THE RIGHT TO HEALTH SOVEREIGNTY
Technical Report
Background, Research, and References

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The Right to Health Sovereignty: Background, Research, and References
Supplementary Research Volume to the Policy Report of the Panel
of the International Health Reform Project (IHRP)

SUPPLEMENTARY RESEARCH VOLUME TO THE POLICY REPORT OF THE PANEL OF THE INTERNATIONAL HEALTH REFORM PROJECT (IHRP)

The Right to Health Sovereignty, Policy and Technical reports, are complementary and reflect the consensus of the IHRP panel. Specific assertions do not necessarily reflect the opinion of individual panel members

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THE IHRP PANEL

David Bell (Co-chair)
Dr. David Bell is a clinical and public health physician with a PhD in population health and background in internal medicine, modelling and epidemiology of infectious disease. He has worked in global health and biotech for the past 25 years. Previously, he was Director of the Global Health Technologies at Intellectual Ventures Global Good Fund in the USA, Programme Head for Malaria and Acute Febrile Disease at FIND in Geneva, and was a Medical Officer and Scientist in infectious diseases at the World Health Organization. He currently consults in biotech and international public health co-leads the REPPPARE project on the evidence base behind the pandemic agenda at the University of Leeds.

Ramesh Thakur (Co-chair)
Professor Ramesh Thakur PhD is emeritus professor in the Crawford School of Public Policy, The
Australian National University, a former United Nations Assistant Secretary-General, Fellow of the Australian Institute of International Affairs. Born in India and educated in India and Canada, he has held fulltime academic appointments in Fiji, New Zealand, Canada, and Australia and been a consultant to the Australian, New Zealand and Norwegian governments on international security issues. He has served on the international advisory boards of policy-oriented research institutes in Africa, Asia, Europe, and North America. He is a founder-member of Australians for Science and Freedom. His books include *Global Governance and the UN* (Indiana University Press), *The Oxford Handbook of Modern Diplomacy* (Oxford University Press), and *The United Nations, Peace and Security* (Cambridge University Press). He has published opinion articles in *Asahi Shimbun, Asian Wall Street Journal, Australian, Australian Financial Review, die tageszeitung, Financial Times, Globe and Mail, Guardian, Hindu, Hindustan Times, Indian Express, International Herald Tribune, Japan Times, Newsweek, San Francisco Chronicle, Süddeutsche Zeitung, Times of India, and Washington Post.*

Roger Bate
Dr. Roger Bate researches international health and development policy, with a special interest in medicines and nicotine products. He has a PhD in economics from Cambridge University and is currently a fellow at both the International Center for Law and Economics and the Brownstone Institute. His writings have appeared in, among others, the New York Times, Lancet, Journal of Health Economics and the British Medical Journal. He has been an advisor to the South African Government. Dr Bate conducted extensive research in India and numerous African countries on the public health consequences of the counterfeit and substandard medicine trade. He has published over two dozen peer reviewed papers on the problem, especially with respect to antimalarial medicines. He is the author or editor of 14 books and over 1,000 journal and newspaper articles. His broader interests include aid policy in the developing world, evaluating the performance and effectiveness of both US Government agencies (especially FDA and USAID) and global agencies (especially World Bank and WHO).

Garrett Wallace Brown
Professor Garrett Wallace Brown is Chair of Global Health Policy at the University of Leeds. He is Co-Lead of the Global Health Research Unit and WHO collaborator on evidence and analytics for health emergencies. His research focuses on global health governance, health financing, health system strengthening, health equity and estimating the costs and funding feasibility of pandemic preparedness and response. He has over 25 years of research and policy experience, has published over 100 articles in global public health, and has worked with NGOs, governments in Africa, the UK Department of Health and Social Care, the UK Foreign Commonwealth and Development Office, the UK Cabinet Office, World Health Organization, G7 and G20.

Héctor Carvallo
Dr. Héctor Eduardo Carvallo was born in Buenos Aires, Argentina, in 1957. He graduated from de Buenos Aires School of Medicine in 1983, and reached the degree of Adjunct Professor of Internal Medicine in the same School, in 2006. Dr. Carvallo has dedicated his professional life to teaching, assisting and developing humanitarian projects, and has written widely on internal medicine, endocrinology and antibiotics. He has participated as invited speaker in multiple international forums, and has

received the City Keys from Sidney (NE) and Seneca Falls (NY). He has also been awarded with a Proclamation from the New York Senate at Albany (NY).

Thi Thuy Van Dinh

Dr. Thi Thuy Van Dinh moved from Viet Nam to study law in France, obtaining a PhD in law at the
University of Limoges. Completing the United Nations National Competitive Examination in Legal Affairs, she joined the UN Secretariat to support the implementation of anti-corruption and human rights treaties in the United Nations Office on Drugs and Crime and the Office of the High Commissioner for Human Rights. Subsequently, at Intellectual Ventures Global Good Fund (USA), she managed multilateral organisation partnerships and led environmental health technology development efforts for low-resource settings. She currently advises on procedural and policy matters related to United Nations entities in general and the World Health Organization in particular.

Harriet Green

Dr. Harriet Green holds an MA with Distinction in Political Theory and a PhD for her research on
Global Health and Distributive Justice. Her thesis focused on unpacking the United Nations' Sustainable Development Goal 3.8 of Universal Health Coverage (UHC), assessing what UHC ought to deliver as a driver of global health development. Harriet has worked with the World Health Organization as a policy consultant and reviewer, culminating in a report which critically evaluated the existing Action Review processes. She has published on global development and health.

Youssoupha Ndiaye

Dr. Youssoupha Ndiaye studied in Cheikh Anta Diop University, Dakar – UCAD (MD), University of Leeds (MPH) and achieved a PhD with UCAD – LSHTM co – supervision.
For the past 25 years, he has worked within the Senegal health system, rising to Director for Planning, Research and Statistics and coordinating strategic partnerships. He has worked internationally in Government-to-Government direct financing and delivery strategies. Dr Ndiaye piloted and published diverse operational research, on health policy, malaria, HIV, reproductive, mental and Global health. He is a public health strategist, highly committed in health system strengthening, who has successfully led committees for national plans and reforms in Senegal.

Reginald Oduor

Prof. Reginald M.J. Oduor, Ph.D. is Associate Professor of Philosophy at the University of Nairobi, with more than thirty-six years of university teaching experience. He holds a Ph.D. in Political Philosophy from the University of Nairobi, and has written widely on the need for context-sensitive models of democracy for African States. He has also written feature articles and opinion pieces on Covid-19 vaccine mandates, the growing centralisation and corporatisation of medical care, the WHO Pandemic Agreement, and amendments to the WHO's International Health Regulations. He has also spoken in several webinars and press conferences on the emerging global public health architecture, with an emphasis on the need to uphold medical ethics and public health ethics grounded in human rights. He is Co-Chair of the Pan-African Epidemic and Pandemic Working Group. He was the first person with total visual disability to be appointed to a substantive teaching position in a public university in Kenya. He is also Co-Founder and former Chair of the Nairobi-based Society of Professionals with Visual Disabilities (SOPVID).

Wellington Oyibo

Professor Wellington Oyibo is a Tropical Diseases Specialist, Professor and consultant Medical Parasitologist at the College of Medicine, University of Lagos, Idi-Araba, Lagos, Nigeria. With over two and a half decades of experience working in the space of tropical diseases and over 120 papers published in peer review journals, Wellington continues to contribute to tropical diseases research and scholarship. He is Director of the Centre for Transdisciplinary Research in Malaria and Neglected Tropical Diseases (CENTRAL-NTDs) and a Bioethics Fellow of the NIH-sponsored South Africa Research Ethics Initiative (SARETI).

Elisabeth Paul

Professor Elisabeth Paul holds a PhD in Management Sciences from the University of Liège (2006), with a thesis on the application of incentive theory to the improvement of public resource management in developing countries.

She combines an academic and field career, with about a hundred technical support, evaluation and research missions to her credit, mainly in West Africa. She is currently Associate Professor at the School of Public Health of the Université Libre de Bruxelles (ULB), and the Director of the Research Center on "Health Policies and Systems – International Health". She teaches various courses related to health policies (planning and evaluation), health financing and health systems (performance) analysis. She is also an independent consultant, and a former member of the Technical Review Panel of the Global Fund and of the Independent Review Committee of Gavi, the Vaccine Alliance. Her areas of expertise are global health systems and policies, development aid effectiveness, performance-based financing, international aid and public finance management.

Co-Chairs' Foreword

International cooperation on health is a widely accepted global good. Capacity building and development assistance reduce historic health inequalities and, as a result, strengthen economies. Management of cross-border infectious disease threats is best managed through joint surveillance, data sharing, and response. Collaboration on norms and standards provides efficiencies and facilitates trade in health products. However, the interaction between disease, the environment, and human populations is complex, and threats are heterogenous in their effects and gravity. Collaboration must therefore take such variability into account, with decision-making ultimately based around those affected.

At the same time, cooperation in public health also requires an understanding of the principles of human rights, medical ethics and ethical public health that must underpin public health actions and the policies behind them. Post-World War Two human rights are based on an understanding of the sovereignty and equality of individuals, and of the States that represent them – an understanding that underpins the United Nations itself. Thus, any institution tasked with managing health cooperation must be based on this understanding and be fully subject to the States it is intended to serve.

Health, in its well accepted definition in the constitution of the World Health Organization (WHO), encompasses physical, mental, and social well-being. Public health must be implemented in this context, encompassing a systems approach that aims at improving overall health outcomes. Public health policy and actions must also take geographic, cultural, and social contexts into account. Fundamentally, their target populations must have a key role in their development and implementation.

It should surprise no one that, after nearly 80 years of existence in a greatly changed world, the WHO is perceived by many to have drifted from this original model. Fundamental shifts in its funding base, and now the exit of its largest State funder, present both an opportunity and an urgency to reassess the optimal way in which States should work together to serve the health needs of their populations, applying the fundamental principles on which public health should be based to a greatly changed and evolving world.

WHO and the state of international health cooperation

The WHO constitution, signed in 1946 by 51 States then comprising the United Nations, had little input from most current African and Asian States. Its governing body, the World Health Assembly, gradually expanded as States broke from colonialism or foreign mandates to achieve sovereignty. The WHO took on a broad mandate including support for these less-resourced States, coordinating crossborder outbreak management, disease elimination, and the setting of international normative standards. It was hoped that the improvements in health and longevity that economic development had brought to wealthier countries could be accelerated in the lower income countries, reducing the inequalities resulting from colonialism and neglect.

The WHO's 150 country offices form a strong framework to strengthen local capacity and health systems. The organisation is well known for successes through its early focus on the major drivers of well-being and longevity such as improved sanitation, nutrition, and access to basic healthcare, and disease-specific programmes such as smallpox eradication. Major programmes in tuberculosis, malaria, vaccination, and child health have set standards for disease management and reduced overall disease burdens. A global decline in infectious disease mortality, continuing today, is testament to the success of multilateral cooperation in improving the basic drivers of longevity, reducing poverty, and improving healthcare access.

However, a drift over recent decades away from core functions of capacity-building at State and community level towards a focus on centralized, commodity-driven responses to relatively lowburden disease outbreaks, rather than the major drivers of health resilience and the high-burden endemic diseases that paralyze many countries, raises questions as to the influence of both state and non-State actors in directing WHO priorities through specified funding. A parallel rise of publicprivate partnerships and private philanthropy has further driven these changes. Such homogenous commodity-based and disease-specific responses to highly heterogenous disease risks are an inevitable outcome of the shift in WHO financing and consequent external influence. This must be reversed if international health cooperation is to fulfil its promise.

The International Health Reform Project (IHRP) report

The IHRP brings together independent professionals with experience in the WHO, UN, academia, and international public health from a diverse range of countries. The Technical Report presented here supports the accompanying Policy Report to address the crisis in the management of international public health, reviewing the human rights, ethical principles, and State and institutional responsibilities upon which public health and the collaboration of States must be based. It then summarizes the key attributes of an international health organisation fit for such a purpose and considers the WHO against this standard. The two reports are intended to provide a template that countries can use as a basis for discussions on deep reform, or the creation of a new organisation which may replace the WHO in its entirety, or complement WHO by taking on functions that are poorly compatible with an organisation focussed on what should be the WHO's core mandate. Deep reform is necessary, if we are to return international public health to an ethical and effective footing.

Public health needs to be recentred on basic principles of individual rights, and the role of States through which populations collaborate and interact on the international stage. A decentralized structure is needed to reflect diversity of epidemiology and community priorities, whilst maintaining the advantages of global collaboration. An emphasis on building resilience of peoples to disease, and of States to promote and sustain the well-being of their populations, should form the basis of endemic disease control and mitigation of cross-border health threats. Whether the radical reform needed to achieve this can be achieved through the WHO, or can only be achieved through a replacement organisation, is a question that only countries can debate and decide.

These reports which we now present have been agreed to by the eleven IHRP panel members. As cochairs we are indebted to our fellow panellists for the exceptional depth of knowledge, experience, and judgement they brought to the preparation of this report over a long and gruelling

year of meetings and conversations. They brought many different personal views to the table, and the report on which we have agreed does not necessarily reflect in all respects the preferred views of any one of them. This is particularly true of the optimum levels of autonomy and the terms of the engagement among the different levels of local, national, and international health actors; of the list and hierarchy of principles of international public health; and of the key question of the choice between reforming the WHO or establishing a new international health organisation (IHO). But we are agreed that the existing set of arrangements and practices is not the best that we can or should hope for.

David Bell *Ramesh Thakur*

Co-chairs

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ACRONYMS AND ABBREVIATIONS

ACRONYMS AND ABBREVIATIONS

ASEAN	Association of Southeast Asian Nations
BMGF	Bill & Melinda Gates Foundation
BMJ	*British Medical Journal*
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CCPR	Committee on Civil and Political Rights
CEA	Cost-effectiveness analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEPI	Coalition for Epidemic Preparedness Innovations
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRDP	Convention on the Rights of Persons with Disabilities
CRS	Creditor Reporting System
CSO / CSOs	Civil society organization(s)
DALY	Disability-adjusted life year
DAC	Development Aid Committee
DAH	Development assistance for health
DRC	Democratic Republic of Congo
EBM	Evidence-based medicine
EEAS	European External Action Service
EID	Emerging Infectious Disease(s)
EU	European Union
FDA	US Food and Drug Administration
FENSA	Framework of Engagement with Non-State Actors
FCTC	Framework Convention on Tobacco Control
G7	Group of Seven Nations
G20	Group of Twenty Nations
GAVI	GAVI, the vaccine alliance
GBD	Global Burden of Disease
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHG	Global health governance
GHIs	Global health initiatives
GHSA	Global Health Security Agenda
GOARN	Global Outbreak Alert and Response Network
GPW	General Programme of Work
VIH/SIDA	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HQ	Headquarters
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights

ACRONYMS AND ABBREVIATIONS

IEG	Independent Evaluation Group
IHG	International Health Governance
IHME	Institute for Health Metrics and Evaluation
IHO	International Health Organization
IHP	International Health Partnership
IHR	International Health Regulations
ILO	International Labour Organization
IMF	International Monetary Fund
IPAPI	International Partnership on Avian and Pandemic Influenza
IPCCR	International Covenant on Civil and Political Rights
ISC	International Sanitary Convention
ISRs	International Sanitary Regulations
LICs	Low-income countries
LMICs	Low- and middle-income countries
M&E	Monitoring and evaluation
MDBs	Multilateral development banks
NCDs	Non-communicable diseases
NGO / NGOs	Non-governmental organisation(s)
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
OECD - DAC	OECD's Development Aid Committee
OHCHR	Office of the High Commission on Human Rights
PAHO	Pan-American Health Organization
PEF	Pandemic Emergency Financing Facility
PHC	Primary health care
PHSM	Public health and social measures
PPP / PPPs	Public-private partnership(s)
PPPR	Pandemic Prevention, Preparedness and Response
QALY	Quality-adjusted life year
R2P	Right to Protect
R&D	Research & development
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Development Goals
SDOH	Social Determinants of Health
SEARO	South-East Asia Regional Office
SWAp / SWAps	Sector-Wide Approach(es)
TT HATS	Task Team on Health as a Tracer Sector
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UHC2030	International Health Partnership for achieving UHC by 2030
UN	United Nations

ACRONYMS AND ABBREVIATIONS

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNSIC	United Nations System Influenza Coordination
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WHR	World Health Report

EXECUTIVE SUMMARY

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Background

The desire to maintain good health and lead a long and contented life unites virtually all of humanity across cultures, religious beliefs, geographical barriers and political affiliations. Moreover, health is essential to the possibility of anyone living a minimally decent life, touching on much of daily activity and human interaction. Health is defined broadly within the constitution of the World Health Organization (WHO) as:

""a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Thus, public health encompasses the effort to put conditions in place at community and broader levels to maximize the chances of good health, namely:

"the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society"

A broad range of epidemiological, behavioural, and social influences promote or mitigate against good health. Along with pathogens and environmental factors implicated in human disease, many epidemiological influences are not confined by national borders. Thus, cooperation among States to improve the health of their populations is consequently a well-recognized global good. It makes good sense to coordinate and assist each other on a global level. Efficient and effective cooperation can benefit from several communities working together to achieve shared objectives, whilst humanitarian principles of solidarity are supported by collaboration between States with greater capacity and those with less.

