally important are the wider ideological pressures associated with neoliberalism for deregulation, small government and the continuing denial of any limits to growth.

We need to recognise also the fields of information, knowledge and ideology as an important domain of global governance. The structures of this domain (including universities, think tanks, publishers and media barons) shape who shall access what information; who shall create or access knowledge and how we shall understand the world we live in. A simple example of the power of ideology would be the role of the financial press in shaping how we understand the global economy and in determining what analyses of the global economy shall be privileged and which shall be discounted. The control of information is equally powerful; illustrated by the quality of information released by WikiLeaks, which would otherwise have been kept secret.

Finally we need to recognise civil society as a key domain of global governance. This domain includes various familiar civil society institutions such as churches and unions, political parties, sporting and cultural bodies and advocacy organisations. It includes professional associations such as PHAA; peak bodies such as the WFPHA as well as the international association of food and beverage producers. These are important players in the network of governance both at the national and at the global levels, even though they do not have their hands directly on the levers of state or corporate power.

Within this domain of 'civil society' we need also to recognise the fluctuating alliances and tensions within and across the many diverse 'communities of shared identity' both within countries and internationally (variously analysed in terms of nationality, class, race, gender, income, ethnicity, sexuality, religion, etc). There are many cases which illustrate the usefulness of this perspective: the impact of racism on health and the structural factors which reproduce racism; impact of gender inequality on health and the structural factors which reproduced gender inequality. One of the important dynamics in this analysis is the emergence of a global middle class with a shared interest in consumer goods and the good life and negotiable loyalties to poorer people in their own and other countries. The power of this global middle class identity may be illustrated by the support among the middle classes of low and middle income countries such as India for tariff reductions so that imported consumer goods might be cheaper. The 'free trade' bandwagon would not have made the progress it has without this shared perspective across the global middle class. Unfortunately the sense of shared identity among farmers or workers in different countries is sometimes much looser.

The dynamics of global health governance

This listing of the structural domains of GHG only takes us so far. We also need to understand how they interact to reproduce the prevailing regime and how the health crisis inheres in this regime. We can approach this question through an exploration of particular episodes, such as the 'access to medicines' case.

With the advent of highly active anti-retroviral drugs (ARVs) in the mid 1990s the plight of people living with AIDS became politically critical because the disease had become treatable. However, at a time when big pharma was selling a year of treatment for \$US10,000, the Indian generic manufacturer Cipla was able to supply a year of treatment to Medicins Sans Frontieres (MSF) for \$350. When the South African government sought to procure ARVs through parallel importation (buying them in the open market in countries where the prices were lower than in South Africa) big pharma, supported by the US (under Clinton), took the South African Government to court. After three years of mounting civil society protest in South Africa, in the US and in many other countries, the US and big pharma withdrew their suit in May 2001 (and paid costs). Later that year

the members of the WTO affirmed that trade rules should not be an impediment to public health.

The perceived legitimacy of the TRIPS regime (the WTO's Trade Related Intellectual Property Agreement) was damaged by this episode and the US project of further tightening of global IP laws suffered a significant setback. The setback was only temporary. The Global Fund for AIDS, TB and Malaria (from 2003) and the US Presidents' Emergency Fund for AIDS Relief (PEPFAR, from 2005) stepped into the breach with massive funding to ensure wider access to ARVs (deploying a charitable solution rather than promoting market access at reasonable prices based on a reformed IP regime).

The macroeconomic context of this episode deserves closer attention. With the move of manufacturing from the high wage economies to 'emerging' economies, the 'post industrial' economies of the North America, Europe and Japan have become increasingly dependent on the export of products with a high IP rent (including monopoly pricing and monopoly profits as well as explicit payment of royalties and license fees). The US economy has come to depend, more than any other country, on rent from intellectual 'property' through royalties, license fees associated with pharmaceuticals, seeds, software, music and film, consumer goods and arms. In 2007 the surplus earnings from royalties and license fees (exports - imports) comprised \$57 billion without which the US trade deficit would have been 7.5% greater. The USA earns three times as much in royalties and license fees (exports) as it spends (imports). The closest IP net exporter is Japan which earns 40% more than it spends.

