

# **WHO governance reform**

## **Report by the Secretariat**

1. In line with the requests of the Executive Board at its 132nd session,<sup>1</sup> the Secretariat is reporting on the following aspects of governance reform: external governance related to WHO's engagement with non-State actors; and WHO's role in global health governance. In addition, reports have been prepared on reform of internal governance related to streamlining the work of the governing bodies,<sup>2</sup> and an updated version of the high-level reform implementation plan, which incorporates the recommendations of the Joint Inspection Unit, and a progress report on reform implementation.<sup>3</sup>

### **1. WHO'S ENGAGEMENT WITH NON-STATE ACTORS**

2. Discussions on WHO's engagement with non-State actors have been based on two central concepts: first and foremost, WHO is an intergovernmental body in which Member States have the exclusive right of decision-making. Second, today's global health landscape is different and more complex than when WHO was founded in 1948.

3. The fundamental starting point for the debate is that although the issues surrounding how WHO should engage with non-State actors are complex and contested, it is impossible for WHO to fulfil its convening role if it cannot engage with all the actors that contribute to and influence global health. Engagement is a critical aspect of WHO's role in global health governance and non-State actors play a critical role in supporting WHO's work to fulfil its constitutional mandate.

4. This report responds to the request of the Executive Board,<sup>4</sup> to submit, for the consideration of the Board at its 133rd session, overarching principles for WHO's engagement with non-State actors, defining separate operational procedures for both nongovernmental organizations and private commercial entities. It draws on opinions expressed throughout governing body discussions and in consultations with the stakeholders concerned with WHO governance reform.

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<sup>1</sup> See decisions EB132(11) and EB132(13).

<sup>2</sup> Document EB133/3.

<sup>3</sup> Document A66/4.

<sup>4</sup> See decision EB132(11).

## **NON-STATE ACTORS**

5. Non-State actors are entities that do not belong organically to any State institution, that participate or act in international and national relations, and that have the power to influence and cause change.

6. A very large number of actors active in health fall within this group. They range from grass roots community organizations, civil society groups and networks, faith-based organizations, national and international nongovernmental organizations, philanthropic foundations, academic institutions, laboratory networks, trade associations, trade unions, private commercial enterprises, transnational corporations, media and communications organizations, professional groups, and patient groups. This list is far from exhaustive. It does not include United Nations and other intergovernmental organizations that are established by agreement between Member States, but it does include hybrid partnerships such as the GAVI Alliance and the Global Fund to Fight AIDS, tuberculosis and malaria, in which State and non-State actors have an equal role in governance, and which therefore do not belong to any established institution of a State or groups of States.

7. The functions and roles of non-State actors are diverse: service provision, policy analysis, advocacy and lobbying, research and development, funding, manufacturing, sales, marketing, and public information. Interests vary from the purely ideological to the solely commercial with many variants in between. From a public health perspective, changes in health outcomes attributable to non-State actors can be both positive and negative.

8. WHO's engagement with non-State actors takes different forms. Much of the debate about engagement has focused on the role of non-State actors in the governing bodies meetings of WHO. Although this issue is important, and is addressed later in this report, there are a wide range of other interactions that also need to be considered in drawing up a set of principles and operational procedures. In countries affected by disaster or conflict, for example, WHO works closely with and coordinates a wide range of national and international nongovernmental organizations. In large parts of the world, nongovernmental and private providers constitute a significant part of the health care system. Improving the quality of services thus requires interaction with those providers and their representative associations. WHO works with non-State actors in the public and private sector to collect information – for example on the cost and availability of medicines. Similarly, both public and private organizations are a vital source of technical information used in policy-making and normative activities.

9. Lastly, WHO's relationships with individual non-State actors can have multiple facets: as a technical partner providing normative guidance, as a supporter of programme development and implementation in countries, as a coordinator in the context of the health cluster in emergencies or development cooperation through initiatives such as the International Health Partnership, as a host, and, on occasion, as an active member of governing boards of partnerships and similar entities.

## **CHALLENGES**

10. The fundamental challenge is: how can WHO work with the wide range of non-State actors that currently have a significant role in global health in ways that benefit population health; advance the Organization's objectives; contribute to better health governance; and at the same time use engagement with non-State actors as a tool to pursue the strategic objectives set by the governing bodies and protect the Organization's decision-making, policy processes, and normative work from any vested interest?

11. A series of questions to solicit opinions on this challenge and how they should be managed have been used to frame consultations and discussions to date. Most recently, a public, web-based consultation held between 6 and 24 March 2013 asked for views on: the scope and range of non-State actors; how and whether they should be categorized; what benefits accrue to non-State actors from their relationship with WHO; what challenges are likely to arise in different contexts, including those related to non-State financing of WHO; what would constitute a set of overarching principles to guide engagement, and what modalities are needed beyond such general principles to guide interaction in different circumstances.