The WHO was established in 1948 to achieve these ends, following a series of earlier international health agencies and conventions. It continues nearly eighty years later as the central global agency in this role, though in an increasingly crowded and complex international environment very different from that in which the WHO was born. These changes have inevitably impacted the Organization and its ability to carry out its intended role. The recent withdrawal from WHO of its previous largest funder, the United States, also significantly changes the resources for, and context of, WHO's operations.

This report examines the human rights and ethical basis for public health cooperation, the principles on which international cooperation in public health should be based, and what an ideal multilateral International Health Organisation (IHO) should therefore look like. The WHO is then examined against this standard, together with its organisational structure and funding.

Human rights and health

Since the end of the era of global colonialism in the mid-twentieth century and the wide abuses associated with and before the Second World War, the international community has codified human rights and developed laws and norms that protect them. These are based on the concept that each person should have ultimate control over themselves, being of inestimable intrinsic worth and equal to all others – enshrined in the concept of individual sovereignty outlined in the Universal Declaration of Human Rights, various international conventions, and the founding documents of the United Nations concerning the status of States and their peoples.

Public health, being intended to benefit individuals and populations within the wider complexity of their personal, family, and social life, must therefore be based on such an understanding. Public health interventions must consequently occur at the behest of those populations and individuals who are impacted by them, and be subject to their ultimate control within the societal structures developed to enable this.

Everyone, however, lives within or interacts with others in a community, and their actions impact on the lives and well-being of others. The concept of modern sovereign States provides, in intent if not in practice, collective expression of individual autonomy within a population, and most international cooperation relies on State sovereignty as the collective expression of the individuals and communities there-in. International cooperation on public health must therefore be based firmly in the concept of individual sovereignty – bodily autonomy and the right of an individual to make decisions regarding their

own health – within the structures required to achieve joint expression and to allow communities to interact with, and relate to, one another.

Within medicine the understanding of individual sovereignty and worth has been commonly characterized for more than two thousand years to reflect the primacy of beneficence, non- maleficence, and patient confidentiality in a practitioner–patient relationship. A fourth concept of voluntary informed consent underlines the patient's rights to ultimate decision-making (bodily autonomy) within this relationship. Public health must therefore be broadly based on these principles of ethics of clinical medicine, but also on principles that extend these to address the need for cooperation to achieve joint goals and to recognize the impacts of individuals and their states on others.

A right to health is widely recognized as a driver of health policy within this framework. As a positive right, this imposes a responsibility on people or society to act in the interests of the health of others. It is important to the fulfilment of a good life, but subject also to the limitation that others cannot be forced or coerced to act in another's interests. Good public health policy recognizes the right to health as a fundamental responsibility of states and communities, implemented in the context of negative non-derogable human rights with which all humans are endowed. As a basis for the existence of an international health organisation (IHO), the right to health underlines the importance of decisionmaking occurring at a level where local context is fully understood, where local populations can determine their own priorities, and determine how implementation occurs even when it is necessary to ask for help.

Public health and multilateral cooperation

Multilateral cooperation among states and their communities must therefore be based fundamentally on core principles of human rights. This report lays out an example of the expression of these in the context of an international health organisation. Such principles must be embedded within its constitution or governing rules and characterize its actions and programmes if basic human rights are to be protected as the fundamental basis of human interaction.

To be effective, an IHO must also adhere to a principled approach to public health that prioritizes evidence and science translated into action within the context in which individuals live, taking into account geographical, environmental, cultural, economic, religious and other characteristics. This requires a structure that emphasizes decentralisation or 'subsidiarity'. While central collaboration is invaluable for collating data, analysing trends and forming advice, legitimate public health responses must be interpreted by those at a more peripheral level who best understand the context in which they will be enacted.

Good public health policy also recognizes the broad basis of human health, emphasizing the primary determinants of health across the WHO's definition; physical, mental and social well-being. At a global level, these determinants – the predominant reasons people in well-resourced countries live longer and die less from readily-avoidable disease – include good nutrition, sanitation, a reduction in environmental threats, adequate living space, basic clinical care including access to certain medicines, and a well-functioning health system able to provide these. Where resources are inadequate or major burdens of disease persist, disease specific approaches including vaccines, diagnostics and pathogenspecific therapies become increasingly important.

For interventions to be sustained, and for the achievement of broad gains in human well-being across the spectrum of health and disease, a systems approach is required. This recognizes the interactions between diverse factors varying across geographies and populations, and the necessity of building sustainable capacity that addresses local context. This includes the need for preparation and response to health emergencies such as disease outbreaks or environmental changes for which the importance of cooperation across borders is clear. However, the effectiveness of such interventions requires adaptation to local context and consideration of competing priorities.

Health is closely linked to economics and self-esteem. Social capital is associated with longer lifespans and greater resilience against disease, further raising the importance of individual and local control of major life decisions and the impacts of these on mental and social well-being. The resilience of a society is further associated with its economic health and consequent ability to ensure a healthy environment, good nutrition, and good public and clinical services for its population while having appropriate capacities to respond effectively to intermittent threats.

However, health is also affected by, and impacts on, commercial and political interests. The commodification of health and the growing health security agenda, in many ways brought to prominence through the Covid-19 outbreak, have paralleled the growing influence of commercial interests on the international health agenda, with implications for national economies in countries producing and consuming healthcare products. This has raised challenges in ensuring proportionality, balancing approaches that provide potentially lucrative markets for commercial interests with approaches that prioritize high burden endemic diseases in low-income populations and seek to build underlying environmental and population resilience.

Structure of an International Health Organisation (IHO)

For an IHO, it is therefore necessary to define a core set of functions that address the major determinants of well-being whilst respecting the sovereignty of individuals and states, building the long-term resilience of both. This must occur within an environment in which vested interests are seeking to influence public health policy and the IHO itself. On a practical level, IHO priorities include: building systems and individual resilience to reduce future need for the IHO itself, whilst continuing functions best addressed at a multilateral level such as data collection and analysis, and harmonisation of norms and standards. Health emergencies crossing borders present a special case that are mitigated by improvements in underlying resilience but also require occasional rapid scaling of cooperative action that may be best addressed by a quite different multilateral structure.

Based on the sovereignty of individuals and the states that represent them, and the heterogeneity of determinants of health and people's priorities, an IHO should advise rather than require adherence. Loss of local prioritisation and interpretation would risk public health more broadly and violate understandings of human rights that must form the basis of an IHO's activities.

In order to fulfil its role of serving populations rather than vested interest, an IHO must have firewalls guarding its staff from subservience to specific funders, thereby reducing inappropriate influence. A decentralized staff with rotation and term limits will reduce institutionalisation while keeping decision making close to the populations affected. This requires an emphasis on assessed funding with strict limitations on private sector support. Embedding clearly defined term limits and emphasis on subsidiarity within its constitution will limit mission-creep and the potential for unfettered and centralized bureaucratic growth.

The World Health Organization

After nearly eighty years, the WHO works in an international health environment barely recognizable from that in which it was formed. The emergence of states from colonialism drove an increase in membership of World health Assembly (WHA), the WHO's governing body, to 194 before the recent withdrawal of the United States. The WHA, based on one country – one vote, is now dominated by former colonies and lower- and middle-income countries in terms of numbers. However, a divide persists between wealthier donor states and recipient countries, frequently former colonies' that now struggle with fewer resources, lower capacity and higher remediable disease burdens.

In terms of disease, infectious disease rates have steadily declined overall, whilst some that were previously common are now rare and, in the case of smallpox, eradicated. Advancing technology has transformed the way diseases are diagnosed, distinguished from background, and managed. Access to core health services has been transformed, though highly unevenly, through improved infrastructure and communications.

The increased array and availability of health commodities have contributed significantly to improvement in overall health outcomes but also brought challenges to the management of international health and to the way in which WHO and other multilateral organisations function. International public health has become a vast marketplace for the products of biotech, pharmacology and communications, raising concerns about how to appropriately weigh public benefit against return on investment, and public good against private profit. While profit and public good are by no means mutually exclusive, health policy and implementation inevitably become of interest to the private sector and of States invested in this sector. The same commodification of healthcare has also transformed the environment within which the WHO works, its areas of work now overlapping or even competing with an array of influential public-private partnerships (PPPs) and private entities with budgets equivalent to WHO.

The WHO has also undergone a major transition in its funding. Previously, a budget based primarily on assessed contributions from states enabled WHO to set its own priorities based on technical expertise, disease burdens, country requests and capacity and WHA guidance. Now, approximately eighty percent of its funding is earmarked for tasks specified by the funder – either state or private. Third parties can thus determine much of WHO's work in

an environment in which many of those parties have specific interests that may differ from population need.

Without firewalls to protect against vested interests, public policy formed under these conditions can become a marketing strategy for healthcare commodities. This risk is raised by changes in the way WHO is funded; its largest funder at the end of 2025 was a private foundation and its second largest was a PPP with direct industry involvement.

The WHO's loss of autonomy has paralleled an increase in interest in health emergencies over longterm disease burdens, and a commodity-based approach to preparing for and dealing with them. This is most apparent in the pandemic agenda, including the response to Covid-19 but evident in two decades of prior WHO Global Programmes of Work. It has also been associated with an steady expansion of the organization, despite markedly declining infectious disease (and pandemic) burdens since the first of WHO's predecessor organizations in the early 1900s. A concentration on the health security agenda has led to increasing centralization and a reduction in a focus on fundamental determinants – and traditional WHO priorities—such as nutrition support and access to primary care. In parallel, declines in some major disease burdens such as malaria and tuberculosis have stalled or reversed. Most concerningly, there is an apparent drift away from a focus on human rights and from traditional public health principles of balance and proportionality that should guide international public health.

While the WHO's constitution entrenches the role of the WHA's Member States in governance, the drift in funding forces changes in budget allocations, and inevitably influences how the WHO Secretariat acts, and indeed, their very job security. Competition with an increasing number of global health initiatives (GHIs) and rigid staffing rules also promote bureaucratisation, pressuring staff to prioritize job security and the organization's growth over downsizing and transferring health responsibilities to national levels; a condition that would require a better WHO focus on local capacity building and system resilience.

The WHO has contributed greatly to good health outcomes over its 80 years, but the WHO of today, and the structure and funding that supports it, is far from the organization that initially reflected values and aspirations of the decolonizing, human-rights-focused world at its inauguration. Having grown in many respects out of the League of Nations Health Office, WHO began as a greatly transitioned agency to address a changed world. Such a transition is needed again today, whether it occurs through deep change of the current structure or a replacement multilateral organization.

Recommendations

Given the requirements for an IHO that adheres to the basic principles for legitimate and evidencebased public health, the inadequacies of the current WHO structure to achieve these, and the changing global public health environment, the following are recommended as a basis for considering fundamental reform or replacement of WHO with an effective multilateral approach that addresses the requirements of individual and national sovereignty whilst responding effectively to global public health need.

Constitution

The operation of an IHO must be based on rules that entrench human rights and public health ethics, mitigating against mission creep and the temptation to abrogate these and ignore wider and longer-term public health implications in an emergency.

- Embed fundamental human rights based on individual sovereignty, and consequent medical and public health ethics, as inviolable guiding principles for policy and implementation.
- Codify the equality of states, the organisation's independence from non-state actors, and establish checks and balances to prevent capture.
- Require super-majority approval for amendments, ensuring stability of purpose and immunity from political or commercial manipulation.
- Explicit conflict-of-interest clauses and financial transparency requirements.

Focus

- Capacity building and health systems strengthening
- Support to strengthen underlying addressable determinants of health and resilience, including in nutrition and sanitation
- Support to control and reduce major addressable disease burdens, with an emphasis on states with weaker health systems to support the building of needed capacity Data collation and information sharing to improve decision-making
- Setting international norms and standards to improve effectiveness and efficiency of crossborder cooperation
- Coordination of international responses to health emergencies, providing information and support for a contextualised approach at a population level.

Structure

An IHO's structure must ensure local context and priorities drive interventions.

- Decentralised organization: Regional offices and smaller groupings hold operational responsibility.
- Smaller, modular staffing: Focus resources at regional and national levels, ensuring equitable staffing that emphasises regional experience and required expertise. Mobilise local insight and increase localized capacity.
- Direct country representation: Voting blocs small enough to balance influence among large and small states.
- Streamlined secretariat: Leadership limited to coordination, knowledge management, and facilitation.
- Promote an internal culture of radical transparency, open communication, and constructive criticism to counter any suppression of new ideas or criticisms.

Staffing

Staffing must ensure current technical expertise and relevant country experience, whilst avoiding institutionalisation and role stagnation.

- Enforce term limits, rotation, and periodic external service to avoid institutional ossification.
- Prioritise technical competence and field experience.
- Create clear conflict-of-interest disclosure and cooling-off requirements for staff moving to or from private industry.

Funding

An IHO should be governed by countries and prioritise based on technical expertise and need, rather than specific funder preference.

- Base funding of all staffing and operations on assessed national contributions to preserve independence.
- Voluntary and private funds, if accepted, must remain unspecified and within capped, transparent limits.
- Budget formulas should prioritise high-burden, low-income regions with emphasis on time-bound capacity-building aiming at local self-reliance and national ownership.
- Require full public disclosure of contributions.

Long-term vision

Continued growth should be seen as antithetical to the mission of an IHO since it should aim to build national capacity and to contribute to reducing disease burdens. Some functions, however, constitute long-term global goods.

- Build an IHO that acts primarily as a forum and facilitator, not a governing authority.
- Emphasise local capacity-building over control or continuous external intervention.
- Design time-limited programmes that strengthen health systems, enabling progressive IHO redundancy rather than perpetuate dependency.

While the drift to centralisation, biomedicalization and securitisation goes beyond WHO, the WHO remains the central pillar of multilateral health policy. There is global goodwill toward the concept of health cooperation and traditionally the WHO has been seen as a positive example of this global good. However, few would suggest now that an IHO such as the WHO should be directly shaped by individual funders, and particularly by non-state funders with apparent vested interests in certain health care approaches. The WHO finds itself with both external and internal challenges to prioritizing the well-being of the populations it is intended to serve.

The recent exit of the United States, formerly WHO's largest funder, and ongoing debates on the Pandemic Agreement and related matters raise an opportunity and an urgency to rethink how an IHO should best serve national and global interests. The WHO has made a major contribution to global well-being over much of its existence, but this alone should not be a reason to retain it in its present form. In order to serve the health of populations and ensure contextualisation of health policy to address the requirements of global health, a change in WHO structure including greater subsidiarity, and major changes in the way the organisation is funded, are needed. This could involve deep reform or an orderly and sensible replacement.

Inaction will allow a continued drift. This risks poor public health outcomes, increasing fragmentation and dissatisfaction with the idea of health cooperation. This report, together with the accompanying Policy Report, is intended to stimulate discussion towards a return of international health to a solid, ethical and effective framework that serves population need, consistent with the WHO's original intent.

PART I:

BACKGROUND

I.1. INTRODUCTION

I.1.1. The justification for public health

Well-being, and disease, have always been key concerns of human society. Beyond our ability to exist, well-being and disability determine the strength and functioning of economies, social interaction, and family life, which are influenced by our environment, nutrition, living conditions, and social capital, and thereby directly and indirectly by actions of others. This is the justification for public health – a cooperative effort to benefit the health of others as well as ourselves.

Premature death, disability and well-being are not only influenced by the environment and economies but directly limit our ability to improve both. Poor health exacerbates inequality between individuals, communities and States. The actions of healthier, wealthier individuals and States in bearing part of the health burdens of those less well will, if applied in a way to improve overall well-being of the recipient, reduce such inequality. We assume in this report that, all humans are born with equal and inestimable worth, and that reducing inequality to the extent of allowing all to exercise their rights as a human is a justifiable societal goal. From a utilitarian perspective, gross inequalities lead to unstable societies and an unstable world, which it is of mutual benefit to avoid.