To maintain national income from the export of products with a high IP rent two policy objectives have been critical: first, to establish and entrench a global IP regime with the lax patentability standards of the US but the rigorous policing of the WTO and the USTR; and second, to access the middle class markets of the 'emerging' economies. Creating a global IP regime with lax patentability but rigorous policing has been progressed advanced through the TRIPS Agreement and the TRIPS plus provisions in bilateral and regional trade agreements combined with big power bullying, most notoriously through the USTR working in close alliance with big pharma. Opening L&MIC markets has been progressed through the continued promotion of the ideology of neoliberalism (universities, media, think tanks, etc); through the brutality of IMF conditionality; and through the sanctions associated with the dispute settlement procedures of the WTO.

The neoliberal IP agenda suffered a public relations setback with the revelations in the late 1990s that big pharma was happy to deny access to treatment to millions of people living with AIDS/HIV in order to maintain profit flows and that their national sponsors, the US in particular, were fully in support. In early 2001 WHO hosted a workshop (including the World Bank and big pharma) on access to medicines which recognised the problem and recommended the charity solution. In fact the sentiment at

the Doha Ministerial Council later that year was much more sympathetic to a regulatory solution and decided in principle to reform the TRIPS Agreement to enable compulsory licensing for export. However, in succeeding years, the US was able to stonewall such reforms and the charity solution, involving the Global Fund, the Gates Foundation and PEPFAR, was geared up sufficiently to take the pressure off the regulatory reform path.

This exploration of the medicines and IP case provides insight into how the structures of global governance work and how global *health* governance is embedded in the wider structures of political and economic governance. The story shows how the interests of big powers, their elites and corporations drive particular policies, create particular institutions and promote particular ways of seeing the world. The story also shows how such policies and truths can be resisted and alternatives promoted through particular combinations of nation state diplomacy, civil society sentiment and social movement activism (such as the AIDS movement in this case). The role of knowledge, information and ideology should be highlighted in reflecting on this case study: knowledge as the basis for IP; the role of information illustrated by the role of civil society websites in the struggle over access to medicines; and ideology illustrated by the forces promoting neoliberalism as the truth about the global economy. Further insights into the dynamics of global governance and how global health governance is embedded in these dynamics would be obtained from similar explorations of the global food crisis or the global financial crisis.

The structures, norms and dynamics of international assistance for health warrants a similar analysis as a case study of the workings of the prevailing regime of GHG. Such a presentation would explore:

- the ways in which 'national interest' shapes donor policies; eg the 'gag rule' under GWBush; the refusal of PEPFAR to procure generics;
- the links between the corporate interest of Microsoft (lax patents and tight policing) are served by Gates Foundation support for the charitable solution to access to medicines (as opposed to IP reform);
- the fragmenting effects on health systems of narrow disease-focused assistance programs;
- the transaction costs of multiple donors in poor countries and the the lack of accountability of donors in terms of realising the principles of the Paris Declaration;
- the variable effectiveness of technical assistance projects including expenditures which are repatriated through salaries, travel and accommodation of expatriate technicians and sourcing of supplies and equipment;
- the role of international assistance in obscuring the structured imbalances and unfairnesses in the way the global economy works and maintains poverty and inequality.

So do we need WHO?

It is evident that any assessment of the 'proper role' of WHO will be shaped by judgements about how well the wider GHG regime is working including international assistance for health (both multilateral and bilateral assistance; both financial and technical assistance).

The above analysis points towards the need for a strong (adequately funded), efficient and independent WHO properly accountable to its member states which can fearlessly promote policies, programs and practices at the global, regional, national and local levels which strengthen health systems and address the social (including political and economic) determinants of health; and hold the various donors accountable for the integrity and coordination of their 'development assistance' programs.

WHO's Medium Term Strategic Plan identifies the core functions of WHO as follows. These core functions are expected to guide the work of the Secretariat at global, regional and country levels.

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed ;
- shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge ;
- setting norms and standards, and promoting and monitoring their implementation ;
- articulating ethical and evidence-based policy options ;
- providing technical support, catalysing change and building sustainable institutional capacity ; and
- monitoring the health situation and assessing health trends.

These 'core functions' provide a useful framework for reflecting first on how well WHO performs, at country, regional and global levels. It seems self-evident that some of the regional directorates and many of the country offices fall somewhat short against these aspirations.

However, these core functions also provide scope for very flexible interpretation: what are 'matters critical to health'; when is 'joint action' needed and who should be the 'partners'; what kind of 'change' needs to be 'catalysed'; what kinds of 'trends' shall be monitored?