12. Opinions varied as to how these concerns can be addressed, and how the inherent risks to the Organization can be mitigated or overcome. The most common issues raised in this regard relate to: a defined typology of actors and/or interactions; missed opportunities to access the expertise and resources of non-State actors towards improved public health outcomes; institutional conflicts of interest; the potential for reputational damage through engagement with particular sectors; and issues concerning funding from non-State actors.

13. One body of opinion argues for WHO to develop a robust typology of non-State actors, particularly one that would distinguish those organizations purely devoted to public interest issues from those associated with commercial concerns. An equally strong body of opinion resists the idea of differentiation. This second group maintains that all non-State actors have an interest whether it is commercial, technical or ideological. Many people also point out that some advocacy groups have strong commercial backing and that some commercial groups are active in work that is purely in the public interest. They make the case that hybrid organizations with elements that are commercial and elements that are public interest are increasingly common.

14. Another point made relates to the need to distinguish different types of engagement. Although it is clearly undesirable for representatives of a pharmaceutical company to influence treatment guidelines for products in which they have an interest, should WHO be precluded from tapping the expertise of such companies on, for example, distribution systems in low-income countries? Positions vary on whether engagement with non-State actors should always be limited to those whose interest and objectives appear to be wholly convergent with those of WHO, or whether relationships can also be developed with entities that are not primarily engaged in public health but which may have capacities and expertise that WHO needs (e.g. logistics, communications, information technology). There is wide agreement on the need to prevent commercial influence with regard to WHO policies, norms or standards. However, notwithstanding this agreement, views differ on the extent to which WHO should be engaging private commercial entities in the context of WHO's other activities. Some assert that any relationship at all with a commercial entity, even with adequate safeguards to prevent conflict of interest, can be seen as a benefit to the company concerned and a reputational risk to WHO, others say that the key is full transparency of all interests, commercial or otherwise.

15. Promoting public health may necessarily involve engagement with those whose activities have the potential to do it harm, with the objective of influencing and changing behaviours. Indeed, some respondents argue that policy is enriched by engaging with those that have different and opposing opinions. The counter-argument runs that there should in fact be a list of those groups in civil society or the private sector that should be explicitly excluded from any relationship with WHO. Currently, such a list would include the tobacco industry.

16. One of the most contentious issues concerns funding from non-State actors. There is consensus that WHO cannot be funded for normative activities that influence the commercial interests of the donor. However, many are concerned that any form of funding from non-State sources will distort or undermine the intergovernmental process of priority setting. Others assert that there is a need to

consider carefully what is permissible and under what circumstances benefits can accrue from such an engagement with WHO. In addition, it is suggested that WHO is missing important opportunities to access private sources of funding that can readily be pooled or ring-fenced in ways that ensure there is no link between the donor and the purpose for which funds are used.

## TOWARDS A FRAMEWORK FOR ENGAGEMENT

17. Navigating these troubled and contested waters and finding common ground between widely divergent views is far from straightforward. However, progress is possible.

18. The remainder of this section of the report sets out the elements of a framework to be considered by the Executive Board, comprising several components:

- a set of overarching principles applicable to any form of engagement with any kind of non-State actor;
- a typology of interactions;
- rules of engagement (policies and procedures) that relate to each type of engagement;
- specific tools to increase overall transparency and specifically to manage conflicts of interest;
- systems for compliance, reporting and that enable senior management and WHO governing bodies to systematically oversee all elements of engagement with non-State actors.

### Overarching principles

19. The starting point, as the Board suggested, is at the level of overarching principles. **Four principles** are proposed that should apply to all interactions with non-State actors, irrespective of the nature of the non-State actor in question, and regardless of context, including work at country level:

- WHO is an intergovernmental organization comprising Member States and the Secretariat in which responsibility for policy and decision-making rests exclusively with the Organization's governing bodies. This being the case, no non-State actor can expect to have the decision-making privileges of engagement with the Organization on the same basis as Member States.
- WHO is a science and evidence-based Organization espousing a public health approach. The development of norms, standards, policies and strategies must continue to be based in all circumstances on the systematic use of evidence, and the process by which they are derived must be protected from influence by any form of bias or vested interest, commercial or otherwise.
- Transparency is the key safeguard that needs to underpin all interactions with non-State actors. This principle implies that WHO will make public the nature of its interactions with non-State actors. All non-State actors in relationship with WHO will in turn be required to make public their organizational objectives, membership, institutional structure, sources of funding and the nature of their relationship with WHO.

- Conflicts of interests, real or perceived, individual and institutional must be adequately managed and be seen to be managed in ways that are accessible to all stakeholders. The need to effectively manage potential conflicts will be a lens that is applied to all aspects of WHO's work.