A moral responsibility to address and support a basic level of healthcare access must be viewed within a clear framework of fundamental human rights, expressed in turn through rights of communities and countries. Equality is not served from a human rights perspective through one group forcing actions of another. Nor is it served by structures that entrench long-term dependency. Any public health approach at a local or international level must navigate these complexities, discussed in detail later in this report, in order to maintain legitimacy based on the post-World War Two understandings of human rights and medical ethics on which modern understandings of public health are based.

Health and economies

Healthcare consumes resources, but also supports economic growth by reducing the costs of illness and supporting workforces. This has implications at community and national levels, but also internationally, including through benefits of trade and reducing dependency. Multilateral cooperation in international public health is therefore a widely recognised mutual benefit to global well-being, beyond and probably of far more importance than the immediate issues of avoidance of spread of disease.

Healthcare is also a marketable commodity, whilst perceived risk of illness and death serve as compelling drivers of fear. This presents an inevitable risk to any public health programme or institution, as market forces that may provide resources also compete for priorities with populations who are resource-poor and so, in many respects, less able to exert influence. There will therefore be a tension between resourcing programmes to ostensibly benefit poorly resourced communities and States, and the decision-making on how and where resources shall be applied. We believe this underlies many of the tensions rising in international public health today – with a drift of focus from areas primarily promoting well-being and addressing high burdens of disease to an increasing focus on less common, lower burden but highly profitable commodity-based approaches involving increasingly centralised control. These have given rise to concerns of an erosion of individual and States' rights.

Public health has an unenviable history of abuse and of siding with authority over the rights of populations and individuals. The part played by the health professions in the eugenics movement and forced sterilisation campaigns of the pre-World War Two period, and in support of European fascism and politico-military expansionism elsewhere in the lead up to and during World War Two were drivers behind the codifying of standards for medical research, clinical medicine and human rights in the years following. This period shaped WHO during its formation and early years, as decolonisation rapidly increased the number of independent States.

It should not surprise that, almost 80 years on, this early momentum has faded, and other forces have come to influence the world's central public health organisation. Geopolitical alliances have changed, health technologies have changed the trajectories of disease and the potential

profits to be gained from managing them, while philanthropy and private foundations have arisen with amassed wealth from the software and technology sectors that dwarfs the budgets of many WHO Member States. These influences have also changed WHO and the environment within which it works, with rapidly growing public-private partnerships taking much of the ground that WHO once considered its territory, allocating resources that dictate much of the health agenda that WHO formerly set.

WHO's performance during the Covid-19 outbreak and its subsequent focus on the pandemic agenda have brought wider attention to its work, and made it subject to far more criticism than ever before. A perception that WHO's priorities have drifted from population health to specific interests of certain State and non-State actors has tarnished its image, but also brought an opportunity for change. The withdrawal of the United States, formerly WHO's largest funder, will force a contraction of WHO's work while the new US global health strategy emphasises bilateral relationships and local capacity building in place of multilateral institutions exerting a more centralised model. The failure to uphold certain fundamental principles of population health during Covid-19 and the misrepresentation of pandemic risks highlighted in recent University of Leeds reports supports the impression that narrow agendas are prioritised over health burdens and the building of capacity that is essential for long-term public health resilience.4 The management of international public health must change, and this change must reemphasise the role of individuals and States as the primary determinants of policy.

I.1.2. Understanding "health"

The preamble to the 1946 WHO constitution provides a broad definition of health:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Health, or 'well-being', is thus considered to entail not merely an absence of physical ailments or limitations, but a full ability to function in, and enjoy, interactions with others within human society. They are not listed by WHO in a hierarchical way, and each of these three aspects influence the others. Any public health intervention must therefore take all three aspects into account; a response to a physical ailment that harms mental health or limits social interaction may not provide a net benefit.

Accordingly, health should not be viewed as a discrete variable, but as a continuous variable which evolves and is influenced by several factors in a complex way. Health and illness or disease occur on a continuum in the same person over time, expressed in a multitude of ways as the result of an overall physiological dysfunction within the same person.

A more reductionist approach ('Pasteurian paradigm') views health and disease as binary variables, with health being the absence of disease. Diseases typically are considered to have a single cause (e.g., a pathogen or cancerous growth), through a linear, one-way causal relationship (e.g., SARS-CoV-2 alone causes severe Covid-19). This approach aims to relieve or prevent symptoms through focusing on direct, biological causes and addressing them through a discrete intervention such as an antibiotic or vaccine. It is a common approach to infectious disease management, but also sometimes cancers and the risk factors of non-communicable diseases (NCDs) (e.g., medication to reduce hypertension or treat obesity).

The reductionist approach is not wrong, but incomplete. Severe Covid-19 is generally a result of a SARS-CoV-2 virus infection in a non-immune person with significant metabolic impairment (e.g. due to obesity, diabetes mellitus, micronutrient deficiency). The virus is critical to the development of illness, but so is the underlying host State that prevents a sufficiently protective host response.

Good public health, like individual clinical management, aims to address the root causes (determinants) of (ill-)health through a systemic approach embracing the underlying complexity of causes of disease. This 'holistic' approach is particularly necessary to tackle non-communicable diseases – which account for about two-thirds of deaths globally, but is also critical to long term outcomes of infectious disease management.

Most gains in longevity in wealthy countries over the past 200 years have occurred due to improvements in a broad range of factors related to host resilience and exposure; improved nutrition, sanitation and living conditions. Antibiotics played an important role in reducing mortality due to infectious syndromes such as pneumonia and sepsis, while mass vaccination, with the exception of smallpox and to a lesser extent pertussis, came after most mortality from their target diseases had resolved but sometimes played important roles in reducing pathogen circulation. In lower resource settings, the major risk factors for infectious diseases still exist and the relative importance of environmental approaches (which take longer) and treatment or vaccination (rapid) will differ, but addressing through both approaches is critical if sustainable outcomes are to be achieved based on the broad understanding of health in the WHO definition.

I.1.3. Why this report?

The debate around WHO's future role seems heavily polarised between the positions of (1) further strengthening and centralising WHO on the assumption that greater resources and power will overcome its shortcomings, and (2) dispensing with the idea of global or multilateral health bodies as an inevitable path to bureaucratic fiefdoms and a concentration of power. A more nuanced approach would acknowledge the threats that are encroaching on WHO and public health with the growing profitability of healthcare and the drift from the States-based organisation initially envisioned, whilst also recognising the advantages of broad cooperation in standards-setting, data sharing and technical and capacity building where historical and other influences have entrenched inequality between States and poverty among their populations.

Returning to the human rights norms underpinning WHO's foundation, and required adherence to the medical ethics that accompany them, should provide a consensus basis for this. An international health organisation (IHO) can then be designed within which departure from these norms is impermissible, together with the sovereignty of States that forms the basis of the UN Charter. It would recognise also the responsibilities of States for the welfare of their citizens, and not be in a position to take their place. The IHO henceforth described in this report is a normative benchmark, not a proposal for the immediate creation of a new international institution.

Nearly 80 years after the formation of WHO, there is clearly a need for reform. This may involve changes to WHO, or may involve a replacement – this would depend not on the wishes of any international organisation but on the will of the States that must exert their authority and control. Restating the fundamental understanding of human rights and ethics on which international public health should be based, how an IHO may function within that, and how WHO compares with such an IHO, will provide a basis for such a discussion.

I.1.4. Why IHRP?

The International Health Reform Project is an independent group with experience in working within and with the United Nations, World health Organization and other international health bodies. It includes experts from a range of geographies and economies, from the fields of health, international law and relations, and academia.

The intent of the IHRP is to provide a template, based on broadly accepted principles of human rights and public health, as a basis for guiding reform or replacement of the WHO, and a reevaluation of the way in which international health is managed more widely. Ultimately, the only entities with a mandate to make such changes are sovereign States, as representatives of the individuals and populations whose health and well-being will be impacted. Such considerations are already clearly in process, with the withdrawal in 2026 of at least two major States, including the largest funder, from WHO.

The world should expect better than the present state of international health cooperation, but cannot afford to destroy what is good within the current system. A clear conversation regarding international public health, leading to broad and deep reform, is needed. The IHRP, as an independent and self-convened panel, has a role in contributing to this discussion, pointing out the accepted basis of medical and public health ethics and of international cooperation, and consequently what an IHO should look like that adheres to these accepted norms. We seek to point out areas where the current model, focussed on the WHO as the UN's mandated health agency, falls short.

I.2. IHRP REPORT STRUCTURE AND ANALYTICAL APPROACH

This Technical Report is a joint product of the IHRP panel and accompanies The Right to Health Sovereignty Policy Report. Together they seek to outline the IHRP's discussions and findings from the point of view of policy development and change at the level of the States which must ultimately determine the future of WHO or any alternative IHO or multilateral mechanism, and the justification for these changes.

I.2.1. IHRP report development

The IHRP held an initial three-day meeting in London on 10th to 12th April, 2025, to determine the scope of the reports and the areas to be covered within the two Right to Health Sovereignty reports. The meeting identified themes that were necessary to address (e.g. WHO financing, accountability) and a basic strategy for how the panel would function, including basic divisions of labour, panel communications, topic assignments, and next steps. Thematic areas were divided between panel members for initial research and drafting. Each section was assigned at least two main authors to distribute workload as well as to assure that ideas received a level of internal debate prior to wider deliberations between the Panel. Although panel members had individual assignments, it was agreed that all members would review and contribute to every section of the report. All disagreements were fully discussed and deliberated with the aim of reaching consensus. All produced materials would be uploaded onto a shared drive, which would be managed by an administrator responsible for collecting and organising any submissions to the shared drive.

A second IHRP three-day meeting was held in London on 28th to 30th August, 2025, to discuss draft material, identify problems arising, to discuss controversies and agree next steps.

An IHRP four-day editorial workshop was held in Washington DC on 16th to 19th February, 2026, to review drafts of the Policy and Technical reports, address remaining gaps, and find consensus on remaining sticking points. The full IHRP panel reviewed and advised on the final documents.

I.2.2. Structure of the IHRP report

The panel agreed at the second IHRP meeting in London that two Right to Health Sovereignty reports would be produced, a Policy Report and a Technical Report. The Policy Report would be oriented toward a policy audience addressing wider concerns of global health governance, the role of an international health organisation in international health cooperations, key issues involved in WHO reform, and issues of country ownership, sovereignty and representation in global health policy. The Technical Report, presented here, is aimed primarily at the expert community of global public health decisionmakers, health practitioners, academics, and the public. The role of this Technical Report is to address important details involved in global public health writ large, the WHO, and its future. The report is meant to stand alone, but also compliments and informs the Policy Report.

This Technical Report follows the following aims and methodological logic:

1) To outline key ethical principles that underlie global public health and to detail the importance of them as foundations for any international health organisation as well as their significance as policy guardrails.

2) To outline key principles that should consequently underlie an international health organisation (IHO) in terms of global health policy design and implementation. These principles include issues of governance, accountability and financing.

3) To outline what an ideal IHO would look like in response to 1 and 2 above. Here, the aim is to identify what an IHO ought to resemble normatively and institutionally. By doing so, it provides a baseline to identify gaps and measure how WHO operates later in the report.

4) To measure WHO against 1, 2, and 3 above to

determine where WHO satisfies normative and institutional ideals and where it continues to have shortcomings or failures. By identifying these gaps, it is possible to provide specific recommendations for how to improve WHO as an international health organisation, and to further determine the feasibility of whether WHO reform is possible in line with standards set in 1, 2 and 3.

5) To provide a series of recommendations for reform of institutional multilateral health cooperation and to discuss the feasibility of instituting these reforms under curr replacement with a new IHO are more likely to succeed.ent circumstances. This allows for a more reflective discussion of whether WHO can be reformed or if strategies for replacement with a new IHO are more likely to succeed.

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The IHRP Technical Report is structured along this logic, broken into five sections made up of:

I. Introduction,
II. Underlying basis for international public health
III. Outline of an ideal IHO based on the above requirements
IV. Assessment of WHO against the IHO standard
V. Conclusion with recommendations

I.2.3. Analytical approach

An analysis of the requirements of an ideal IHO and the WHO is presented following a general format established by Moser and Bump (2022). This systematic review of the academic literature on WHO reform found that there were no standard methods for assessing the WHO, revealing a need for a more 'rigorous and inclusive' research agenda. Moser and Bump designed an analytical framework for WHO assessment adapted from various studies and discussed in more detail in Parts III.1 and IV.1 of this report. The IHRP followed their general framework (Figure I.1), addressing five areas:

1. Identity (including culture, norms and values)
2. Legitimacy and governance (including accountability)
3. Authority and external relationships
4. Goals and strategy (including learning and innovation)
5. Structure and performance (including organisational purpose, workforce and finance).

IHRP's adaptation makes four alterations to the framework and its use in the organisation of this report (Figure I.1).

First, the category of Identity has been moved to the top of the framework and subsequent IHRP analysis, since we believe that institutional norms and values are fundamental to how an institution prioritises its programme of work as well as how that work is executed. Moreover, disparities between theory (normative values) and practice (how it performs) are often prominent at the level of institutional identity, thus often providing useful insights about the need for institutional normative shift and/or the need to realign an institution with its original normative foundations.

Second, we have expanded the number of subcategories under each categorisation to capture a wider range of reform topics and issues. The IHRP seeks to include questions that were not prevalent or were undervalued within the academic literature, particularly issues in post-covid WHO reform debates and concerns arising regarding recent Overseas Development Assistance (ODA) cuts.

Third, although WHO financing has impact across all five categories, we have added a specific subcategory of WHO financing under the category of Structure and Performance due to the important role it plays in WHO's organisation, performance and ultimate sustainability.
Fourth, the IHRP framework places a greater emphasis on external relationships than provided by Moser and Bump. This is because WHO has become increasingly reliant on individual nongovernmental actors as well as other Global Health Initiatives (GHIs). Moreover, WHO operates within an increasing cooperative and competitive global health policy landscape with unique outcomes. These conditions are set to increase with the withdrawal of the United States, thus increasing the relevance of alternative streams of WHO funding, competition for that funding, and the limits of global health partnerships. A key aim of IHRP is to examine the nature of these relationships, thus necessitating its own subcategory of analysis.

Figure I. 1 – Framework of organisational effectiveness and applied questions to assess WHO.
Adapted from original of Fabian Moser, Jesse B. Bump, Assessing the World Health Organization:
What does the academic debate reveal and is it democratic?, Social Science & Medicine, Volume 314, 2022, 115456,
https://doi.org/10.1016/j.socscimed.2022.115456

I.3. KEY CONCEPTS

I.3.1. Concepts of global public health

Before going further, it is useful to review several basic concepts of global public health relevant to understanding the purpose of an IHO.

Justification of public interventions

Modern public health is often dated to the actions of John Snow in identifying the source of a cholera outbreak in London in 1854 and stopping the outbreak by shutting off the Broad Street pump from which water contaminated with Vibrio cholerae bacteria was being drawn. Subsequently, water testing, filtration and chlorination, management of sewerage, education, the use of targeted vaccination have made cholera outbreaks relatively rare and limited in scope. Exceptions such as the outbreak in Haiti from 2010 and the outbreaks in Yemen from 2016 are associated with a breakdown in the ability of society to maintain such management due to external pressures and/or severe poverty. In the case of Haiti, a lack of good waste management by the United Nations compound also highlights the interdependence of communities on each other to maintain health - local residents suffered as UN staff failed to undertake actions (waste management) that were purely for the protection of others.

This example explains the rationale for public interventions, compared to letting the market play to achieve an overall benefit and efficient allocation of resources. Effort and expenditure are required at a community level in order to protect against current or future threats of harm that may or may not impact those exerting the effort and resources. It is a public good. Such interventions frequently require organisations to design and maintain them (e.g. a safe drinking water system for a city) and are often implemented at a national level. However, these interactions and common goods can also frequently be generalised to an international level, as the actions of one country affects another in similar ways to the impact of the Haiti UN compound on residents beyond its walls. Public health becomes not just a public good but a global public good, requiring mechanisms within which countries can interact with each other if they are going to effectively and efficiently realise such goods.

Provision of (Global) Public Goods

Economists differentiate between four types of goods and services depending on two characteristics: whether they are 'rivalrous' (i.e. their consumption by one person reduces the availability of the good or service to another person) and their excludability (i.e. it is possible to prevent someone from using them if they do not pay for it). These are:

Private goods, which are both rivalrous and excludable (e.g., a car, a medicine).

Public goods, which are both non-rivalrous and non-excludable (e.g., sunshine, clean drinking water), and two types of Quasi-public goods:

Club goods, which are excludable but non-rivalrous to a certain extent (e.g., being part of an international organisation).

Common (pool) goods, which are rivalrous but non-excludable (e.g., land and other natural resources).

If clinical medicine and healthcare are, to a great extent, private goods, some aspects of health can be viewed as public goods.