The flexibility of these 'core functions' explains why so many grass roots health activists continue to return to the [Declaration of Alma-Ata](#) as a vision document which could/should be guiding the work of WHO. The Declaration of Alma-Ata offers a much clearer analysis of the structural determinants of health at the global level (with its reference to a new international economic order) and articulates clearly principles such as community involvement and intersectoral policy collaboration ('health in all policies'). If there are any strategic insights evident in the present leadership of WHO they are more about institutional survival than global health.

Key issues facing WHO and possible directions for advocacy

Some of the key issues facing WHO are discussed in the rest of this paper. The analysis and suggestions reflect my (David Legge) personal perspective. They are submitted here as a possible starting point for further discussion.

Increase assessed contributions and untied donations

The dominance of highly conditional earmarked donations to WHO is seriously damaging the organisation: distorting organizational priorities; fragmenting organizational coherence and carrying high transaction costs.

Operating revenue for 2008-09 was \$3,759 m, down from \$4,050m in 2006-07.

Operating revenue	2008-09		2006-07	
	\$m	%	\$m	%
Member state assessed contributions	940	25	889	22
Voluntary contributions	2,745	73	2,932	72
Other	74	2	229	6
Total	3,759	100	4,050	100

Table 1. WHO operating revenue 2006-09. From [Financial report and audited financial statements for the period 1 January 2008–31 December 2009](#).

Obligatory (assessed) contributions provide 25% of program revenue, up slightly from 2006-07. Voluntary contributions constitute 74% (72% in 2006-07).

Member States are the largest source of [voluntary contributions](#), contributing 52% of the total non-assessed (voluntary) budget. Income from the United Nations and intergovernmental organizations was 17%, through funding for joint programmes. Foundations (21%), nongovernmental organizations and other institutions (5%), and private sector (5%) donations accounted for the remaining voluntary contributions.

WHO categorises voluntary contributions into:

1. Voluntary contributions - core
 - a. fully or highly flexible (directed to supporting the Program Budget as a whole)
 - b. designated or medium flexible (directed to supporting specific purposes within the Program Budget); and
2. Voluntary contributions - specified (earmarked and in some cases subject to further conditions)

Voluntary contributions	2010		2008-09	
	\$m	%	\$m	%
Core (highly flexible)	116	7	160	6
Core (medium flexible)	7	0	151	6
Specified (not flexible)	1,348	86	2,170	83
Other	94	6	147	6
Total	1,565	100	2,628	100

Table 2. Breakdown of voluntary contributions. From [WHA64/A64_29Add1](#)

Countries which give more as Core than they give as Specified include: Belgium, Denmark, Ireland, Luxemburg, Spain, Switzerland and Hong Kong (China). Almost all of the non-member state contributions are specified. Bill and Melinda Gates (\$213m in 2010) is the second largest individual donor (after the USA - \$274m in 2010); in both cases specified contributions.

Possible directions for advocacy

Urge member states to support an absolute increase in assessed contributions for the biennium 2014-15 perhaps to 150% of the current level of assessed contributions.

Urge member states currently providing earmarked and conditional funding to WHO to convert these funding streams to untied donations to be spent in accordance with the priorities determined by the governing bodies.

Urge member states to work towards a revenue base for WHO in which assessed contributions and untied donations comprise at least 50% of total budget by 2015-16 and 70% by 2017-18.

Urge member states to discourage the DG from seeking to solve WHO's financial difficulties by making deals with private foundations which stand likely to compromise the integrity of the Organisation.

Guidelines regarding conflict of interest

The possibility of conflicts of interests affecting expert advisors has been recognised within the Secretariat for many years. However, of equal importance is the possibility of conflicts of interest arising in WHO's relationships with various corporate entities. This is particularly relevant in view of the amount of funding WHO receives in voluntary donations. The risks of conflicts of interest here are self-evident but it appears that WHO does not have protocols in place to identify and manage such conflicts of interest.

The recent [Expert Review of the International Health Regulations](#) concluded that WHO lacks ' a sufficiently robust, systematic and open set of procedures for disclosing, recognising and managing conflicts of interest among expert advisors'.

In a [statement read to the 64th WHA](#) an *ad hoc* coalition of NGOs called for more rigorous management of conflicts of interest arising in global immunisation governance. Of comparable concern is the involvement of the food and beverage industry in WHO consideration of, and action, on non-communicable diseases.