### Typology of interaction

20. Although principles are necessary, they are far from sufficient as a basis for better governance. Recognizing the many challenges inherent in making a clear, unambiguous and acceptable typology of non-State actors, a prior step is to consider the nature of engagement. It is possible to define **six basic types of interaction** between non-State actors and WHO:

- **Consultation:** in which the Secretariat seeks the opinion of others, seeks to influence their activities, or solicits information from non-State actors. Consultation is thus part of the process of policy development, but is distinct from final policy decisions which remain the prerogative of Member States.<sup>1</sup> Consultations may take place with different groups together or separately.
- **Collaboration:** in which WHO works with non-State actors on joint initiatives. Well-established forms of collaboration include the provision of support by non-State actors to WHO's work in the implementation and monitoring of norms and standards, delivering care and complementing the efforts of national health systems, and joint action (including with WHO collaborating centres) or partnerships to direct attention towards matters critical to health.
- **Financing:** in which WHO receives funds and other forms of support such as drug donations and in-kind support from non-State actors. A key principle in this regard is that policy and priority setting is separated from resource mobilization. It is also important to note that, in relation to financing of WHO more broadly, priority setting remains the prerogative of Member States culminating in the approval of the biennial programme budget.
- **Contractual:** in which WHO contracts a non-State actor for specific services. WHO contracts with a wide range of non-State actors to provide services for which the Secretariat specifies deliverables and defines terms of reference. The choice of partner in this relationship is based on competition and value for money. Unlike the collaborative relationship where congruent interests and values are paramount, the contractual relationship may involve non-State parties (for example private sector management companies) that have non-health-related corporate objectives, but can offer services (IT, transport, maintenance etc.) that WHO needs.
- **Non-State actors in WHO's governance:** in which non-State actors interact with Member States at governing body meetings (at regional and global level) and in processes established by governing bodies such as intergovernmental working groups, and other processes such as the financing dialogue. A key issue here is the revision of current accreditation processes and procedures for nongovernmental organizations for WHO's governing bodies (see also under "Rules of engagement" below).

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<sup>1</sup> As part of the normative process experts have a role (in guidelines development, as members of expert committees etc.) but they act in their individual capacity with strict policies and procedures in place to manage any individual and institutional conflict of interest.

- **WHO as part of the governance of non-State actors:** in which WHO is part of the governance structure of a non-State actor. The WHO Secretariat nominates board members for several external partnerships (such as the GAVI Alliance and the Global Fund to fight AIDS, tuberculosis and malaria) as well as partnerships hosted by the Organization. The governance role is separate from the technical collaboration that takes place with these entities, and by definition, focuses on ensuring that the partnership concerned is strategically managed and serves the interests of population health as effectively and efficiently as possible. The specific proposals on hosted partnerships endorsed by the Board at its 132nd session<sup>1</sup> and the WHO partnerships policy,<sup>2</sup> will ensure that the governing bodies of WHO will have greater and more formal oversight as to how the Secretariat's relationship with hosted partnerships is conducted.

### **Rules of engagement – procedures and policies**

21. The typology of relationships with non-State actors provides the basis for the next steps in the process: namely to define detailed rules of engagement to develop operational procedures and policies that relate to each type of engagement and, where appropriate, to different types of non-State actors.

22. In terms of rules of engagement (as well as some of the tools and systems discussed below), the Secretariat is not starting anew. Examples of such structures and systems include the current principles to govern relations between WHO and nongovernmental organizations, the Secretariat guidelines on interaction with commercial enterprises to achieve health outcomes,<sup>3</sup> WHO's processes concerning collaborating centres, and policy related to partnerships.

23. However, integration of existing pieces into a harmonized, comprehensive approach for governing and managing WHO's engagement with non-State actors faces the challenge that these policies/procedures were developed independently, in the absence of an overarching framework. With agreement on the overall approach outlined in this report, an immediate step will be to review where there are already structures and systems in place that can form the basis of a more rigorous and comprehensive operational framework. These pieces will then be strengthened, refined, or adjusted as necessary to ensure alignment with the broader framework for governing and managing WHO's engagement with non-State actors. In addition, the Secretariat will take advantage of the experience of other multilateral organizations and Member State governments that have effective systems already in place.

24. In this regard, agreement on the overall approach outlined in this report will enable the development of rules and procedures specific to each of the interaction "types" outlined above. The Executive Board's request<sup>4</sup> to harmonize draft policies for collaboration with nongovernmental organizations and private commercial entities can also be implemented through the rules of engagement.

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<sup>1</sup> Document EB132/5 Add.1.

<sup>2</sup> The policy on WHO engagement with global health partnerships and hosting arrangements was endorsed in 2010 by the Sixty-third World Health Assembly in resolution WHA63.10.

<sup>3</sup> Document EB107/20.

<sup>4</sup> See decision EB132(11).

25. One issue related to rules of engagement to address in the short-term concerns the accreditation of nongovernmental organizations to attend WHO's governing bodies. The Executive Board requested the Director-General to proceed with the revision of accreditation procedures for nongovernmental organizations,<sup>1</sup> in particular the de-linking of participation in meetings of WHO's governing bodies from a period of working relations. The Board is invited to provide guidance on flexible solutions which define parameters for the participation of nongovernmental organizations in the meetings of WHO's governing bodies (or in working groups, special conferences and other meetings emanating from the work of the governing bodies).