> *"For example, no one in a population can be excluded from benefiting from a reduction in risk of infectious disease when its incidence is reduced, and one person benefiting from this reduction in risk does not prevent anyone else from benefiting from it as well".*

Similarly, public health can be considered a public good because it depends principally on structural, social, and political conditions that create the conditions in which good health of individuals within the population is more likely to be maintained. These conditions are features of social structures that are not owned and not buyable by individuals, and are "*both non- excludable and non-rivalrous, ...[such as] policies that incentivize healthier foods and efforts to minimize pollution*".

The problem is that public goods can be under-supplied by free markets, as their usefulness to the general population is not matched by the usefulness to an individual and therefore the likelihood that an individual will purchase them. There can be little commercial incentive to produce them without a market being assured by the public sector.17 Non-rivalry also leads to a 'free rider' problem: the entity investing in a public good cannot prevent others from benefitting from it, and everyone expects to benefit from public goods paid by someone else (for instance, tax-payer funded medical research benefits a large population, but its investment costs are too high for most individuals to support. Wealthier individuals have limited

incentive to finance an innovation whose benefits will be used by others). Hence the need for, and fairness of, public intervention and investment to ensure their provision.

Global public goods are public goods "whose benefits cross borders and are global in scope".18 For instance, their benefits accrue to several population types and/or extend to both current and future generations, while it is impossible to exclude some countries from benefiting from the efforts of others. For instance, eradicating infectious diseases of global scope, such as smallpox, provides a benefit to all countries without causing direct detriment to others (beyond arguments of use of its own resources). Therefore, a similar problem lies in who, or which public bodies, will invest in global public goods whose benefits accrue to all: To ensure fairness, the costs of collective action necessary to maintain health taken at the international level should therefore be shared as widely as possible. An IHO has a role in ensuring a fair distribution of such costs.

Global public goods used in the health sector, also termed common goods for health, can be considered in five broad categories: 1) policy and coordination, 2) regulation and legislation, 3) taxes and subsidies, 4) information collection, analysis and communication, and 5) population services. Examples considered by the WHO are shown in Table I.1.

Category definition	Select examples
1. Policy and coordination: Formation of national policies, institutional capacities and coordination mechanisms	• Planning and management of emergency preparedness and response • Health security and environmental risk policies and strategies • Community engagement and management • Institutional capacities and plans • Coordination platforms/systems • Sector and subnational policies and strategies
2. Regulation and legislation: Full range of legal instruments	• Regulation of the safety of medicines and medical devices • Legislation • Environmental regulations and guidelines (such as for biodiversity, water and air quality) • Accreditation of health facilities and providers
3. Taxes and subsidies: Financial instruments to influence individual and market behaviour	• Taxes on products with health impact to create market signals leading to behavior change
4. Information collection, analysis and communication: Collect and analyse information, and monitor population-level change	• Human and animal disease, environmental and risk (such as, AMR, chemicals and radiation) surveillance • Communication and dissemination • Community behavior change communication • Research and development • Monitoring and evaluation
5. Population services: Services that impact all of society and are fundamental to public health	• Sewage treatment and control • Vector control • Medical and solid waste management • Emergency response operations

Table I. 1 – Examples of common goods for health categories

Source: World Health Organization, https://www.who.int/publications/i/item/978924003420

World Health Organization, 'Financing common goods for health'. Geneva: World Health Organization; 2021.

Public goods and markets

Some activities by private firms or individuals may have side effects on other parties, be they positive (e.g., education) or negative (e.g., pollution). In such cases, because social costs and benefits are not reflected in private decisions, markets do not ensure the right (economically efficient) price and/or the provision of the right amount of those goods or services that ensure public benefit. Therefore, public intervention may be justified to support or limit the production or consumption of those goods and services creating negative externalities (e.g., through subsidies or public purchase, or negatively through taxation or regulations), Positive interventions may include preventive services such as vaccination and prevention of sexuallytransmitted diseases, to ensure that benefits extend to communities in which individuals at significant risk live. Conversely, smoking may be limited in public places as well as prohibiting driving under the influence to protect others whom these activities may put at risk. While these are community or national level concerns, some health-related activities, goods and services have international externalities, thus justifying the intervention of an IHO.

Fairness in relation to support for global public goods

The aim of provision of global public goods is to, almost by definition, ensure all have reasonable access to their benefits. There is also a requirement for fairness in the allocation of access to benefit, and of cost in public resource required to provide such access. Inequity in costs and benefits can occur between individuals or communities and between countries at an international level. While this is somewhat inevitable (some people, communities and countries are richer than others, some have, for reasons of geography, history or other, greater health burdens), it is essential to understand what makes fairness more or less likely in developing national and international public health policy, and in defining the roles of public health institutions.

Information asymmetry occurs when one party in a transaction has more or better information than the other, and this inequality then distorts the allocation of two types of information:

> Adverse selection happens when the buyer has less information about the good or service they intend to buy than the seller and is thus unable to appraise its right price. This is exemplified by the relationship between a patient and a health professional. Alternatively, someone contracting health insurance knows her health status better than the insurer, hence the risk for health insurance to attract only people who are at high risk of needing costly healthcare.
>
> Moral hazard happens when someone having contracted an insurance policy is incentivised to take more risks than she would take if she had to assume the consequences of her behaviour shouldn't she be insured, or to overuse healthcare services.

Public intervention can be justified to avoid an inequity in resource allocation created by information asymmetry, for instance through regulation, public information campaigns, or mandatory health insurance.

Reasonably equitable access to goods such as medicines can require public intervention. Monopolies or oligopolies can distort prices and reduce output below socially optimal levels, in which case public intervention is justified to correct the market through, for instance, price regulation and antitrust laws. In particular, the pharmaceutical market is a major target for public regulation..

Public intervention aimed at equity and social justice seeks to correct imbalances in the distribution of resources, opportunities, and outcomes. These interventions are grounded in both normative theories of human rights and justice (Sections II.1.1-2) and empirical evidence showing persistent inequalities between countries and populations (Sections II..1.3, II.3.6).

Public health institutions

There are various ways of organising relationships between actors within society. At one extreme is the market (every relationship is contractual), at the other extreme is the firm (contracts are internalised through hierarchical rules). Between those two archetypes, many forms of organisation may emerge. Indeed, (large) organisations need to develop procedures to organise relationships within and between their members and departments. Here we introduce two concepts that are relevant for IHOs, such as WHO; bureaucracy and New Public Management (NPM). WHO, while itself inevitably suffering from weaknesses of large bureaucracies, also tends to promote some NPM approaches to Member States, such as resultsbased management (see Part IV).

Bureaucracy

Bureaucracies have been described as a rational-legal authority, characterised by hierarchical organisation, rule-based decision-making, and a clear division of labour. Ideally in this type of administration, officials are appointed based on technical competence, operate

under formalised procedures, and maintain impersonality in their functions, ensuring predictability and efficiency in governance. Bureaucracy in this form has been described as the most rational form of organisation for managing complex societies, but with the risk of creating an "iron cage" of rigid rules that constrain individual autonomy.

Other analyses have been far more critical. For instance, in Bureaucracy in Modern Society (1956), based on empirical studies of U.S. government agencies, the Peter M. Blau notes that while formal rules govern the processes of bureaucracies, informal practices emerge to compensate for rigidity and improve adaptability. Moreover, while smaller units may promote informal cooperation and innovation, large bureaucracies tend to enforce strict control, reducing discretion. Bureaucracies, if unchecked, therefore risk becoming oppressive, making democratic oversight essential.

Also contrary to the view of bureaucracy being a rational system, others characterise bureaucracies as dynamic systems of power relations, shaped by cultural and social factors (Le Phénomène bureaucratique,1963). In this view, formal rules do not eliminate informal strategies, and their coexistence can undermine efficiency. Individuals who make up the bureaucracy are not passive, but strategic actors who will exploit areas of uncertainty to gain autonomy and influence. Excessive centralisation and rigid rules can then create dysfunctions, reinforcing the need for more rules and control (by those at a central level), which further amplify rigidity.

A prominent concern in current politics is the tendency of bureaucracies to continually expand and extend powers over populations. Under this view, they have been described as a cultural and political phenomenon deeply embedded in modern life; becoming violent systems relying on implicit threats of force, where rules are backed by coercion, even if rarely exercised. Contrary to the promise of deregulation, neoliberal reforms have been claimed to produce more rules and red tape, especially in finance, education, and health sectors, with attempts to reduce bureaucracy through market mechanisms ending up creating new bureaucratic layers, often more complex than before. While providing an illusion of fairness and predictability, this increased complexity stifles creativity and spontaneity.

New Public Management (NPM)

New Public Management (NPM) refers to a set of administrative reforms that emerged in the 1970s-1980s, aiming to modernise public sector governance by adopting principles and techniques from private management. It emphasises efficiency, performance measurement, and market-oriented mechanisms such as downsizing of the public sector, privatisation and deregulation, competition and contractualization. NPM advocates for separating policymaking from service delivery, introducing managerial autonomy, and fostering a culture of results and accountability. These reforms sought to address some of the innate inefficiencies of traditional bureaucracies described above, including the need to reestablish the primacy of representative government over them.

Many public organisations, including WHO, in fact adopt a mix of bureaucratic hierarchy and NPM tools (e.g., performance indicators, contracts), creating 'neo-bureaucratic' systems – the latter can ideally combine the strengths of both models, but also may inherit their weaknesses.

The principle of subsidiarity

The risks of centralisation and inexorable expansion of rules and regulations can be mitigated, and such rules theoretically gain greater democratic legitimacy, by moving ultimate decisionmaking closer to those who the rules are intended to affect. This principle of subsidiarity is relevant for democratic legitimacy – ultimately for ensuring the rights of individuals are reflected in rules and regulations that govern them – at any level of governance. They are of particular additional relevance to international organisation such as an IHO that is not tied to a single representative (e.g. national) government and therefore has less legitimate authority from a basic human rights perspective. It therefore becomes critical to ring-fence the competencies of an IHO, especially when compared to national governments and other more representative bodies.

In politics, the idea of subsidiarity means "the principle that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level". According to that principle, "authority should presumptively belong to the entity representing those 'most affected' by its exercise and capable of addressing underlying problems". It is a moral principle aimed at reaching the common good which goes beyond the mere decentralisation of government. It is therefore critical to any discussion of the management of international public health, and the design and limits of the institutions (and their bureaucracies) that are developed to support it.

I.4. OTHER KEY TERMS AND CONCEPTS USED IN THIS REPORT

Table I.2, below, is a box explaining the other key terms and concepts that are used in this report.

Table I. 2 – Definitions and explanations of key terms and concepts used in this report.

Defining and understanding key concepts
Health
This document adopts the WHO definition of health (in the preamble of its 1946 constitution): "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". These three aspects of well-being are not independent of each other and are assumed here of equal importance.
Diseases (and approaches to them)
A typical definition, here from the Oxford English Dictionary, describes disease as a: "*disturbance or impairment of the function (and often also the structure) of the body, a part of the body, or the mind*". Definitions commonly add "*typically manifested by distinguishing signs and symptoms*". Signs are detectable physical changes (e.g. fever, mass), symptoms are reported changes of feeling (e.g. pain, nausea). Disease can arise as a result of an external influence, such as an infection with a microorganism or poisoning, or due to a disturbance of metabolism or other process or structure within the body arising de-novo. Diseases are commonly divided into infectious (communicable) diseases (due to, and transmissible by, an agent such as a virus or microbe, and non-communicable diseases (NCDs). They are not completely distinguishable: for instance, some viral infections may promote certain cancers (e.g. Human papilloma virus and cervical cancer). In turn, NCDs such as diabetes mellitus can result in more frequent and severe disease from infections through immune system impairment. Thus, the two common approaches to disease – the 'terrain theory' emphasising the underlying condition of the host and the Pasteurian approach of concentrating on an infecting organism are not mutually exclusive, and both areas are important for preventing and managing disease, and thereby both are important aspects of any public health approach. The genesis, severity and outcome of a disease is influenced by the nature of the disturbance to normal function, the state of the body when it arises, and the body's response to it. The ability to resist or respond depends on a range of factors including nutritional and metabolic state, genotype, prior exposure (e.g. immunity) and psychological and social factors.
Public health
Public health consists of collective actions within society intended to improve health outcomes. C-E.A. Winslow defined it in 1920 as "*the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals*". This is widely truncated (sometimes attributed to WHO) as "*the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society*". The US-based Institute of Medicine has published a further widely used definition: "*Essentially, it concerns interventions at a population level that will impact individual health outcomes*". These definitions are complementary, and consistent with the use of the term in this report.
International public health, global health

International public health, global health

The terms International Public health, International health, and global health are used inter-changeably in this report. While some sources may suggest nuanced differences between them, they are essentially the same, referring to efforts that cross national borders to develop, implement and monitor public health initiatives.

International Health Organization (IHO)

International Health Organisation (IHO) is used in this document to denote an organisation managed and owned jointly by countries (States) such as an agency of the United Nations, for which the WHO is a current example.
An IHO discussed here therefore differs from public-private partnerships, nongovernmental organisation or health agencies of a specific State.

Outbreaks, epidemics and pandemics

Exact definitions of these terms vary, and they are used here in a general sense in regard to infectious diseases as follows.
Outbreak: A localised increase in infection by a pathogen (or a pathogen-induced disease) significantly above normal level.
Epidemic: Synonymous with an outbreak, but commonly applied when case numbers of geographical area are large.
Pandemic: An epidemic crossing borders between countries – usually involving many countries. Clinical severity is not implied.

States and State sovereignty

The meaning, rights, and duties of States in international law are set out in the 1933 Montevideo Convention. A State must have '(a) a permanent population; (b) a defined territory; (c) government; and (d) capacity to enter into relations with other States' (Article 1). A State referred to in this report is a self-governing, independent (i.e. sovereign) and geographically defined entity, consistent with the Westphalian concept of nation-States and that of the United Nations, with its government representing people within its borders in the context of international affairs. State sovereignty matters in that the State is the mechanism through which individuals can express their sovereignty in contributing to their own governance, and in dealing with communities of other States. States are commonly divided on a spectrum of gross national income per capita, as for example high-, high-middle-, low-middle-, or low-income countries. The World Bank provides a regularly updated list based on these criteria. Of relevance to international public health, low-income countries commonly have far higher burdens of infectious diseases, and also (though less exclusively) nutritional deficiencies. Health services are less well-resourced and so the relevance of IHOs to such countries is quite different from most high-income countries. It is assumed here that a major function of an IHO is to reduce such inequalities, acting as a conduit for assistance from higher-resourced to lower-resourced countries to build their capacity and reduce need for future assistance. None-the-less it is assumed that all countries have equal, sovereign status within an international health organisation, consistent with the constitutional intent of the World Health Assembly in governing the WHO.

Sovereignty and human rights (positive rights and negative rights)

Individual sovereignty, the concept of self-ownership, bodily autonomy, and agency of each individual on an equal basis, is a fundamental concept underpinning post-World War Two human rights conventions. The IHRP adopts this as a basis for its understanding of human rights, and consequently for the ethical principles underpinning medical ethics and therefore as one of the guiding principles of international public health and the function of an IHO.
While individual sovereignty is tied to negative or fundamental human rights (freedom from external coercion), it cannot imply an absolute right to full self-determination in all circumstances. This is so because individuals live in

communities with others who also hold similar rights, and in some circumstances such respective rights of selfdetermination, including a right to life, will clash. This is of particular relevance to public health, where choices of one may impact on another. However, as discussed later, the right of bodily autonomy, sometimes expressed through 'voluntary informed consent', is a negative right that cannot itself be put aside.

Positive rights, the right to certain things such as in particular the right to health, are important concepts in public health. The preamble of the WHO 1946 constitution states this as: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. The IHRP adopts the common recognition that such rights, which involve an expectation of society providing common goods to the benefit of an individual, are critical to the functioning of a fair society and to promoting the ability of individuals to live a fulfilled and good life.

The governance structures of society have an obligation to enable the exercise of both negative and positive rights to a reasonable extent, but not to the point of abrogating the individual sovereignty of its members. These interactions are complex, and discussed at greater length in the main text.

PART II:

THE BASIS OF INTERNATIONAL PUBLIC HEALTH COOPERATION

PART II
The basis of international public health cooperation

To determine the ideal structure and function of an international health organisation (IHO) intended as a centrepiece of international public health cooperation, such as the World Health Organization (WHO), it is essential to first clarify the role and constraints of public health as a discipline or activity within society. As with any public institution, it is subject to limits set by the rights of individuals within society and of the entities that make up its membership, and the bounds which its mandate can legitimately (e.g. based on evidence or reasonable opinion), ethically and legally justify.