Possible directions for advocacy

Urge member states to develop a Charter of Integrity that would include guidelines for identifying and managing conflicts of interest associated with both individual and institutional relationships.

Personnel practices within Secretariat

The domination of earmarked funding has played havoc with the objective of having a coherent human resource regime across the Secretariat (although this is not the only distorting influence). A significant number of staff are appointed initially as fixed term appointments on earmarked funding but then convert to continuing status once they achieve 10 years employment. From hereon their continued employment and retirement benefits (or retrenchment costs) are the responsibility of the Organisation. These staff do not necessarily carry the skills, knowledges and attributes most urgently needed to progress the Organisation's priorities.

Programmes which are largely based in Headquarters and funded through earmarked funding recruit from the circulating pool of talent which is likely to be strongly biased in favour of the rich countries, US and Europe in particular. Career progression through regional offices needs to be supported through systematic support to relevant public health training in the under-served regions.

Possible directions for advocacy

We could urge member states to pursue the reform of personnel practices and conditions of employment. There is an urgent need for a staffing model which corresponds better to the operational requirements of WHO, including the need to adapt flexibly and intelligently to changing circumstances.

We might propose that fixed term appointment should be the main mode of employment. Short term employment should be restricted to quite limited purposes including internships and the management of short periods of unusually heavy workload. Short term employment should not be used as a form of probation. Continuing staff status should be restricted to functions which require continuity and corporate memory; it should not be the reward for 'lasting the distance'.

WHO and the field of public health globally benefit greatly from the movement of personnel from national employment to WHO and back. The staffing model in the Secretariat should support such movement. In many situations specialist expertise can be mobilised through secondments, adjunct appointments and expert working groups. WHO does not need to have resident specialist expertise in every sub-discipline of public health.

The geographical profile of Secretariat staffing is important to ensure a broad range of perspectives and backgrounds corresponding to the global mandate of the Organisation. However, rich countries generally have proportionately more training places and public health / international health practitioners. This points to the need for regional support for public health training in the developing world, in particular in Africa, the Eastern Mediterranean and Asia. We could urge member states who do not have a wealth of training opportunities to encourage regional directors to mobilise support for a full range of training opportunities; both for national employment and inter-governmental work.

Organisational structures

Relations between the three levels of bureaucracy in the Secretariat

When WHO was originally constituted the regional offices were given a high degree of autonomy with the regional director elected by the regional member states. As a consequence the regions have considerable independence from the Geneva based headquarters.

Country representatives constitute the third level within the Secretariat. Country representatives are the critical conduit for WHO's country level work which in many respects is WHO's most important area of work. However, country representatives are appointed by and accountable to the Regional Director and are correspondingly distanced from the specialist units and clusters based in Geneva. The quality of country level work varies widely.

Administrative structure at headquarters

Under the reign of Dr Gro Harlem Brundtland the HQ organisation was decentralised giving the clusters wide policy autonomy, explicit obligations for funds mobilisation, significant autonomy with respect to financial controls and freedom with respect to public communication. This organisational structure was designed by an international management consulting company explicitly along private enterprise lines. Giving the clusters responsibility for mobilising their own funds based on private enterprise model was perceived to be the solution to the reluctance of powerful member states to increase assessed contributions.

This entrepreneurial model has been a disaster leading to rampant competition between clusters and departments for donor funding; weakening the coherence of the Organisation and limiting the capacity of the DG to project any leadership.

Possible directions for advocacy

Urge a formal exploration of the costs and strengths of the current organisational structures and options for structural reform. The core principle which should inform any such restructuring should be to strengthen the downwards accountability of WHO; including the accountability of the country representatives and the regional directorates to member states.

Urge member states to support an organisational restructure which would reduce the autonomy of the 'clusters' and strengthen the capacity of the DG to provide real leadership and to implement change.

Reform of WHO's monitoring and evaluation system

The current approach to 'results based management' (see [Medium Term Strategic Plan 2008-13 Introduction](#)) is mechanistic and ritualistic. It is far from clear that it is the best way of supporting learning and planning.

The key result areas ('organisation-wide expected results') which are identified in the [Medium Term Strategic Plan 2008-13 \(MTSP\)](#) discount the specific challenges facing different member states by using highly abstract generic terms to describe the results that WHO is seeking to achieve. While it is ostensibly based on a review of country co-operation experience this appears to get lost in the result areas and indicators.