### **Tools for increasing transparency and managing conflicts of interest**

26. The concept of conflict of interest and the approaches to manage the risk related to its occurrence are central to the definition of a framework for WHO's engagement with non-State actors. Thus a comprehensive system is essential in order to identify and manage a conflict of interest that may arise when engaging a non-State actor. Specifically, such an architecture requires: a way of enhancing transparency of interaction; definition of what constitutes an institutional conflict of interest (which may vary depending on the interaction 'type'); tools for declarations of interest; and capacity and mechanisms to evaluate conflicts of interest.

27. The first step is greater transparency of engagement. Several models on which to base a new system to enhance transparency of WHO's engagement with non-State actors and conflicts of interest disclosures are being explored. Such models, including electronic, web-based tools, will not only enable stakeholders to gain information about WHO's institutional interactions, but also will enable a more systematic evaluation and management of such conflicts across the Organization.

28. The scope of the conflicts that could affect WHO's integrity also needs to be better defined as part of the process to improve the transparency and accountability of WHO's engagement with non-State actors. In this regard, what constitutes a conflict may be different depending on the type of interaction in question. For example, whereas collaboration with a particular non-State actor within a certain context may constitute a conflict, a contractual fee-for-service arrangement with that same non-State actor may not. A conflict of interest can be defined as a set of circumstances that creates a risk that judgement or actions regarding a primary interest will be unduly influenced by a secondary interest. The conflict of interest does not derive from whether individuals, organizations and institutions that interact with WHO are influenced by secondary interests. This is an unavoidable reality of the diversity of interests in the global health arena. The problems with engagement arise from the secondary interests prevailing over the primary one.

29. Currently, WHO has in place detailed tools, mechanisms, and processes concerning conflicts of interest in relation to staff as well as individuals engaged in WHO's normative work who are providing expert advice in their personal capacity. Although elements of similar tools and mechanisms concerning institutional engagement and conflicts of interest that may arise through WHO's engagement with non-State actors do exist (e.g. WHO's guidelines for interaction with the private sector, due diligence process for WHO collaborating centres, etc.), these mechanisms need to be strengthened, broadened and streamlined across the three levels of the Organization. In this regard, WHO's capacity and systems to identify and manage conflicts of interest and administer relevant

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<sup>1</sup> The policy on WHO engagement with global health partnerships and hosting arrangements was endorsed in 2010 by the Sixty-third World Health Assembly in resolution WHA63.10.

measures to address them need to be strengthened and integrated into a comprehensive institutional conflict of interest architecture.

### **Compliance, reporting, and oversight**

30. The final component of a comprehensive framework is a system for compliance and reporting that enables senior management and WHO governing bodies to oversee systematically all elements of engagement with non-State actors.

31. This system and oversight mechanisms are intended to have the capacity to review the full range of WHO's activities with non-State actors, assess and administer measures and standard operating procedures related to compliance with relevant policies, and report on such interactions to facilitate oversight by WHO's governing bodies.

32. The streamlining of existing compliance and reporting mechanisms under an overarching framework will be predicated on the further development of the other components described in this paper. In particular, effective administration of defined rules of engagement and systems to manage conflicts of interest are both essential in ensuring internal compliance and facilitating oversight and reporting to WHO's governing bodies. Agreement on the overarching framework outlined in this report will ensure that compliance and reporting and mechanisms will be developed and streamlined with a view to ensure strong oversight over WHO's engagement with non-State actors.

## **2. WHO'S ROLE IN GLOBAL HEALTH GOVERNANCE**

33. The Executive Board at its 131st session requested the Director-General "to submit a document ... at its 132nd session that identifies and assesses specific options on the elements set out in document A65/5, in particular on WHO internal governance, including the alignment of headquarters, regional and country offices on the issue of WHO's role in global health governance, and the methods of work of the governing bodies."<sup>1</sup>

34. WHO's role in global health governance is a practical expression of the Constitutional function to act as "the directing and coordinating authority on international health work". This section of the report maps the scope of work in this area, updating Member States on the wide range of activities and arenas in which WHO plays an active governance role. It seeks to dispel the idea that global health governance refers to activities carried out by headquarters alone. It illustrates the role played in health governance by all three levels of the Organization – showing how the division of responsibilities and alignment of positions across the Organization works in practice. This section of the report also identifies links between health governance and other aspects of WHO reform, including those set out in document A65/5. Finally, it responds to the decision taken by the Executive Board at its 132nd session<sup>2</sup> in January 2013 to continue its examination of WHO's role in global health governance. It is an update of an earlier document that was submitted to the Board at that session.<sup>3</sup>

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<sup>1</sup> See decision EB131(10).

<sup>2</sup> Decision EB132(13).

<sup>3</sup> Document EB132/5 Add.5.



## BROADER SCOPE FOR GLOBAL HEALTH GOVERNANCE

35. The fundamental idea underpinning global health governance is that the assets the world has at its disposal to improve peoples' health could be deployed more effectively and more fairly. Health governance implies "the use of formal and informal institutions, rules and processes by states, intergovernmental organizations, and non-State actors to deal with challenges to health that require cross-border collective action to address effectively."<sup>1</sup>

36. Health governance has its origins in negotiations between nation states as they sought to protect or promote people's health – initially on an ad hoc basis to contain the threat of communicable diseases, more formally through treaties and conventions, and arguably through the establishment of the World Health Organization itself.