Public health, has been defined (attributed to WHO) as: "*the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society*". Important in understanding this in relation to its ethical underpinnings is to recall the WHO definition of health; "*...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". Public health therefore cannot be focused on a single disease, but must address disease risk in a broad context of health or well-being, encompassing the endogenous and exogenous influences that impact on the health of individuals and their social interactions. It cannot, however, take a role that overrides the fundamental interests of the individuals forming the communities it is intended to serve, or act irrespective of other priorities those communities hold.

This part (Part II) explores the human rights, ethical foundations and public health principles that underlie the discipline of public health, and thus must determine and constrain an IHO's approach, based on broadly accepted international norms, legal principles and understandings of the determinants of health. It then addresses certain items essential to forming an international organisation. To summarise, human rights must first be secured, then public health understood in order to deliver benefit, and an organisation structure then be put in place (expanded in Part III) to achieve this.

II.1. UNDERLYING PUBLIC HEALTH PRINCIPLES

The term 'ethics' is typically used in two related senses. First, it is used as a synonym of 'morality' – the judging of human actions as being either right or wrong, and the evaluating of human character as being either virtuous or vicious. Second, 'ethics' is used as a synonym of 'moral philosophy', namely, that branch of philosophy which reflects on moral principles and the values on which they are grounded. On its part, the word 'principle' comes from the Latin principium, which denotes 'beginning'. A principle is a fundamental source, fundamental truth or primary element which serves as the basis of reasoning and/or action. In moral theory, a moral principle articulates an ethical value, that is, a standard by which to determine the worth or worthlessness of an action as being either right or wrong, or a trait of character as being either virtuous or vicious. Thus, moral principles reflect moral values in action.

As with all other professions, public health ought to be grounded in ethical principles that are defensible on rational and pragmatic grounds. This is essential as we human beings live with values, because it is they that make life truly human by enabling us to choose our goals and the appropriate means of attaining them, whilst maintaining constructive relations with those with whom we do or must interact. Indeed, all truly human action transcends mere instinct because it is infused with values – standards by which we judge certain things to be worthwhile and others worthless. Consequently, value-free science is incompatible with healthy functioning of society and therefore impracticable, and this has implications on both medicine and public health.

In what follows, we lay out a human rights-oriented ethical foundation for public health that is consistent with widely accepted international norms and standards of human rights discussed in an earlier section, and that formed an early basis of many current public health institutions. To this end, we set out with an explication of the notions of human dignity and human agency upon which human rights rest. We then present four principles of medical ethics that are the foundation of public health ethics. Thereafter, we present thirteen principles of international public health ethics, and provide a rationale for them, before summarising this section.

Healthcare concerns policies and actions that enhance the potential of each person to live a life that is personally fulfilling, physically, mentally and socially, according to their own preferences as an independent, equal human. It supports their fundamental rights as a human, an autonomous being whose worth cannot be measured. As such, it is inextricably bound to the fundamental rights

that we are born with and can work only within this framework. To understand the aims and limits of public health, it is therefore essential first to understand and elaborate the fundamental human rights within which public health operates, and the support of which is ultimately its sole legitimate intent. The international application of human rights also has important implications for the way in which an International Health Organisation can, or should, interact with the national States that represent the interests of individuals.

II.1.1. Human rights norms and laws

Human rights in the Universal Declaration, International Covenants and other treaties: a brief outline of their origin

The modern concept of human rights originates from the Ancient Greek philosophers through the Medieval period and continues with the Renaissance thinkers, but is widely held to reflect concepts of 'natural law' common across human cultures. While concepts are expressed in the US and French revolutionary constitutions, codification at a national level mainly came in the aftermath of the Second World War, in reaction to atrocities committed by States against individuals and their groups/communities but also the aspirations of colonised peoples. The 1948 Universal Declaration of Human Rights (UDHR), non-binding but considered the moral heart of the whole United Nations organisation and its system, enshrines human rights as "a common understanding of these rights and freedoms" and "a common standard of achievement for all peoples and all nations". It proclaims their natural origin, their inalienability and the principles of equality and non-discrimination in the most solemn terms.

"Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, (...) Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom".

"All human beings are born free and equal in dignity and rights".

"Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty".

The placement of the inherent 'dignity' of the human being before 'rights' is important here. The concept of the dignity (or inherent worth) and equality of every person is fundamental to modern human rights law, and to this report. Human rights are inalienable, but they are not all absolute and may well conflict among themselves. However, the inherent dignity or worth of every person is constant. As example, the right to life generates the obligation not to kill, however that right can be negated by the right to self-defence or the defence of others. Defenders of the right to life typically clash on controversial topics like abortion, euthanasia (assisted suicide) and the death penalty, where arguments may be offered for both viewpoints based on ethics and conscience, and ingrained aspects of culture. Management of these competing interpretations is extremely delicate, and it is often hard for both sides to hold an absolutist position without acknowledging, or ignoring, its unavoidable shortcomings. Above all, arguments and arrangements for such examples should recognise human dignity - of the woman, of the baby, of the human being in question - so that their rights shall be respected or balanced. Similarly, in the medical sector, patients do have positive rights to receive care, but the negative rights of physicians should also be recognised if performing such acts is against his/her conscience. Examples are plentiful, all showing the difficulty of handling human rights and the necessity of defending them for oneself and others.

The rights recognised by the UDHR were later codified in two legally binding Covenants adopted in 1966 - the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Both texts entered into force in 1976 (ICCPR on 3 January 1976, ICESCR on 23 March 1976) and enjoy almost universal membership, with respectively 167 and 172 parties. States that ratified these texts are committed to respect these rights and protect the rights holders. The Covenants established respective Committees composed of independent experts nominated and elected for a renewable term of four years by States Parties - the Human Rights Committee for the ICCPR and the Committee on Economic Social and Cultural rights (CESCR). Moreover, the ICCPR is

accompanied by the 1966 Optional Protocol, and the ICESCR by its 2008 Optional Protocol. A State that chooses to become a party to the accompanying Optional Protocol recognises the competence of the relevant Committee to receive and consider communications from individuals subject to its jurisdiction who claim to be a victim of a violation by that State (a communications procedure). In addition, States Parties to the ICCPR may elect to be parties to the 1989 Second Optional Protocol aiming at the abolition of the death penalty. The committees also have a role to provide authoritative interpretations and clarifications of the texts, and examine State's compliance through both self-reporting and complaints (individual and interState) and direct inquiries (Committee's own initiative).

The protection of human rights is further ensured by specific international conventions, each establishing its own Committee to support and ensure implementation. Other core international human rights conventions concluded under the UN's auspices are listed below; most of them being accompanied by optional protocols recognising a communication procedure, and a couple of them by specifically aimed protocols.

International Convention on the Elimination of All Forms of Racial Discrimination (CERD) - adopted on 21 December 1965

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) -adopted on 18 December 1979, and its 1999 Optional Protocol

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)- adopted on 10 December 1984, and its 2002 Optional Protocol

Convention on the Rights of the Child (CRC) - adopted on 20 November 1989, and its 2011 Optional Protocol on a communications procedure, 2000 Optional Protocol on the involvement of children in armed conflict, and 2000 Optional Protocol on the sale of children, child prostitution and child pornography

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families - adopted on 18 December 1990

Convention on the Rights of Persons with Disabilities (CRPD) - adopted on 12 December 2006, and its 2006 Optional Protocol

In addition, the International Labour Organization (ILO), created in 1919, has since developed a large body of standards in its mandated area. Generally referred to as 'international labour standards', they comprise binding international conventions and facultative recommendations on issues relating to work, labour relations and social policy.

Together, these treaties form what is generally referred to as international human rights norms and standards. They are reflected in regional treaties carved for a desired focus on regionspecific issues and cultures. In Europe, the 1950 European Convention on Human Rights and the 1961 European Social Charter bind 46 States of the Council of Europe, while the 2000 Charter of Fundamental Rights of the European Union covers 27 EU States. In the Americas, the 1969 American Convention on Human Rights, the 1985 Inter-American Convention to Prevent and Punish Torture, and the 1994 Inter-American Convention on Forced Disappearance of Persons are the fruits of the organisation of American States. African States have the 1981 African Charter on Human and Peoples' Rights, the 1990 African Charter on the Rights and Welfare of the Child, and the 2003 Protocol on the Rights of Women in Africa. The Asian continent only has the 2012 (non-binding) ASEAN Human Rights Declaration and the 2002 SAARC Convention on Preventing and Combating Trafficking in Women and Children.

Finally, the 2004 Arab Charter on Human Rights was adopted by the League of Arab States (Arab League). The first three regional frameworks are further complemented by human rights jurisdictions, namely, the European Human Rights Court, the Inter-American Human Rights Court, and the African Human Rights Court.

At the international level, a robust body of institutions and mechanisms is mandated to ensure human rights realisation. The UN Commission on Human Rights, as contemplated in Article 68 of the UN Charter and created in 1946 (superseded by the Human Rights Council in 2006), had played a vital role in the instigation of relevant texts and mechanisms. Today, the present Human Rights Council relies on two mechanisms. First, the cyclical Universal Periodic Review - currently at its fourth cycle - is a peer review mechanism where each and every UN Member State has to undergo through reports on their implementation of human rights texts and received recommendations from others. Second, 46 special procedures composed of mostly independent experts,

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Human rights thus form a formidable legal concept that recognises the rights of each individual being part of a social structure. But the overall concept is political and can be politicised, both at the international and national level. After all, at the intersection of individuality, power, and competing interests, it aims at challenging national sovereignty by imposing external standards, whatever philosophical, religious or cultural contexts they might be applied in. Positions on civil liberties are often criticised by countries and regions that prefer to balance these with collective duties or cultural norms. In this respect, the concept has sometimes been used as a geo-political tool for powerful players with particular agendas.

Human dignity, human agency and human rights

According to the Merriam-Webster Dictionary, the term 'dignity' refers to "the quality or state of being worthy of honor or respect". Ethicists usually distinguish between extrinsic or instrumental value (the worth that something has because of its usefulness) and intrinsic value (the worth that a thing has by virtue of its nature). Thus, to describe human dignity, philosophers usually say that the human person has infinite intrinsic value. This is to say that the worth of the human person is within himself/herself, and is not attached to any benefit that others may find in their interactions with them, and that this worth is so much that it cannot be quantified. As noted above, the Preamble to the UDHR, sets out by acknowledging "recognition of the inherent dignity" of each person.

Human dignity presumes human agency. An agent is a being with the capacity to act. Consequently, "agency" refers to the exercise of this capacity, and "human agency" denotes this capacity as exercised by the human person with his/her ability to reason, that is, to make claims and to provide evidence to support them. From this ability springs intentionality, that is, action on the basis of goals that a person chooses for himself/herself. The human person, by virtue of his or her dignity, exercises his or her agency in a distinctly human way. The distinguishing characteristic of human agency is the capacity of the human person to know. This is due to the fact that it is impossible to exercise human agency without the ability to engage in intellectual activity through which to evaluate alternative courses of action and to choose one from among them.

Furthermore, human dignity is the basis of human rights – those entitlements that each human individual has by virtue of their humanity. At the core of those rights is the right of the individual to determine the course of their own life, and this touches on a wide range of issues including the means of earning a living, the kind of political society one wishes to live in, and the kind of system of healing that one finds acceptable. Thus, based on human dignity, the discourse on human rights is about the obligation to respect the human person's entitlement to exercise their agency unhindered.

In sum, a human rights orientation in medical ethics and public health ethics is based on the conviction that each and every human being is endowed with intrinsic infinite worth, usually referred to as 'human dignity'. Coupled with the idea of human dignity is the notion of human agency - the capacity of the person to act out of their own unique viewpoint. At its founding, the United Nations committed itself to respect and protect human dignity, human agency and human rights. Among the aims of the United Nations stated in the Preamble to its founding Charter are:

> *"to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small, ..., to promote social progress and better standards of life in larger freedom, ...".*

Fully consistent with these modern understandings of human rights, but predating them, flow the principles of medical ethics that form a basis of public health ethics.

Universal human rights

Can human rights be hierarchical?

As discussed above, human rights can clash, requiring a value judgement on how they are upheld. An obvious example in public health is the oft-discussed clash between upholding one's bodily autonomy and right to refuse a medical intervention and the interests of others not to have their health risked by being exposed to harm (e.g. in the case of an infectious disease outbreak). Can some rights be more important than, or superior to, others?

The above question stimulates passionate and endless debates. Some rights do appear extremely crucial simply because they make human beings human according to a Cartesian viewpoint - for example, freedom of thought, conscience, and opinion. Scholars also argue, from a human dignity viewpoint, for a minimum of social rights, at least at the level of survival, with or without societal assistance. For them, the right to life would not be meaningful without the rights to food, water, shelter, work, or a healthy environment. Others would not go that far, fearing that recognising that minimum would do harm more than help to the individuals in question.

For the UN, there is no hierarchy of human rights. The 1968 International Conference on Human Rights (Tehran, Iran) highlighted the 'indivisibility' of human rights and fundamental freedoms. The 1993 World Conference on Human Rights (Vienna, Austria) went much farther by proclaiming the "universality, indivisibility, interdependence and interrelation" of each and all human rights:

> *"5. All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms".*

This line of interpretation was doubtless well-intended and constituted a dominant trend probably because it fits well with the majority of stakeholders (State's discourses, activists and advocates' demands). It does have the merit of not neglecting a particular right or set of rights. However, it masks real issues in both theory and practice, and might even risk undermining the importance of certain rights otherwise held inviolate.

While indivisibility asserts that all rights are equally important, it is undeniable that some rights, regardless of how they may be selected, are more important than others. After all, Article 4.2 ICCPR contains a list of non-derogable rights even in emergency contexts. This is similar to the jus cogens concept in international law, which refers to peremptory principles and norms that all States should not violate (prohibition of slavery, genocide, and acts of aggression and illegal uses of force). It does not mean that there is not, or will not be, violation of jus cogens norms. It means that States have the duty to seriously consider before breaking it, and a heavy burden to explain actions and undertake mitigating efforts. In practice, all countries also make prioritisations based on practical reasons including human and financial resources, inevitably, resulting in trade-offs. Calls have thus been made to nuance or replace the notion of indivisibility.

While interdependence suggests that rights reinforce one another and warrant serious monitoring of their application, critics suggest that economic realities often disrupt this dynamic. For example, economic rights may well take precedence over civil rights if circumstances so dictate in a conflicted area. Certain rights may also not align with cultural or religious values, particularly in non-Western liberal traditions, can be subject to selective advocacy and enforcement by powerful States for geopolitical reasons.

The broad and prolonged abrogation of human rights during the Covid-19 crisis have shown that the rights of a small, vulnerable group (old people with co-morbidities) can be prioritised by governments and public health institutions above the rights of the remainder of the society – all rights were indeed not held inviolate. Rights of children to education, the right to work, to family life and to bodily autonomy were widely abrogated by lockdowns and vaccine mandates in many countries, including for vulnerable groups such as pregnant women, ostensibly to protect those more vulnerable to Covid-19. The 'whole-of-society' approach, currently promoted by the WHO in the negotiations of the Pandemic Agreement, by definition involves the abrogation of a wide range of human rights, but demanding widespread prioritisation and compliance of society to target a single priority, rather than leaving individuals and communities to determine their own. This highlights the incongruity of the universality, indivisibility,

interdependence and interrelation approach of the 1993 Vienna conference. It can be necessary to pick and choose between rights. However, the fundamental rights related to autonomy and human agency then logically demand that individuals, or States and their representative bodies, should be the ones to define beneficiaries, through the basis of costs and benefit considerations in local contexts through policy trade-offs and the democratic consequences of these. This must proceed on the basis of certain negative rights being nonderogable, and subsidiary positive rights then being safeguarded based on local context.

Classifications of human rights

To address the necessity of choosing between human rights, and therefore having a hierarchy, scholars classify human rights in categories, although their distinctions are neither absolute nor perfect and have not been formally recognised. There are two common distinctions based on the necessity, or the absence, of implementing policies and regulations: negative rights versus positive rights, and through the nature of the rights (generations of rights). Each has its own usefulness and shortcomings.

Positive and negative rights

Firstly, human rights may be referred to as negative versus positive rights. Negative rights require others, including States, to refrain from interfering with the individual's actions. They include broadly recognised fundamental rights and freedoms (civil and political rights) such as the right to life, freedom of speech, freedom of religion, and the right to privacy, which require others, including States, to provide certain services or benefits to the right holders in order for them to be exercised. They mostly encompass economic, social and cultural rights, like the rights to education, food and housing. The 'human right to health' is a positive right. Noteworthily, not all agree with the positive versus negative rights distinction, less its usefulness. In fact, many countries chose to rely on legislating contours and extents of each human right, including the ones considered sacred or generally inviolable, for tradition, order, faith or community purposes. In truly free societies, libertarians would argue, positive rights do not exist unless they are created under a contract.