Most of the indicators developed in the MTSP (see [Strategic Objectives 1-8](#) and [Strategic Objectives 9-13](#)) and cited in the [Program Budget Performance Assessment Report \(PBPAP\)](#) are silly; hard to measure, open to gaming and only marginally relevant to the results they are supposed to measure.

While the narrative accompanying the results, indicators and targets recognises the dynamics of change this perspective is not reflected in the results areas and indicators. The Secretariat needs to develop and adopt a more country focused approach to evaluation and monitoring and a more logical framework for assessing the achievement of key result areas.

These judgements are supported by the UK Department for International Development (DIFD) Multilateral Aid Review (MAR) which commented that WHO has no clear results chain; confuses processes with outputs; and does not have a formal system to follow up on evaluations. [About the MAR. Detail of DFID assessment of WHO.](#)

The DG has advanced a reform plan comprising three main initiatives: a World Health Forum, unspecified managerial reforms, and an evaluation of one cluster (or strategic objective) to be conducted by the transnational management consulting firm Deloitte. The logic of leading the process with this evaluation has not been explained. It appears to have been discussed with the Gates Foundation before bringing it to the WHA.

We see an urgent need to review the Organisation's approach to the monitoring and evaluation of its work. Such a review should include in its scope a review of the distortions created by earmarked funding and by the McKinsey recommendations of a decade ago which have proved so damaging to WHO. Such a review should start from the premise that what matters is what happens at country level.

Possible advocacy directions

Urge member states to require a thorough review and reform of the existing monitoring and evaluation system. Hiring a management

consultant to 'evaluate' the achievement of one strategic objectives does not meet this need.

Build closer links between the priorities reflected in the resolutions of the governing bodies and resource allocation within the Secretariat

There is presently a disconnect between the highly structured planning framework which has been developed by the Secretariat and the resolutions adopted by the governing bodies.

The allocation of resources within the Secretariat is shaped by the 11th Global Program of Work (2006-2015); the Medium Term Strategic Plan (2008-13) and the Biennial Program Budgets 2010-11, 2012-13. In a situation of tight resource constraints these budget allocations are not easily varied.

Not all governing body resolutions call for variations in the GPW, MTSP or PBs but some do suggest a rethinking of priorities. It is presently unclear how these different priority setting mechanisms should cohere. This problem is complicated by the requirement to raise funds from donors to support new initiatives.

We deplore suggestions that some restrictions might be placed on the right of member states to bring resolutions before the governing bodies. However, there is a problem here which needs to be worked through.

Possible Advocacy Messages

Urge member states to work towards greater coherence between the formal planning structures of WHO and the resolutions of the governing bodies. This could be achieved in some degree if member states proposing resolutions were to formulate them with more specific reference to the relevant commitments of the Global Program of Work, the Medium Term Strategic Plan and the Biennial Program Budget.

There should be no restriction on the right of member states to bring forward resolutions for debate and adoption. However, there maybe some benefits in formulating at least some resolutions with closer reference to GPW, MTSP and PB.

Focus on country level work

There is very little publicly available information from which to judge at the individual country level how effective WHO is in supporting health development. HQ website provides nothing. Regional and country offices vary widely in terms of the information they provide.

Insights into member state perceptions of WHO's performance can be drawn from two recent studies: first, [Document WHA64/6, the Medium Term Strategic Plan 2008-13, Interim Assessment](#), and second, [The DIFD Multilateral Aid Review, WHO Findings](#).

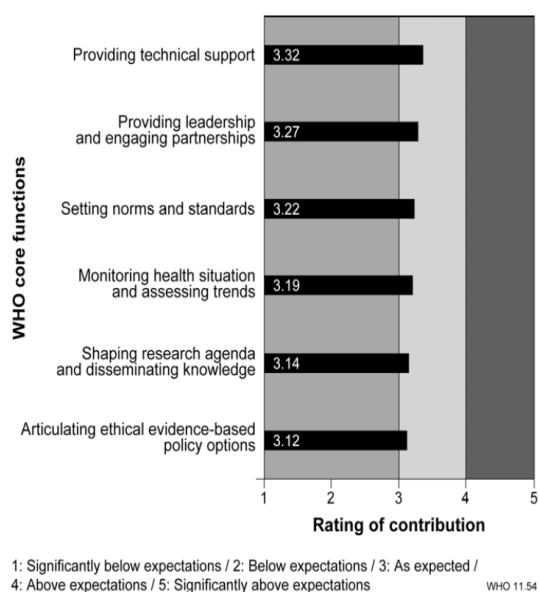
The Interim Assessment of the MTSP uses 'respondent expectations' as the benchmark for evaluating WHO performance at the country level.