37. Good health governance has several beneficial outcomes. First, it helps to prevent or mitigate the negative health impacts of threats emanating from one country that may otherwise affect many others, for example through instruments such as the International Health Regulations (2005), and the Pandemic Influenza Preparedness (PIP) Framework. Secondly, effective global health governance allows countries to develop common approaches and strategies to address shared global, regional or subregional problems (for example, the WHO Global Code of Practice on the International Recruitment of Health Personnel or the global plan for artemisinin resistance containment which has global, regional and particularly subregional elements). Much of WHO's normative work on treatment guidelines and protocols also falls into this category. Thirdly, better governance can make development cooperation more effective. For example, the International Health Partnership and related initiatives (IHP+) has been engaged in translating the principles agreed at the Second, Third and Fourth High Level Forums on Aid Effectiveness (held in Paris, Accra and Busan, Republic of Korea, respectively) into practice in the health sector. Fourthly, governance processes can provide an overall sense of direction and purpose for global health not least through the solidarity and momentum that comes from agreements on shared goals (for example, the health-related Millennium Development Goals, and voluntary goals and targets proposed in relation to noncommunicable diseases).

38. Many of the products of global health governance have the characteristics of global or regional public goods. Thus, use of an instrument or strategy by one country does not reduce the availability of that instrument to others. Similarly, no one can be excluded from using a treatment guideline or protocol once it is made publicly available. The present report returns to this issue in the concluding section.

39. Several factors have been instrumental in both broadening the health governance agenda and making it more complex to manage:

- (a) *Multiple voices*: health governance is no longer the exclusive preserve of nation states. Civil society networks, individual nongovernmental organizations at international and community level, professional groups, philanthropic foundations, trade associations, the media, national and transnational corporations, and individuals and informal diffuse communities that have found a new voice and influence thanks to information technology and social media – all of these actors have an influence on decision-making that affects health. This issue is particularly important in how WHO conducts its health governance role: ensuring the primacy

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<sup>1</sup> Fidler DP, Calamaras JL. *The challenges of global health governance*. Council on Foreign Relations Press. New York, May 2010.

of Member States in making policy decisions and protecting WHO's normative work from any vested interests, while still finding ways of constructively engaging with other stakeholders.

(b) *New actors*: As point (a) above suggests, the institutional landscape of global health is increasingly complex; incentives that favour the creation of new organizations, financing channels, and monitoring systems over reform of those that already exist, risk making the situation worse. This issue is particularly important in relation to health governance in low- and middle-income countries with many development partners.

(c) *Wider concerns*: The dynamic in many governance discussions revolves around how to protect human health while minimizing disruption to travel, trade and economic development. Although getting this balance right remains a critical concern, there are added dimensions to the debate, most notably a concern for fairness and equity, well illustrated in the negotiation of the PIP Framework and the continuing discussions of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination.

(d) *Not just health governance but governance for health*:<sup>1</sup> Implicit in the social determinants approach to health, as articulated in the Rio Political Declaration, are two distinct concepts: *governance of health* that addresses many of the issues referred to above – essentially a coordinating, directing and internal coherence function for entities whose primary purpose is the advancement of health. The second concept – *governance for health* – is an advocacy and public policy function that seeks to influence governance in other sectors (with a different primary purpose) in ways that have a positive impact on human health. This aspect of health governance is well illustrated by WHO's work on noncommunicable diseases (see paragraph 46 below).

## **HEALTH GOVERNANCE: A LEADERSHIP PRIORITY FOR WHO**

40. The draft twelfth general programme of work identifies health governance as one of eight leadership priorities. Specifically, this priority is defined in terms of greater coherence in global health, with WHO playing a coordinating and directing role that enables a range of different actors to contribute more effectively to the health of all peoples.

41. WHO's health governance role, which has many practical expressions, is examined in the present report from three different angles. First, from the perspective of work to position and promote health in a range of global, regional and national processes. Secondly, by highlighting governance issues implicit in the other programmatic leadership priorities in the draft programme of work. Thirdly, by linking the analysis of health governance, the governance of WHO by Member States, and the components of reform that will enhance WHO's effectiveness in its health governance role.

### **Positioning and promoting health**

42. *The post-2015 development agenda*: The manner in which the next generation of global goals are framed will have a major influence on development priorities and funding for several years. Ensuring that health is well-positioned and its role clearly articulated is a major health governance

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<sup>1</sup> The publication, *Governance for Health in the 21st Century*, World Health Organization, Regional Office for Europe, document EUR/RC61/Inf.Doc./6, provides many examples of how better collaboration between different health actors can address the social determinants of health and improve health outcomes in the context of the European Region.

challenge and a priority for WHO. The environment in which negotiations are taking place is fluid, complex and competitive between the many sectoral interests that seek to be represented. The consultative process that is currently under way requires alignment across the levels of the Organization and consistency in messaging as WHO interacts with Member States and other stakeholders. WHO's approach to this challenge will be discussed in more detail under provisional agenda item 14.1 of the Sixty-sixth World Health Assembly.