Generations of human rights

Secondly, human rights may be classified by generations. Civil and political rights form the first generation of human rights; economic, social and cultural rights, the second generation. Hence, the ICCPR contains the rights of the first generation, the ICESCR the rights of the second generation.

The third generation of human rights, although widely discussed and even recognised in declaratory texts, do not enjoy wide support. Generally, they encompass solidarity or collective rights, such as the right to peace, the right to a healthy environment, or the right to development. Unlike first- and second-generation rights, they are rarely enshrined in national laws (exception noted of the right to a healthy environment). These rights are characterised by a lack of precise legal definitions and lack of clarity regarding the right-holders, making them very difficult to be implemented. Their collective dimension causes additional complexities in interpretation. The right to development might require a wealth redistribution by rich or well-resourced countries, but such communitarian proposals would be unlikely to be agreed. The right to a healthy environment might make some sense at a manageable level and when the identification of both users and polluters is clearcut, but it becomes controversial at the inter-State level when scientific evidence is not convincing, or when a level of pollution may be an economic necessity in some States to ensure other priorities or rights. For these reasons, perhaps this concept should be referred to as aspirations, rather than rights.

Neither of these 1966 Covenants sets out the distinction of generations. The respective texts however contain a major difference in their beginnings. The ICCPR states that:

> *"Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".*

The ICESCR states that:

> "1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures".

It also allows that "developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals". Consequently, it is understood that States have the obligation to respect and uphold the first generation rights almost without exception (minus the exceptions stated by Article 29.2 UDHR and relevant articles of ICCPR), and the second generation rights would be of "progressive realization" based on available national means and resources. The third-generation rights pose multiple technical problems regarding their definition, implementation, justiciability and control, and thus should not prevail over other rights.

Human rights and public health

Limitations of human rights: derogable and non-derogable rights

The debate on whether human rights should or should not be limited reflects a tension between the idealist view of natural rights on one side, and the practical view of ensuring security and public order on the other. Arguments against limitations deplore the erosion of moral imperatives, real risks of abuses by, and unaccountability of, States. In contrast, those in favour of some limitations allow for the necessity to ensure public order and human security in emergency situations. Nevertheless, those highlighting the necessity to balance with societal or cultural norms are much less tolerated (e.g. polygamy) and may be prohibited by international law (e.g. slavery, torture, female genital mutilation). This debate holds as a result that respect for human rights should be the principle, and their limitation, the exception.

General limitations on the grounds of 'public emergency', 'public order', 'moral' and 'public health'

If one accepts the natural origin of human rights, it is difficult to accept that these rights may be limited by a sovereign under normalcy. But when there is an external or internal threat, it is legitimate for a nation to require a degree of social cohesion. Procedures for emergency powers are systematically described in national constitutive texts. Thus, human rights treaties have introduced the idea with ease. The UDHR recognises that States may impose limitations to human rights through legal regulations in two situations: i) to respect the rights and freedoms of others, and ii) the just requirements of morality, public order and the general welfare in the society (Article 29.2). It specifies two types of limitations: a general limitation of all civil and political rights, with few exceptions of non-derogable rights, on the basis of a public emergency, and a specific limitation of specific rights on other bases including public health.

Regarding the general limitation, the ICCPR allows States to restrict some civil and political rights "in time of public emergency which threatens the life of the nation" (Article 4), while the ICESCR does not include a provision on derogations.

ICCPR, Article 4:

> "1. In time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.
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> 2. No derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16 and 18 may be made under this provision".

This reflects similar wording in the UDHR, Article 29:

> "1. *Everyone has duties to the community in which alone the free and full development of his personality is possible*.
>
> 2. *In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.*
>
> 3. *These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations*".

Importantly, there emerges from Article 4.2 ICCPR but also from other specific provisions a list of non-derogable

rights under public emergency: right to life (Article 6), freedom from torture cruel inhuman or degrading treatment or punishment, or from medical or scientific experimentation without consent (Article 7), freedom from slavery or involuntary servitude (Article 8), right not to be imprisoned for contractual debt (Article 11), right not to be convicted or sentenced to a heavier penalty by virtue of retroactive criminal legislation (Article 15), right to recognition as a person before the law (Article 16), and freedom of thought, conscience and religion (Article 18). In addition, for the 91 States Parties to the Second Optional Protocol to the ICCPR, the abolition of death penalty is not derogable. In 2011, the Human Rights Committee commented that freedom of opinion is also not derogable.

Although the exception is generally well delimited (being a threatening situation to the life or survival of the Nation), it is usually not difficult in practice to develop justifications to this, particularly for political ends. For a clearer delimitation, the 1985 Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR (non-binding interpretative guidelines developed by the International Commission of Jurists) provided the definition of public emergency as a situation that:

> *"a) affects the whole of the population and either the whole or part of the territory of the State; and b) threatens the physical integrity of the population, the political independence or the territorial integrity of the State or the existence or basic functioning of institutions indispensable to ensure and protect the rights recognized by the Covenant".*

The CCPR's General Comment No. 29 on Article 4 (2001) clarifies the legal and material requirements for States, as summarised below:

- *"Measures derogating from the ICCPR provisions must be of an exceptional and temporary nature. Before invoking Article 4, two fundamental conditions must be met: the situation must amount to a public emergency which threatens the life of the nation; and State must have officially proclaimed a state of emergency" (para. 2)*

- *"Not every disturbance or catastrophe qualifies as a public emergency which threatens the life of the nation" (para. 3)*

- *"Derogating measures must be limited to the extent strictly required by the exigencies of the situation, as regard to the duration, geographical coverage and material scope of the state of emergency and any measures of derogation resorted to because of the emergency. The obligation to limit any derogations to those strictly required by the exigencies of the situation reflects the principle of proportionality which is common to derogation and limitation powers" (para. 4)*

- *"The fact that some of the ICCPR provisions have been listed in Article 4.2 as not being subject to derogation does not mean that other articles may be subjected to derogations at will, even where a threat to the life of the nation exists" (para. 6)*

- *"Derogating measures do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin" (para. 8)*

- *"No derogating measures may be inconsistent with the State's other obligations under international law, particularly the rules of international humanitarian law (para. 9), and with peremptory norms of international law" (para. 10)*

- *"The invocation of Article 4 cannot be used as a justification to exempt State and individuals who acted under State's authority, from responsibility regarding the commission of crimes against humanity" (para. 12)*

- *"Safeguard measures should be put in place, especially regarding non-derogable rights" (paras. 15, 16)*

At the beginning of the Covid crisis, the CCPR made a statement "*on the derogations from the Covenant in connection with the Covid-19 pandemic*", recognising that States parties may invoke Article 4 to resort to the use of emergency powers on a temporary basis. All other Committees to core human rights treaties also released their statements (some jointly with a special rapporteur, see compiled document). Furthermore, OHCHR released the guidance on "*Emergency measures and Covid-19*" based on the CCPR General Comment No. 29. For the Committees, unfortunately, the life-threatening emergency situation of Article 4 ICCPR was considered to apply, the prolongation of emergency measures accepted or encouraged. Remarkably, sloganeering (*"no one should be left behind"*) was used to justify recommendations

inconsistent with previous texts. For example, the Committee on the Rights of the Child called on States to "*ensure that online learning does not exacerbate existing inequalities or replace student-teacher interaction*". However, this outcome was inevitable as lower income children have poorer or absent online access. A slogan would not stop the resultant exacerbation of inequalities, while clear opposition to closure of in-person learning may have. In essence, the six principles of legality, necessity, proportionality, nondiscrimination, strict interpretation and justification burden (the authorities have the burden of justifying restrictions upon rights) were reiterated, but States were recognised as masters to design their own emergency powers. OHCHR even went further to accept that "*even without formally declaring states of emergency, States can adopt exceptional measures to protect public health that may restrict certain human rights*". This position may be disappointing for human rights defenders, but it reflects the necessary non-intrusive nature of lines of conduct by international institutions.

Prior to March 2020, Article 4 ICCPR was invoked occasionally through a weak safeguard mechanism regarding States parties' obligation to notify their peers through the UNSG (Article 4.3), potentially opening themselves up for criticism by other States and NGOs. It should be noted that multiple nations have previously invoked their emergency provisions for various security priorities (e.g. natural disasters, public health crises) and international obligations such as anti-terrorism and biodefense.

The 'protection of public health' and 'protection of the rights and freedoms of others' as grounds for human rights limitations

Another specific category of limitations is also delimited by the ICCPR. Several rights and freedoms may be restricted by 'public order', 'public health', 'public morals', 'national security', 'public safety', 'rights and freedoms of others', 'the rights or reputations of others', or 'restrictions on public trial', which were defined by the 1985 Siracusa Principles and confirmed and clarified by the CCPR.

The ICCPR recognises "*the protection of public health or morals"* and *"the protection of the rights and freedoms of others*" as grounds for limiting specific human rights (Article 18.3: freedom to manifest religion or beliefs. Article 19: right to opinion and expression. Article 21: right of peaceful assembly. Article 22: right to freedom of association with others). Their interpretations were set by the Siracusa Principles and later confirmed by the CCPR in various General Comments.

As stated within the Siracusa Principles:

> *"iii. public order (order public)*
>
> *22. The expression "public order (ordre public)" as used in the Covenant may be defined as the sum of rules which ensure the functioning of society or the set of fundamental principles on which society is founded. Respect for human rights is part of public order (ordre public). iv. 'public health'*
>
> *25. Public health may be invoked as a ground for limiting certain rights in order to allow a State to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.*
>
> *26. Due regard shall be had to the international health regulations of the World Health Organization".*
>
> *v. 'public morals'*
>
> *27. Since public morality varies over time and from one culture to another, a State which invokes public morality as a ground for restricting human rights, while enjoying a certain margin of discretion, shall demonstrate that the limitation in question is essential to the maintenance of respect for fundamental values of the community*
>
> *vii. 'public safety'*
>
> *33. Public safety means protection against danger to the safety of persons, to their life or physical integrity, or serious danger to their property".*

These broad definitions easily accommodate decision-makers. Any crisis or outbreak can be determined to constitute a serious threat to the health of the population or its individual members, and the decision-makers are then free to set the thresholds based on their own determination of the seriousness of the crisis. The resemblance of these and the definitions of public health emergency of international concern (PHEIC) in the International Health Regulations (IHR) and the new

terminology of pandemic emergency in the new Pandemic Agreement is remarkable.,74 It may not be the role of lawyers to determine scientific or medical thresholds, numbers and percentages in this case. However, the real problem that arises from this type of definition is that the risk of abuse is high. The PHEIC declaration by the WHO DG for SARS-CoV-2 (30 January 2020) and the ones on Mpox (2022 and 2024), concerned risks to the health of a small and well-defined group (2022) and relatively low-risk burden and geographically confined outbreak (2024). This reflected the earlier mindset and health context of the 1950-1980 era where the IHR, first adopted in 1951 then revised in 1969, were considered vital to prevent the cross-border threat of serious and quarantinable infectious epidemics (cholera, plague, yellow fever, smallpox, typhoid, relapsing fever) rather than limited and readily managed outbreaks. Success of previous international control of diseases has frequently been credited to WHO management and the IHR rather than to a general improvement of hygienic conditions and nutrition, accessible primary care centres and antibiotics that underlie the major gains in higher income countries, and certain childhood vaccinations. The 1995 WHA's criticism of a too narrow IHR's scope subsequently led to the 2005 revision, which allowed one single person – the WHO DG – to declare PHEICs and recommend States to voluntarily take restrictive measures including goods and peoples' quarantine, contact tracing, testing, health treatments and vaccination.

The biodefence agenda versus human rights

From their primary mandate in monitoring peace and security, UN entities have moved considerably to the biosecurity/biodefence agenda, based on a concern that there are real risks for human lives, but also for peace and international security. Biodefence is defined as "actions to counter biological threats, reduce biological risks, and prepare for, respond to, and recover from biological incidents, whether naturally occurring, accidental, or deliberate in origin and whether impacting human, animal, plant, or environmental health" (2022 US National Biodefence Strategy). At the national level, these threats are real, possibly trans-border, and involve, or at least require coordination with, intelligence and military bodies.

Prevention and counteraction measures inevitably operate with some infringements of several human rights and freedoms, including the most basic or negative rights (freedom of movement, right to property and privacy) and frequently including in practice non-derogable rights (right against torture, arbitrary arrest and detention). The legislature and the judiciary are entrusted with the job of overseeing and limiting such practices in an ideal system, but in practice have often been reluctant to limit national authorities in times of crisis or conflict.

The international biodefence agenda is composed of a large number of international conventions, all of which require States to establish criminal offences in their legislation and the obligation to prosecute or extradite. It has grown to encompass anti-terrorism texts, commonly called CBRN (Chemical, Biological, Radiological and Nuclear) terrorism. Protocols were further added to these treaties and others touching on security-sensitive areas regulating continental shelves and maritime transport. The most notable texts include:

- 1968 Treaty on the Non-Proliferation of Nuclear Weapons (NPT)
- 1972 Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction (BWC) - 189 States Parties)
- 1979 Convention on the Physical Protection of Nuclear Material
- 1993 Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on their Destruction (Chemical Weapons Convention)
- 1997 International Convention for the Suppression of Terrorist Bombings
- 2005 International Convention for the Suppression of Acts of Nuclear Terrorism (ICSANT)
- 2010 Convention on the Suppression of Unlawful Acts Relating to International Civil Aviation (Beijing Convention)

Successive terrorist events in high-profile cities (e.g. London, Paris, Nairobi, New York) have rendered societies less resistant to temporary and permanent measures restricting their rights. The Covid responses further accustomed populations to the imposition of restrictive measures such as travel restrictions and stay-at-home orders.

The introduction of the security vernacular into public health therefore raises real risks of human rights abuse, as public health is placed on a par with physical or military threats to a nations' security. The WHO entered this trend with its 2007 annual report 'The world health report 2007: a safer future: global public health security in the 21st century'. (See Section II.3.2). Such messaging is increasingly used now for health occurrences such as infectious disease outbreaks which, despite the concerning claims to the contrary, are actually taking less lives than prior eras when they were simply considered public health concerns. A steadily declining infectious disease mortality, driven predominantly by improved living conditions, nutrition, sanitation and antibiotic access, is increasingly being represented as a dire threat that could justify restrictive measures. Risks of abuse are increased where this is at least promulgated, if not enforced, by an IHO such as WHO that is not subject to direct judicial or legislative oversight.

The rights and obligations of States and of the WHO in relation to human rights law

Since the WHO is not a party to the ICESCR, it does not have the obligation to implement ICESCR. Its rights and obligations based on its mandate and operational principles are obviously different from those of States. Being mandated to 'to act as the directing and coordinating authority on international health work' based on Article 2 of its constitution, WHO convenes meetings, proposes binding international health standards and norms (e.g. Framework Convention on Tobacco Control [FCTC], IHR) and non-binding recommendations, develops and promotes health policies, strategies and good practices. It also has a crucial role in information gathering and dissemination, and research and technical assistance, with full respect of a State's sovereignty (upon the State's request) (WHO constitution, Article 2).84 Since States are sovereign under the UN system, the WHO was designed as a meeting convener and an advisory and supporting office. The WHO's constitution also sets diplomatic privileges and immunities, and states the principle of independence (without political influence) for the whole organisation and its staff (see Section IV.3.1).

Generally speaking, States Parties to a treaty concluded within the WHO are to be bound by it, and they are expected to implement it in good faith ('Pacta sunt servanda' - Article 26, Vienna Convention on the Law of Treaties). Can a State refuse to implement an obligation from a WHO binding text if it considers that such obligation goes against domestic human rights legislation? The Vienna Convention on the Law of Treaties does not appear to allow States to invoke internal law to justify their failure (Article 27). In addition, it might be a delicate matter for countries with a monist legal system that recognises the superiority of international law over domestic law, and, to some extent, the direct applicability of the international provision in question in domestic legal order (for example, Article 96 of the Constitution of Spain), to argue against inappropriate recommendations. However, it may well be valid for these States, as well as for those with a dualist legal system, to invoke the existence of their domestic human rights law.

Theoretical limitations on human rights by the UN and its specialised agencies

Scholars often overlook the possibility of the UN and its agencies themselves limiting human rights. It is nevertheless useful to briefly discuss it in this report, as a way to stimulate debate and propose solid principles for any IHO.