Without knowing more about respondents' expectations it is difficult to know how to read such a report. Consider the following para from the Interim Assessment.

For each strategic objective, Member States were asked about the adequacy of WHO's contributions with regard to the six core functions articulated in the Eleventh General Programme of Work. They were asked "How would you rate the adequacy of the contribution of WHO in support of this strategic objective since 2008?" Replies ranged from below or significantly below expectations, through as expected, to above or significantly above expectations. Overall, and across strategic objectives, WHO's contribution is meeting Member States' expectations, with 92% of respondents assessing WHO's contributions as meeting or above expectations and 8% as below expectations.

Figure 6 (copied below) provides additional details by core function. These are not inspirational responses. All this tells us is that most respondents were familiar with WHO's work. Member state perceptions of WHO's performance do not provide a rigorous evaluation of how effective the Organisation is with respect to the unique challenges each country faces.

Figure 6. Adequacy of WHO's contribution in support of the strategic objectives



The DFID Multilateral Aid Review also surveyed countries in their evaluation of WHO. Among other conclusions they concluded that:

- WHO's ability to deliver strategic results at a country level, as assessed by both itself and through country visits is variable. We could find no evidence that WHO benchmarks itself against similar organisations.
- WHO does not publish sufficient detail about its projects and programs.

WHO has shown great sensitivity in NOT publishing material which might reflect poorly on individual countries or governments. However, it is at the country level where WHO's programs and operations either do or do not contribute to improved population health. This failure of transparency at the country level is a major weakness. We anticipate that greater interest from civil society, nationally and internationally, may help to encourage greater accountability and transparency.

The proliferation of vertical disease programs since the late 1990s has exacerbated the fragmentation of health related foreign aid. This carries high transaction costs and leads to perverse outcomes at the country level. This is a new challenge to health development. Clearly the definitive answer would be to reduce the number of narrow vertical donors but in the meantime there is an urgent need for the existing donors to be held to account for their aid practices in terms of health development. WHO should be in a prime position to take on this responsibility, focusing on country level coordination and outcomes.

Possible advocacy messages

Urge member states to require of the Secretariat an increased focus on country level work and greater transparency regarding achievements and shortfalls in this field.

Urge member states and the Secretariat to strive for greater coherence between on-the-ground realities in countries and the work of regional offices and headquarters. The principle needs to be affirmed that regional and global programs are oriented around the needs of countries and in a sense accountable downwards to country offices for the support they provide to country priorities.

Review the process of appointing country representatives.

Urge WHO to play a greater role in holding donors accountable for their performance in providing health related financial assistance to individual countries.

Proposed World Health Forum

The WHF proposal was launched by the DG; it did not arise from any deliberations of governing bodies of the Organisation. It appears to be a modification of the proposed Committee C which was initially proposed as a mechanism for enabling non-state actors (NSAs) to contribute to WHO decision making. At the March 2011 consultation regarding the proposed WHF two alternatives were discussed: first, the large 'carnival' and second the more select 'council'.

It appears likely that the 'non-state actors' for whom space is to be made on such a 'council' will include:

- the pharmaceutical, food and insurance corporations;
- the large private foundations, in particular the Gates Foundation;

- various narrow vertical funding ‘partnerships’ and
- the World Bank.

It does not appear that consultation with public interest civil society organisations is a high priority.

It is true that there are many organisations involved in providing health related advice and funding to developing countries. It is true that WHO has a critical role in monitoring these organisations and holding them accountable for their policies and practices and we strongly urge WHO to take its proper place as the paramount global leader in health development. But this proposed WHF more likely to provide a platform for a diverse range of special interests to ‘shape’ WHO’s agenda; not for WHO to project global health leadership.

Possible advocacy messages

The case for the World Health Forum has not been made. There are significant risks and costs associated with this proposal and there are alternative and better options for strengthening WHO’s capacity and reach for consultation with non state actors. This is not the platform for WHO to project global health leadership.