43. *Health and sustainable development:* Preparations for the Rio+20 Conference in June 2102 illustrate a related aspect of WHO's governance work: effective synergy in advancing health interests between the Secretariat, Member States and other stakeholders. The first draft of the Rio+20 outcome document made only passing reference to health. WHO staff at the headquarters and regional levels therefore worked with Member States in Geneva and New York, as well as with groups of nongovernmental organizations, in order to develop a convincing position on the role of health, which was eventually taken up by negotiators in Rio. The final text includes virtually all of WHO's health concerns.<sup>1</sup> In the follow-up to Rio+20, health provides an important link between the process of developing sustainable development goals and the post-2015 agenda. In addition, work with other sectors such as sustainable energy, water and sanitation, and climate change adaptation and mitigation, is showing the value of health indicators as a means of measuring progress across the three pillars of sustainable development.

44. *Health and United Nations reform:* WHO is committed to a more coherent approach to the work of the United Nations at country level, to the alignment of support to national priorities, and to promoting the place of health in United Nations Development Assistance Frameworks and One UN plans. The recent independent evaluation of Delivering as One pilot countries has indicated that reform of United Nations operations has made some headway at country level, but that further progress will depend on whether Member States are ready to support greater integration at headquarters level.<sup>2</sup> In these circumstances, WHO's priority is to strengthen the role of country offices to work as part of a United Nations country team, to support regional United Nations Development Group teams and regional coordination mechanisms in those regions where they function effectively. At headquarters level, priority is given to high-level representation on Chief Executives Board (and the High-level Committee on Programmes, which deals with policy issues) and much more selective engagement with the many different working groups of the United Nations Development Group.

45. *Development Cooperation post-Busan:* The Busan Partnership for Effective Development Co-operation<sup>3</sup> was formed after the fourth High Level Forum on Aid Effectiveness was held in the Republic of Korea in November 2011. The outcome document signals that a framework based on "aid" has given way to a broader, more inclusive, international consensus that emphasizes partnership approaches to cooperation, particularly South-South and triangular relationships. In the context of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, health has had a leadership

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<sup>1</sup> The outcome document from Rio+20, *The future we want*, includes nine paragraphs on health and population. It begins "We recognize that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development". This opening sentence is followed by references to the importance of universal health coverage, AIDS, tuberculosis, malaria, polio and other communicable diseases, noncommunicable diseases, access to medicines, strengthening health systems, sexual and reproductive health, protection of human rights in this context, and commitments to reducing maternal and child mortality.

<sup>2</sup> For the final main report see: <http://www.un.org/en/ga/deliveringasone/mainreport.shtml>.

<sup>3</sup> For the outcome document, see: [http://www.aideffectiveness.org/busanhlf4/images/stories/hlf4/OUTCOME\\_DOCUMENT\\_-\\_FINAL\\_EN.pdf](http://www.aideffectiveness.org/busanhlf4/images/stories/hlf4/OUTCOME_DOCUMENT_-_FINAL_EN.pdf).

and tracer role, demonstrating through initiatives like IHP+ that despite the many different players, coordination around national health strategies can be improved. Such approaches extend beyond the United Nations to include bilateral organizations, development banks and nongovernmental organizations, and can show increases in both efficiency and health outcomes.<sup>1</sup> As the new post-Busan Partnership begins to take shape over the course of 2013, it will be important to revitalize the International Health Partnership and similar initiatives that bring together different funding streams in support of national health priorities.

46. *Health and regional economic integration:* In all parts of the world there is increasing regional and subregional integration. Although many institutions tend to focus primarily on economic development, they have the potential to be equally influential in health and social policy. There are several potential components to the relationship:

(a) *Political:* Some regional and subregional blocks have been influential in the field of health either by providing an opportunity for WHO to apprise high-level decision-makers of key messages (e.g. maternal and child health in Africa); using regional influence to have issues included on the global agenda (e.g. noncommunicable diseases at the United Nations General Assembly); and acting in concert to push particular positions in global health negotiations (e.g. in the area of access to medicines).

(b) *Strategic partnership:* WHO forms strategic partnerships with regional organizations – particularly with the secretariats of the continental blocks (such as the European Commission and the New Partnership for Africa’s Development) and the regional development banks; for example, the African Development Bank is a key partner in Harmonization for Health in Africa.

(c) *Development cooperation:* Regional bodies can help bring greater coherence to health and development.

(d) *Peace and security:* Several regional and subregional bodies have, as part of their mission, maintaining the security of their region. In this role they can be important partners in humanitarian action.

(e) *Resource mobilization:* Regional bodies, particularly the development banks and the European Commission, are important sources of funding for WHO’s work. It is, however, important to avoid confusing strategic relationships with resource mobilization and to prevent them from becoming subservient to resource mobilization.