Article 29.3 of the UDHR states that "(*t)hese rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations*". In the same vein, Article 46 of the ICCPR states:

> *"Nothing in the present Covenant shall be interpreted as impairing the provisions of the Charter of the United Nations and of the constitutions of the specified agencies which define the respective responsibilities of the various organs of the United Nations and of the specialized agencies in regard to the matters dealt with in the present Covenant".*

These safeguard provisions imply that human rights and freedoms should align with the purposes and principles of the United Nations, and that civil and political rights shall not override constitutive texts of the UN and its specialised agencies, such as the WHO. With such broad scope, they theoretically legalise abuses by institutions often driven by ideologies and self-purpose (expansion and survival).

In fairness, this is balanced by the UN Charter's obligation for the UN to promote universal respect for, and observance of, human rights and fundamental freedoms, and State's pledge to act to achieve that purpose. This implies that a Member State has the faculty to reject obligations, guidelines and measures stemming from the UN or its specialised agencies that may lead to an abrogation of human rights.

Article 55 of the UN charter states:

"With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

a. higher standards of living, full employment, and conditions of economic and social progress and development;

b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

c.universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion", while Article 56 adds:

"All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55"

The UN and the WHO were born in the specific post-WWII context - "maintaining international peace and security", with the goal of "the attainment by all peoples of the highest possible level of health". Overtime, like any institution, they have embraced complicated objectives used to justify human rights restrictions. For instance, cutting fossil fuels purported to address climate change and decarbonisation goals may also curb economic growth, particularly in low-income energy-poor economies, directly affecting the realisation of social and economic rights, at least in the short term.

An IHO, as discussed in the following sections, must have in its constitution the principle of promoting and upholding fundamental rights and freedoms, not the other way around. An ethical code built into its constitution should ensure that leadership and staff apply self-restraint and avoid allowing political, or even health goals to over-ride the negative rights that form the basis of any individual's relationship with any authority.

The Right to health in international law

Foundation of, and limitation to, the right to health in international law

The human right to health, or the right to health, is recognised in core international human rights texts (UDHR, ICESCR) and treaties related to specific groups like women, children, and persons with disabilities (CEDAW, CRC, CRPD). It is enshrined in the Preamble of the WHO's Constitution, regional human rights texts and national Constitutions. Article 25 of the UDHR recognises the right to an adequate standard of living, which encompasses the right to health. Soon after, the WHO's Constitution specifies that "the highest attainable standard of health is one of the fundamental rights of every human being". Later, the ICESCR adopts this definition, but implies that this is a progressive right ("achieve full realization"), and enumerates four specific groups of measures to be taken to reduce infant and child mortality, improve environmental and industrial hygiene, prevention and control of diseases, and make available medical service for sick people. Since 2002, an independent rapporteur on the right to health has been nominated by the Human Rights Council.

"Article 25, UDHR

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection".

"Preamble, WHO Constitution

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

"Article 12, ICESCR

1. The States Parties to the present Covenant

recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness".

The ICESCR echoes the WHO's Constitution in underlining two complementary facets of health - physical and mental health, and recognises that the right to health shall be of progressive realisation based on State's capacity and resources, without discrimination, and related to other human rights. It highlights an "illustrative, non-exhaustive" list of obligations for States. Its Committee (CESCR) adopted the General Comment No. 14 in 2000 to explain the interpretation on the right to health and State's obligations, including the following key points:

- *"The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, nonconsensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".*

- *"The notion of "the highest attainable standard of health" takes into account both the individual's biological and socio-economic preconditions and a State's available resources. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".*

- *"The Committee interprets the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels".*

- *"The right to health in all its forms and at all levels contains the following interrelated and essential elements: i) availability of health facilities, services and goods; ii) their physical and economic accessibility without discrimination; iii) information accessibility; iv) acceptability; v) quality".*

- *"The right to health imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health".*

- *"States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law".*

- *"While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental*

organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. States parties should therefore provide an environment which facilitates the discharge of these responsibilities".

The CESCR also provided guidance on the interpretation of the four sub-paragraphs of Article 12.2. Firstly, the right to maternal, child and reproductive health (12.2.a) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services and access to information and resources necessary to act on that information. Secondly, the right to healthy natural and workplace environments (12.2.b) would include preventive measures in respect of occupational accidents and diseases, the requirement to ensure an adequate supply of safe and potable water and basic sanitation, the prevention of the population's exposure to harmful substances, the minimisation of causes of health hazards in the working environment, adequate housing and supply of food and proper nutrition, the discouragement of the use of tobacco, drugs and other harmful substances. Thirdly, the right to prevention, treatment and control of diseases (12.2.c) requires the establishment of prevention and education programs for behavioural-related health concerns such as sexually transmitted diseases, the promotion of social determinants of good health such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care for accidents, epidemics and health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to State's efforts to make available technologies, using and improving epidemiological surveillance and data collection on a desegregated basis, the implementation or enhancement of immunization programs and other strategies of infectious disease control. Lastly, regarding the right to health facilities, goods and services (12.2.d), the Committee highlights the provision of adequate, affordable services and goods, preferably at the community level, and of appropriate mental health treatment and care. It also underlines the improvement of the population's participation in preventive and curative health services such as the insurance system and the organization of the health sector, as well as their "*participation in political decisions relating to the right to health taken at both the community and national levels*".

The ICESCR allows States parties to restrict the right to health. Unlike Article 4 ICCPR (public emergency), Article 4 ICESCR doesn't specify the permissive grounds for limitations but only the conditions (legality, compatibility of the nature of the rights, for the purpose of promoting the general welfare in a democratic society).

"Article 4, ICESCR

The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject rights only to such limitations as are determined by law only in so far as it may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society".

Furthermore, CESCR commented the following on the limitations to the right to health and the possible use of public health as a ground for limiting human rights:

"Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States (...) Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society (...) In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review".

CESCR appears to refer to Articles 18, 19, 21, 22 of ICCPR that specifically mention public health as a ground for restricting the right to manifest one's religious belief, freedoms of opinion and expression, association and peaceful assembly, since ICESCR does not mention it. This thoughtful comment could have been applied to multiple Covid-19 emergency measures that might not have been reasonably compatible with the nature of the right to health. For example, the measures that limited the exercise of the right (to health) of individuals needing healthcare, the closure of public and private medical facilities, mask mandates, quarantining, Covid testing and vaccine mandates, particularly involving coercive measures and lacking of fully informed consent.

In essence, General Comment No. 14 by the CESCR on the right to health is a reasonable and clear substantive guidance for implementing the right to health both at the national (by States) and international level (by UN entities and through State's cooperation with these and among them). It was summarised in the 2008 joint WHO/OHCHR Factsheet 31, and was a standard reference regarding the interpretation of the right to health. States who are bound by their obligation to implement Article 12 ICESCR have the ultimate responsibility to make their own interpretations and decide on appropriate measures. The implementation obviously varies since each State is unique in terms of culture, geography, population's background, characteristics and needs, immediate and long-term priorities, and available resources.

II.1.2. Public health principles

This section introduces (or recalls) basic concepts in public health that will be used to appraise the raison d'être and performance of WHO in the subsequent sections. We first point to the fact that health is broad, multidimensional, and needs to be comprehended in its complexity. Then we differentiate between medicine – treating individual health – and public health. Obviously, an IHO should not interfere with individual health and thus should limit itself to acting in the field of public health. In practice, public health can be implemented through shaping (i) health policies and (ii) health systems. These are also the two "*pathways to impact*" of an IHO to support countries in pursuing "*the attainment by all peoples of the highest possible level of health*."

However, there is an 'ontological' or 'paradigmatic' battle in public health, opposing a diseasespecific, symptomatic and reductionist approach (Pasteurian paradigm) to a holistic, complex (terrain) approach to health. The methodological advantage of the former over the latter is at the root of the over-specialisation of medicine, the biomedicalization of public health and the securitisation of global health, which are introduced at the end of this section.

Public health

Medicine vs. Public Health

Medicine aims to care for individuals' health, in a one-to-one relationship. This can involve various modalities of medicine, including traditional practices of various cultures. Globally, allopathic medicine, often considered Western medicine, arising initially in the United States and Europe but becoming dominant only over the past 150 years or so, is the dominant approach and by far the major focus of IHOs, including the WHO. This generally refers to a "*system in which medical doctors and other health care professionals (...) treat symptoms and diseases using drugs, radiation, or surgery*". Of note, this definition is closely aligned with the 'binary' or *Pasteurian* approach discussed in Section I.3.1, focusing on symptoms and clearly defined diseases. A result is that allopathic medicine "*is inherently siloed: clinical guidelines, medical education, and research tend to focus on single conditions*", even if "*this stratification of specialties is artefactual and reductionist*".

While fields of modern medicine arising from allopathic medicine are increasingly taking a broader view, such as through the impacts of the microbiome or chronic inflammation on overall health, the disease – treatment paradigm continues to dominate approaches. In many cases, including those with direct public health implications, this makes sense. For instance, tuberculosis requires a specific set of diagnostic approaches and tailored drug regimen based on diagnostic results (pathogen resistance etc.) which requires such a focus. However, the progress and outcome of an infection of *Mycobacterium tuberculosis*, the organism associated with the disease, is also highly dependent on a range of other host factors, including nutritional state and co-morbidities (HIV/AIDS and other immunosuppressed states are among the largest risk factors of tuberculosis mortality). Thus, medical care based on a single pathogen or disease state would generally be poor and inadequate. In public health, the breadth of scope is broad by definition, as it deals with the diversity of such infections or diseases within a population, and the environmental and other factors that promote them and limit overall wellbeing (*physical, mental and social*).

Public health aims to care for populations' health. Contrary to the WHO's definition of health, which is widely used, there is no consensual definition of public health, which is sometimes mixed up with other concepts. However, WHO is widely quoted, noted earlier, as adopting the definition "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society", which in turn is derived from a 1920 definition of C-E.A. Winslow:

> *"the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals".*

The US-based Institute of Medicine defined it more briefly as what "we as a society do collectively to assure the conditions in which people can be healthy". A more descriptive understanding is provided in the Encyclopaedia of Health Economics:

> *"a collective social effort to promote health and prevent diseases – both communicable and noncommunicable – and disability that involves population surveillance, regulation of determinants of health (such as food safety and sanitation), and the provision of key health services with an emphasis on prevention".*

The intent is to describe of necessity a more holistic approach than an allopathic clinical consultation may encompass, but it potentially encompasses a range of approaches.

Of note, it is a field of research and practice rather than a discipline, and it can be approached through numerous disciplines and methodologies. Public health is close to, but distinct from other fields, in particular:

(i) Population health, which is "*an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally*".

(ii) Community health and health promotion: "*Public health and community health have the same objective, which is to improve the health of populations. To achieve this objective, public health uses a technocratic process, whereas community health uses a participatory process. Health promotion, on the other hand, seeks to reduce social inequalities in health by employing a process of empowerment*". (translated from French)

Unified List of Essential Public Health Functions

More practically speaking, there is a consensus regarding the 'Unified list of essential public health functions' all governments should be able to perform. These include:

Public health surveillance and monitoring of population health status, risk, protective and promotive factors, threats to health, and health system performance and service use.

Public health emergency management.

Public health stewardship: establishing effective public health institutional structures, leadership, coordination, accountability, and regulations and legislations.

Multisectoral planning and financing for public health.

Health protection: protecting populations against health threats, including environmental and occupational hazards, communicable and non-communicable diseases, food insecurity, chemical and radiation hazards.

Disease prevention and early detection of communicable and non-communicable diseases.

Promoting health and well-being as well as actions to address the wider determinants of health and inequity.

Community engagement and social participation for health and well-being.

Public health workforce development.

Health service quality and equity: improving the appropriateness, quality, equity in provision and access of health services.

Public health research and knowledge.

Access to and use of health products, supplies, equipment and technologies: promoting the equitable access to and rational use of safe, effective and quality assured health products, supplies, equipment and technologies.

These essential public health functions (EPHFs) encompass both service-oriented and enabling functions, as shown in Figure II.1):

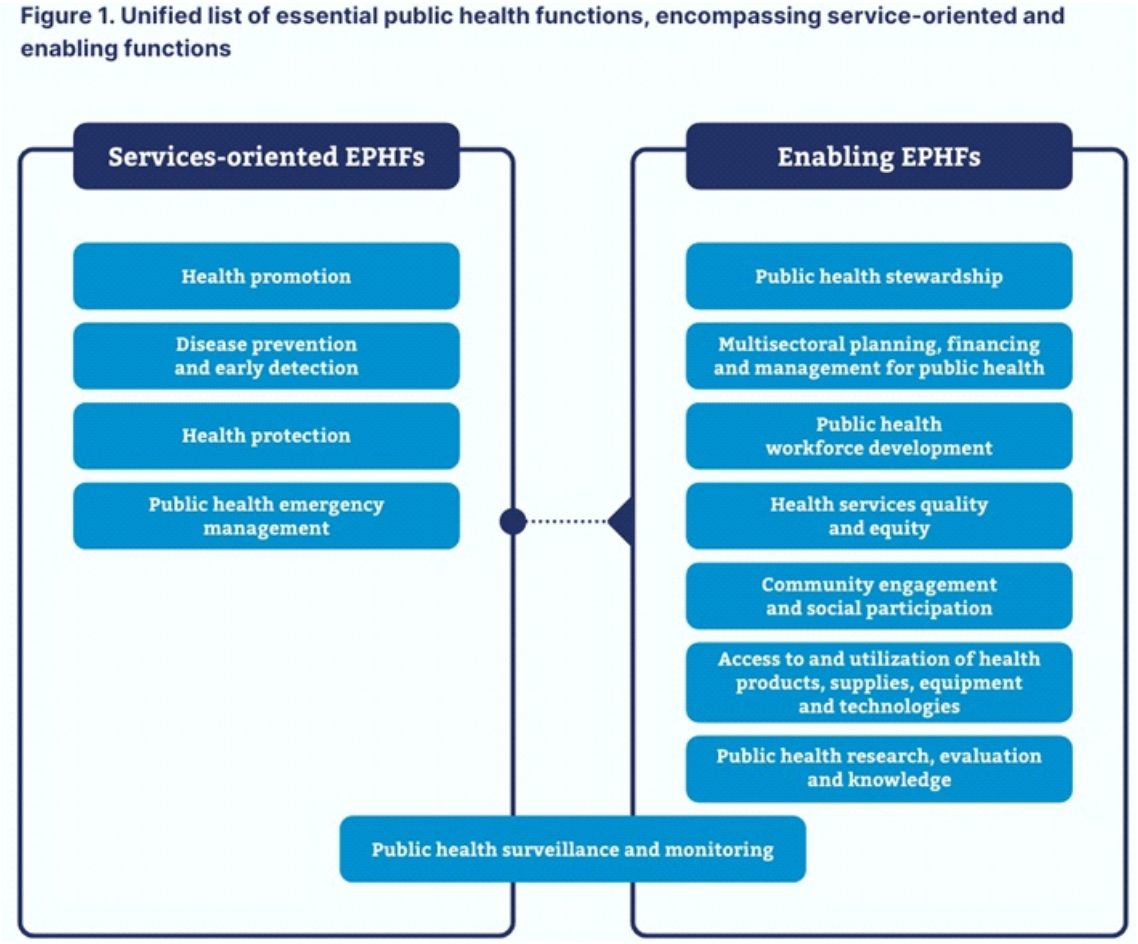

Figure II. 1 – Unified list of essential public health functions, encompassing service-oriented and enabling functions
Source: excerpt from WHO, https://www.who.int/publications/i/item/9789240113596

Clearly a public health organisation will only address certain functions, depending on need, expertise and the level of the health system at which it functions. An IHO, for example, may be too far removed from local context to have a role in implementation of product access or research and surveillance, but may have a role in developing policy and standards and collating data for the same.

Public Health Governance

Acknowledging the lack of explicit definitions of public health governance in the literature, a recent WHO report defined 'governance for public health' as referring to:

> *"the processes, structures and mechanisms for decision-making and oversight to guide, coordinate and ensure accountability regarding the collective efforts of all stakeholders in the delivery of all essential public health functions and services within a designated context. It involves clear authority with agreed mandates, resource stewardship, operational and scientific independence, and collaborative arrangements across all levels within and beyond the health sector".*

Public health governance typically involves many stakeholders from various sectors across society, calling for institutional mechanisms to enable coordination, oversight and accountability.