WHO’s leadership role in global health governance

WHO was established as the paramount global authority in population health (see [Constitution](#)). During the 1980s and 1990s it has been increasingly hobbled and bypassed, first by the World Bank and later by the proliferation of narrow vertical disease ‘partnerships’. This process has been partly a consequence of intrinsic disabilities and partly because, for WHO to properly fulfil its mandate, would require that occasionally it challenge the policies and interests of the hegemonic powers, particularly the USA.

During the short period of unipolar global governance (from the collapse of the Soviet Union to the 2008 global financial crisis) the USA has been able to impose its will on the structures of global health governance but as we transit to a new multipolar world the possibility emerges of WHO resuming its role as the paramount inter-governmental leader in global health.

Examples of pressing issues which call for global leadership from WHO include:

- coordination, and in due course amalgamation, of the narrow vertical disease-based aid programs;
- confronting the need for more effective global regulation of transnational corporations, including big oil, big pharma, big finance, as well as big food and big tobacco;
- describing and analysing the ways in which macroeconomics (including the ‘too big to fail’ financial system) shapes health,

for example, employment prospects under neoliberal globalisation;

- promoting the rational use of medicines (quality, safety and efficacy) despite the opposition from powerful vested interests.

Possible advocacy messages

Member states need to rethink and reshape WHO so that it can re-assume its proper role as the paramount inter-governmental leader in global health development.

External relationships and consultative structures

The proposal for the WHF speaks in general terms about external stakeholders and presents the WHF as an appropriate structure for generalised 'consultation' with such stakeholders. In fact WHO's external relationships are quite heterogeneous with different obligations and objectives which call for different consultative arrangements.

Consultation with vaccine manufacturers about efficacy, price, volume calls for very different arrangements from those transnational corporations involved in agri-commerce, food manufacturing and retail.

Consultation with large private foundations with buckets of money and their own very specific agenda needs to be approached carefully. The wealth of the Gates Foundation is based on a particular intellectual property regime which is highly contentious in relation to drug development and drug pricing. The Secretariat needs to exercise caution about becoming compromised through dependence on Gates funding to a position where it is unable to deal objectively with issues of intellectual property and access to medicines.

Consultation with the various vertical disease-focused funding partnerships is also essential. However, WHO has specific responsibilities in relation to such bodies: in particular to ensure that they are accountable for coordination and health policy coherence and in due course to resorb them all into a much smaller number of organisations.

Consultation with the World Bank offers parallel challenges. The World Bank has buckets of money and the capacity to produce superficially persuasive glossy reports. However, in appraising WHO's relationship with the World Bank it is important to appreciate the harm to people's health which has flowed from the policies of the IMF and the Bank and the fragmenting impact of Bank policies for health systems development. It is worth recalling that the Commission on Macroeconomics and Health was commissioned to study the impact of health ON the macroeconomy ('to assess the place of health in global economic development'; 'the importance of investing in health to promote economic development') while the impact of macroeconomic policies on health (including the now discredited 'Washington Consensus') was excluded from its terms of reference. This absence should stand as a warning to WHO about the need for rigour and integrity in its relationships with the Bank and other inter-governmental bodies.

The proposition that a small friendly World Health Forum is the most appropriate way of dealing with all of these bodies is highly questionable. There are many issues where these various 'stakeholders' might combine around a common position significantly constraining the capacity of the WHO to take a different position.

Consultation is important but it must be approached strategically.

Possible Advocacy Messages

Member states need to systematically review WHO's external relationships with various constituencies; to consider what WHO needs to achieve in each relationship and to develop appropriate consultative arrangements accordingly.

WHO's collaboration with civil society at the country, regional and global levels

We use the term 'civil society' to refer to various public interest non-government organisations and social movements. We do not include private enterprise organisations, including peak bodies and front organisations, in this definition.

In many countries civil society health activists (individuals, organisations and networks) play a critical role in:

- institutional accountability and reform;
- policy formation and implementation;
- service and program planning and delivery; and
- working with communities to consider and adapt to evolving science and circumstance.

This includes a range of people's health movements, working towards the achievement of Health For All, whose general purposes are highly congruent with those of health officials and whose mode of work is highly complementary to the work of health officials.

Closer consultation and collaboration between health officials and health activists offers great potential for improving our collective effectiveness in the struggle for Health for All.

Possible Advocacy Messages

Member states need to recognise the role that civil society and health activists are playing in the struggle for Health for All and encourage the Secretariat to explore the scope for closer consultation and more effective collaboration with civil society health activists at the national, regional and global levels.