## **WHO’s leadership priorities**

47. Given the diversity of the challenges in health and the growing number of actors, it is not surprising that the governance landscape is complex. Rather than “architecture” health governance is better described in terms of “overlapping and sometimes competing [governance] regime clusters that involve multiple players addressing different problems through diverse principles and processes”.<sup>2</sup> This description is particularly apt in relation to **completing work on the health-related Millennium**

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<sup>1</sup> *IHP+ Results 2012 Annual Performance Report: Progress in the international health partnership & related initiatives (IHP+).*

<sup>2</sup> Fidler DP, Calamaras JL. *The challenges of global health governance.* New York, Council on Foreign Relations Press, May 2010.

**Development Goals** where overlapping circles of governance through United Nations agencies, partnerships, advocacy groups and funding instruments compete for control, and, inevitably, for resources. This situation has several implications for how WHO interacts with partnerships and other stakeholders, which are discussed below. A critical element of WHO reform is ensuring the capacity of the Organization to help those countries that have many external development partners to manage that complexity and decrease their transaction costs.

48. Work on **noncommunicable diseases**, in contrast, illustrates the importance of governance *for* health. While many health conditions are influenced by governance decisions in other sectors, an analysis of the causes and social determinants of noncommunicable diseases points to a particularly wide and multi-layered range of interrelated **social, economic and environmental determinants**. These range from environmental exposure to harmful toxins, diet, tobacco use, excess salt and alcohol consumption and increasingly sedentary lifestyles. These in turn are linked to income, housing, employment, transport, and agricultural and education policies, which themselves are influenced by patterns of international commerce, trade, finance, advertising, culture and communications. While it is possible to identify policy levers in relation to all of these factors individually, orchestrating a coherent response across societies remains one of the most prominent governance challenges in global health.

49. **Universal health coverage** combines two fundamental components: access to the services (promotion, prevention, treatment and rehabilitation) needed to achieve good health; with financial protection that prevents ill-health from leading to poverty. Universal health coverage becomes important from a health governance perspective in two ways. First, at country level it represents a goal that is relevant to all countries as they seek to strengthen or reform their health systems. Secondly, in the debate about how to position health in the post-2015 agenda, it has the potential to be part of a unifying set of goals that combine concerns about finishing the work on the current Millennium Development Goals, with the need to address noncommunicable diseases and other causes of ill health.

50. Two of the other strategic priorities highlight an additional aspect of WHO's role in health governance, namely that the negotiation of international instruments needs to be linked to capacity building in countries. This is particularly evident in the case of the **International Health Regulations 2005**. The Regulations provide the key legal instrument needed to achieve collective health security. Their impact, however, depends on all countries meeting the capacity requirements needed to detect, report and act on any new or emerging threat of international concern to public health. Similarly, work on increasing **access to medical products** has been influenced by several international agreements including the Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights and Public Health (and its incorporation into the TRIPS agreement), and the subsequent global strategy and plan of action on public health, innovation and intellectual property. Other governance processes are still ongoing on substandard/spurious/false-labelled/falsified/counterfeit medical products and on follow up to the report of the Consultative Expert Working Group on Research and Development. As in the case of the Regulations, however, the full impact of governance decisions will depend on building or strengthening the institutions at country and regional level needed to put agreements into practice.

### **Health governance and WHO reform**

51. The draft of the twelfth general programme of work defines two measures of success in relation to the leadership priority on governance.

(a) A streamlined and effective system of governance in WHO that enhances synergy across the Organization, that provides strategic oversight, and that is inclusive with respect to the breadth of the issues with which WHO is concerned.

(b) A more coordinated approach to a well-defined multisectoral global health agenda, reflected in better alignment of financial and technical support to country health policies and strategies.

52. The first measure focuses on the internal governance of WHO by Member States at global and regional level. The second refers to WHO's coordinating and directing role. Several elements aim to ensure that WHO has the necessary capacities to achieve these objectives.

53. The internal governance agenda will focus initially on the work of the governing bodies: the World Health Assembly, the Executive Board and the regional committees. For the Board, this will include strengthening its executive and oversight roles; increasing its strategic role; and streamlining its methods of work. For the Health Assembly, a more strategic focus will help to ensure that resolutions enable better priority setting. The work of regional committees will be more closely linked to global governance of WHO, particularly to the work of the Executive Board, and best practice will be standardized across different regions. To complement these changes, the Secretariat will improve the support it provides to governance functions, through briefing of new members as well as better and more timely documents.

54. One major consequence of the growing political interest in health and the recognition of the connection between health and many other areas of social and economic policy is a growing demand for intergovernmental rather than purely technical processes, with a view to reaching durable and inclusive agreements. WHO's convening role is therefore likely to increase and will require that the capacities to support, manage and facilitate governance processes are adequate for the purpose.

55. An additional challenge that emerges in the governance for health agenda is that many of the areas in which change can have a positive impact on health are those in which existing rules and regimes are managed by different international institutions. As a consequence WHO needs to be an advocate for health in the governance of other bodies at global, regional and country level. It will be necessary to make strategic and selective use of scarce resources in order to maximize impact, given the wide range of institutions involved.

56. The analysis of global health governance challenges gives renewed emphasis to the need for WHO to engage with a range of other stakeholders. At the special session of the Board on reform, in decision EBSS2(2), the Board agreed on the principle that governance needs to be a fully inclusive process, respecting the principle of multilateralism. The Board will discuss the principles that should govern the engagement with non-State actors under provisional agenda item 5.

57. In relation to the growing number of health partnerships WHO has a dual governance role: as an active member of the partnership in its own right, and as a board member with responsibilities for the governance of the partnership itself. However, the immediate focus of reform in this area is WHO's relationship with partnerships that are hosted by the Organization. Proposals in this regard have been discussed by the Board and will be presented to the Sixty-sixth World Health Assembly under provisional agenda item 11.

58. Common to all aspects of governance is the need to build capacity across WHO to manage this agenda more effectively. The Secretariat needs to strengthen its own capacity and also offer support to Member States when it is required.

59. For the Secretariat, measures to increase capacity will include building a more sophisticated understanding of WHO's role and in the broader international system among managerial and technical staff, so that they become better able to understand how governance issues affect their work. Specifically, health diplomacy training, already mandatory for WHO Representatives, will be rolled out across other parts of the Organization. Training should include the use of tools from disciplines such as international relations and political science to enable better analysis of complex systems and stakeholder mapping.

60. In addition, WHO's influence will be enhanced by more effective internal coordination, across all levels of the Organization, so that WHO can present consistent and cogent positions in support of health in the various arenas described above.

61. For Member States, strategies to strengthen governance capacity that will be supported by WHO include strengthening international departments in health ministries; inter-ministerial coordination on global health policy issues; preparation of cross-ministry global health strategies; regular exchanges with academic institutions, nongovernmental organizations and other entities on global health issues; staff exchanges between ministries and with international organizations; and staff training on health diplomacy and negotiation.

## CHALLENGES

62. Looking ahead it is possible to identify several key challenges.

(a) Global health governance requires WHO to engage with a wide range of non-State actors. Agreeing and operationalizing the principles that should govern this engagement is critical to this component of WHO reform.

(b) The "seat" of global health governance is becoming more diverse. In other words, decisions that influence global health governance are being made in a growing number of arenas. In particular, health issues are beginning to feature prominently on the agenda of the United Nations General Assembly, notably in relation to universal health coverage and noncommunicable diseases.<sup>1</sup> The number and range of decision-making bodies, globally and regionally, requires that WHO make careful strategic choices as to where it can most effectively influence outcomes.

(c) Many of the products of good health governance have the characteristics of global public goods (see paragraph 38 above). The production of norms, standards and, increasingly, negotiated agreements and conventions requires sufficient and sustainable resources. These can be difficult to generate when sovereign states benefit from investments made by others without contributing themselves (the so-called "free rider" problem).<sup>2</sup> This issue is relevant not just to WHO financing and the deployment of core funds, but, equally, to how judgments are made

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<sup>1</sup> See United Nations resolutions A/RES/67/81 and A/RES/64/265.

<sup>2</sup> Frenk J, Moon S. Governance challenges in global health. *New England Journal of Medicine*, 2013, 368:936–942.

about the Organization's effectiveness through the reviews carried out by the different development agencies whose focus is on direct support to countries.

## **ACTION BY THE EXECUTIVE BOARD**

63. The Executive Board is invited to note the report, in particular to provide guidance on the matters below, and to consider the draft decision point.

64. The first section of this report outlines a framework for WHO's engagement with non-State actors: four guiding principles; a typology of interactions; rules of engagement; tools to increase transparency and manage conflicts of interest; and the establishment of systems for ensuring compliance, reporting, and facilitating oversight by governing bodies. The Board is asked to provide guidance on the overall approach suggested, to endorse the proposed principles of engagement and typology of interactions, and to provide guidance on the development of rules of engagement and mechanisms in order to increase transparency and manage conflicts of interest, as described.

65. In taking forward this work, continued dialogue and consultation will be essential. The Executive Board at its 132nd session decided that two separate consultations, one with Member States and nongovernmental organizations, and one with Member States and the private commercial sector, should be undertaken. Further to the guidance provided by the Board on the overarching principles and typology of interactions, the content of these consultations will be designed to advance work on rules of engagement and systems to increase transparency and manage conflicts of interest.

66. The Executive Board is also invited to provide guidance on how to advance the work related to parameters for the participation of nongovernmental organizations in the meetings of WHO's governing bodies.

## **DECISION POINT**

The Executive Board, having considered document EB133/16 on engagement with non-State actors,

**ENDORSES** the outlined approach to engagement with non-State actors, in particular the overarching principles of engagement and the typology of interactions;

**REQUESTS** the Director-General to advance the work proposed, taking into account the deliberations of the Executive Board at its 133rd session, towards the development of a more detailed framework of engagement with non-State actors for consideration by the Board at its 134th session in January 2014.

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