Medical ethics and public health ethics

Principles of medical ethics

Medical ethics refers to the moral principles governing the relationship between a medical doctor and a patient, intended for the maintenance of, or restoration of, the patient's health. Discussions of medical ethics proceed from the assumption that all patients have equal moral status because of their dignity as human beings (see above). At the heart of medical ethics are questions

regarding what is morally acceptable or morally unacceptable for a doctor to do in the course of his/her care for the sick. One of the best-known texts associated with medical ethics is the Hippocratic Oath, authored in ancient Greece about 2400 years ago. It established several principles of medical ethics that are still considered crucial today. These include the principle of beneficence (to always seek to promote the patient's welfare), the principle of nonmaleficence (to refrain from causing any harm to the patient), and the principle of patient confidentiality (to protect the patient's personal information from third parties). Upon reflection, it becomes clear that the principles of beneficence and non-maleficence are complementary – beneficence stated positively, non-maleficence negatively. Hippocrates himself stated these two principles in one sentence thus: "*As to diseases, make a habit of two things – to help, or at least to not harm*".

The issues that medical ethics address are proving to be increasingly complex, particularly due to the constantly changing landscape of medical practice occasioned by advances in science and technology that force us to reconsider questions we might have previously considered settled. For example, the fact that technology now enables us to sustain the life of people who are classified as brain dead for months or even years, but at great financial cost, forces us to revisit the meaning of the doctor's obligation to do one's best to preserve life. Medical ethics is developing today into a multi-disciplinary field, drawing insights from medicine, philosophy, history, psychology, and sociology, among many others. Thomas Percival's Medical Ethics or a Code of Institutes and Precepts was the basis of the American Medical Association's first Code of Ethics adopted in 1847. The development of a code of ethics marked a radical transition from a personal ethic that focused primarily on elucidating the acceptable conduct of medical doctors to the conduct of a group of professionals.

Consequently, in what follows, we examine the four cardinal principles of medical ethics, namely, the twin principles of beneficence and non-maleficence, patient confidentiality, and voluntary informed consent. The term 'doctor' used below implies any cadre of healthcare professional tasked with supporting a patient in a formal clinical relationship.

The Twin principles of Beneficence and Non-maleficence

In the Hippocratic Oath we read: "*...to help, or at least do no harm*". This maxim states the twin principles of beneficence (the imperative to put maximal effort into promoting the welfare of the patient) and non-maleficence (the obligation to refrain from causing harm to the patient).

According to the principle of beneficence, the doctor ought to do all they reasonably can to improve the situation of the patient. In other words, the principle enjoins the doctor to make diligent effort to follow a course of management that produces maximum benefit for their patient. The principle of non-maleficence is really the flipside of that of beneficence, for it enjoins the doctor to make every effort to refrain from causing harm to their patient; and where harm results, it ought to be with the patient's consent and in pursuit of an overall good.

The rationale for the twin principles of beneficence and non-maleficence is two-pronged. First, the patient entrusts their welfare to the doctor. Consequently, for the doctor to neglect to promote the patient's maximum benefit is a betrayal of the patient's trust, and breach of trust is immoral. Second, the public trusts the medical profession on the presumption that it possesses not only valuable knowledge about how to restore health to the sick, but is also governed by high moral standards that restrain it from misusing its vast knowledge to cause harm. Thus, for a doctor to cause harm to a patient erodes public trust in the medical profession, and this, in turn, may result in poorer health outcomes as the sick seek advice from unqualified personnel.

Patient Confidentiality

Part of the original Hippocratic oath states:

> *"Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private."*

In other words, doctors are morally obligated to ensure they do not divulge a patient's personal information to third parties.

Adherence to the principle of patient confidentiality encourages patients to share personal information with their doctors, and this in turn enables doctors to better determine the best course of treatment for them. The demand, at the height of the Covid-19 public health interventions, that people show their vaccination status, and that such records be deposited in databases

accessible to service-providers, violated this principle. Article 12 of the Universal Declaration of Human Rights states:

> *"No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks".*

Ultimately, the doctor ought to act out of commitment to the highest moral standards, which entails a variety of considerations including not only the patient's good, but also the welfare of society at large. As such, before he/she violates the principle of patient confidentiality, the doctor ought to ascertain that his/her decision to do so would be justifiable on strong moral grounds, and not merely on expedience. Such justification will typically be found where there is a conflict of duties (such as the duty to preserve the patient's personal information and the obligation to protect the public at large). In such a case, there is need to place the conflicting duties in a hierarchy on the basis of a more fundamental moral principle.

Voluntary Informed Consent

The fourth principle of voluntary informed consent, not within the original statements of Hippocrates but accepted as a fundamental extension of individual sovereignty and so consistent with them, stipulates that the doctor is under the obligation to furnish the patient with information about what recommended management entails, the possible benefits and risks arising from it, any available alternative interventions, and thereafter to respect the patient's right to accept or decline it. Thus, the principle upholds the patient's right to both cognitive and bodily autonomy.

Article 3 of the UDHR concurs with this principle: "*Everyone has the right to life, liberty and security of person*". In the light of the fact that violation of this principle may entail force or the threat of force, such violation is also contrary to Article 5 of the UDHR: "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*".

Another area in which the principle of voluntary informed consent is crucial is that pertaining to medical research. Progress in the medical field rides on research. Yet therein also lies the danger of the violation of the moral principles that ought to govern those conducting research on human subjects. A well-known example of such a violation is the Tuskegee Study of Untreated Syphilis in the African American Male (1932-1972). The men used as subjects in the study were never told that they were infected with the disease, and thus denied opportunity for treatment so that the researchers could observe the effects of the disease on the human body. They were lied to that they had 'bad blood', and deliberately deceived that they were under free treatment for it. They were denied treatment even when penicillin became widely available to effectively treat syphilis in the mid-1940s.

Numerous violations of research ethics were also committed in the name of eugenics during the Nazi Regime in Germany. In Doctors from hell: the horrific account of Nazi experiments on humans, Vivien Spitz presents first-hand accounts of victims of the Nazi medical research atrocities, including 'high-altitude' experiments in which concentration camp inmates were forced into chambers without oxygen to simulate conditions at up to 68,000 feet, removal of sections of bone, muscle and nerves, including the removal of whole legs at the hips for transplanting to other victims, wounding of two limbs and treatment of one but not the other with sulphonamide antibiotics, and intramuscular injection with fresh typhus.

The Nuremberg war crimes trials of Nazi atrocities greatly raised awareness of the need for an acceptable code for medical research, leading to the promulgation of the Nuremberg Code in 1947 which resolutely promoted a human rights orientation in medical research. It upheld the medical researcher's obligation to respect the agency of the human subjects of research, affirming their right to voluntary informed consent. Indeed, the Code affirms the human subjects' right to opt out of an experiment at any stage, implying that their right to voluntary informed consent includes their right to withdraw their consent. The World Medical Association's Declaration of Helsinki, initially issued in 1964 and revised several times since, is largely an elaboration of the ethical framework of the Nuremberg Code, as is the Council on International Organizations of Medical Sciences' International Ethical Guidelines on Biomedical Research Involving Human Subjects. Article 6 of the Declaration of Helsinki (2024) states: "*Medical research involving human participants is subject to ethical standards that promote and ensure respect for all participants and protect their health and rights*".

While the Nuremberg Code and Helsinki Declaration are aimed at medical research, their translation to clinical medicine is quite direct, as the same principles apply. This

relationship is noted by WHO. Differences between research and clinical medicine are relative, as biology is complex, the definition of health (e.g. as defined by WHO) is broad, and medical outcomes are always to some extent uncertain. However, the sovereignty of an individual under the understandings of human rights discussed above is not relative. The relationship between a practitioner and patient is therefore essentially analogous to a medical researcher and subject.

The rationale for the principle of voluntary informed consent in medical research and clinical medicine is therefore two-fold. First, the patient, by virtue of being human, is a rational being of equal status to the clinician or researcher – they have the ability, within the limits of psychological competence, to make claims and to provide grounds for themselves. This also implies that they are able to consider the claims made by others and the evidence they adduce to support them. As such, to violate the principle of voluntary informed consent is to disregard their human nature. Second, since the patient will bear the negative consequences of any course of treatment, he/she has the right to decide whether or not to accept it. Upon reflection, it becomes evident that the rationale for the principle of voluntary informed consent rests on human dignity, human agency and human rights discussed in the previous sub-section. The Constitution of the WHO appears to support the right to voluntary informed consent when, in Article 2 (r) it states that one of its functions is "to assist in developing an informed public opinion among all peoples on matters of health". However, the fact that it falls short of unequivocally acknowledging the notions of volition and consent casts doubt on the organisation's full recognition of this principle.

Overview

In the foregoing reflections, we have examined the four cardinal principles of medical ethics:

1. Beneficence (acting for the patient's good)
2. Non-maleficence (refraining from doing harm)
3. Patient confidentiality (Respecting privacy and ownership of personal information)
4. Voluntary informed consent (bodily autonomy).

The first three date to Ancient Greece, the last has gained currency in our time but is consistent with them. Upon reflection it becomes evident that the applicability of each of the principles is not absolute. This is so when there is a conflict between them, which may be most apparent when applied to others in the community beyond the direct doctor-patient relationship, such as a doctor's moral obligations to others perceived to be directly in harm's way. Furthermore, advances in science and technology force a fresh consideration of the meaning and applicability of the various principles. This is where public health ethics become relevant. Nevertheless, since all genuine efforts at promoting health are ultimately geared to individuals, the principles of international public health ethics, including those touching on issues such as equity and the obligation to engage in collective efforts, are derived from the principles of medical ethics and therefore cannot logically override them.

Principles of international public health ethics

Background

As noted earlier, a definition attributed to WHO and consistent with other bodies, characterises public health as: "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society". As such, various measures that governments put in place to improve nutrition and sanitation, contain infectious diseases, enhance road safety, promote the safe disposal of waste, and enact anti-smoking legislation, among others, are primarily public health measures rather than issues of medical care. Thus, public health is heavily intertwined with public policy, and often considered analogous to the building of schools, hospitals, roads or other infrastructure, or the setting up of security agencies – endeavours that single families cannot accomplish, requiring the action of political authorities. Thus, under the auspices of public health, governments set up various institutions to issue directives or recommendations intended to enhance the overall well-being of people under their jurisdiction.

Public health ethics are crucial because once the issue of health as a common good arises, there is need to balance the individual's rights and the collective interests. There are many instances in which the individual's rights to goods such as liberty and privacy may be in conflict with measures that the State may put in place to protect the liberty and privacy of others. In other words, public health ethics is about determining the degree to which an authority is morally justified to use its power to promote the overall health of the population at potential cost to the individual. Within this are covered issues of fair distribution of scarce resources for the enhancement of health. These may include resources for preventive measures (such as screening for various cancers),

mitigating the impact of social inequalities that lead to ill-health, and rationing scarce or costly resources such as medications. Public health interventions devoid of ethical considerations expose society, and particularly its most vulnerable members, to harm or injustice.

As the ultimate beneficiary of all initiatives associated with the promotion of health is the individual, medical care is primary and public health measures, whether domestic or international, secondary. More specifically, public health ethics are derived from medical ethics. This is to say that public health ethics are medical ethics applied at a population level. Thus, ethical public health practice requires ethical medical practice, but must also address a broader scope of issues. As such, any sound principles of public health ethics are ultimately anchored on the principles of medical ethics (beneficence, non-maleficence, voluntary informed consent and patient confidentiality), and thus refrain from violating them. An assumption that the health of the population, as a whole, ought to take precedence over the individual's liberties would constitute a violation of the principles of medical ethics, and therefore be contrary to the genuine promotion of health. Such approaches often proceed from a conception of 'health' as absence of disease instead of understanding it as overall well-being – physical, mental and social, and subject to both endogenous and exogenous influences (Part I.1.2). Thus, where a proposed public health measure has potential to violate any of the four principles of medical ethics, public health practitioners are under obligation to ensure that the individual's fundamental rights are upheld.

Consequently, in what follows, we propose thirteen principles of international public health ethics, consistent with current international norms of human rights and medical ethics discussed heretofore, against which international public health, and an IHO, should be judged.

Principles of international public health

Public health personnel and those designing public health measures should base recommendations on a clear set of principles which ought to be considered inviolable, and fundamental to ethical public health practice. These follow from the four ethical principles that govern the clinical (doctor-patient) relationship, but further address the wider context of the interaction of communities and international public health authorities.

The below principles follow from the fundamental human rights norms discussed earlier in this section and are consistent with a previously published set of public health principles.

Health governance and human rights

1. All people are of equal concern, with sovereign rights over their own bodies. Each person therefore has a right to decide on their own healthcare, and to interpret public health advice within their own context.

2. States have sovereign rights over public health policy within their own borders in their role as representatives of, and expressions of, the self-determination of individuals comprising the population within States.

3. The role of public health, and public health institutions, is to advise individuals on their health risks and management, and populations on their joint health risks and management, to enable those individuals and populations to make evidence-based decisions, taking into account the context in which they live and their own expectations and preferences regarding health matters.

Voluntary informed consent and absence of coercion

4. Individuals or their legal guardians must not be forced or coerced into medical examinations or medical management, including prophylactic and preventive care. (A legal guardian can only act in the interests of the subject).

5. Voluntary informed consent is a fundamental right of all people and a requirement for the provision of medical care.

6. All individuals have a right to interpret health advice applying to themselves according to their cultural and religious beliefs and customs, geographical context and individual health status and experience.

Role of public health institutions

7. Communities are the primary focus for public healthcare, as it is essential that healthcare be tailored to local contexts. They should be the primary decision-making level for public health policies that impact

them. They should also represent, but not override, the health preferences of the individuals within them.

8. Health is influenced by a broad range of determinants, including physical, environmental and social. Responses to individual threats, such as biomedical threats, must be considered always in the context of their effects on these broader determinants.

9. Public health must be free of ideological or commercial conflicts of interests and give health advice based on a summation of available evidence and expertise. This summation should include the expected impact of alternate approaches, tailored to local conditions, and free of influence of entities that stand to benefit financially from such advice. Evidence and expert advice must be available and transparent to ensure opportunities for voluntary informed consent.

10. Public health and the health sciences rely on free and open dialogue, transparent testing and analysis of data, and balancing of risks and benefits within these. The public, and those within the health field, have a right to free expression of ideas regarding all matters touching on health. Censorship is therefore contrary to the principles of public health and must not be used by health institutions to develop or implement policy.

International public health institutions

11. The role of international health institutions is to advise States and communities on areas of healthcare based on available expertise and evidence, to support populations in coordinating areas of cross-border and international health concern, and to provide technical support when requested by States and within the institution's capacity, while respecting the States' and communities' specificities and preferences. In doing so, international health institutions should not override the laws and rules of States and peoples, or directly address the healthcare of individuals within States and communities without their consent.

12. Where States are unable to build strong and efficient health systems and to promote the health of their people, it is the role of international institutions to assist those States in the promotion of public health.

13. International health institutions formed by States must be free of conflicts of interests from private and for-profit entities, and transparent regarding the affiliations of those offering advice. Private and for-profit entities must not have control, direct or indirect, over the functions and activities of such institutions, or the salaries and benefits of their employees.

Some implications of these Public Health Principles

Health governance and human rights

Public health is intended for the benefit of the public, a set of individuals. It follows that the public must ultimately be in charge, and legislation, policy and practitioners must therefore refrain from suppressing freedom of thought and expression in the name of promoting the health of the public, as this would limit the exercise of basic rights, ultimately individual well-being, for which public health is intended.

Democracy and health are generally considered to flourish where people are free to think and to exchange their views. This is in line with the WHO's definition of 'health' as "a state of complete physical, mental and social well-being ..." values healthy social interaction, while Article 19 of the UDHR affirms:

> *"Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers".*

Therefore, individuals have a right to question, and contradict, public health advice.

Deliberation between the public and public health authorities with a view to enhancing the exercise of human agency will guard against a top-down approach to public health at both the international and national levels, thereby promoting a democratic culture. Indeed, if governments rule for and by the people, the people must be able to exercise their agency in public health. There ought to be mutual support among various segments of society within countries and between various countries, while upholding the individual's right to freedom of thought, expression and action, thereby protecting each person from the demand to engage in unquestioning conformity to proposed international public health measures.

Voluntary informed consent and absence of coercion

The right to voluntary informed consent, and accordingly freedom from coercion (involuntary or unwilling compliance), follow from the basic understanding of the agency and autonomy of individuals, and correspondingly basic medical ethics, as discussed earlier. This can be difficult for a self-considered 'expert class' of public health practitioners to accept, particularly in circumstances where there are apparent pressures toward a perceived collective good. As the Nuremberg code notes, however, such moral principles need to be held essentially inviolable to prevent abuse.

The tension between social responsibility and personal liberty, well recognised in the curtailing of civil liberties in the name of combatting terrorism, is now prominent in the trend to securitise international public health in the name of mitigating pandemics and other emergencies (see Sections II.3.2, II.3.7). For example, in sharp contrast to medical care which traditionally upholds patient confidentiality, public health relies heavily on surveillance, with digital storage and communications making personal data potentially available to third parties without patient consent.

Role of public health institutions

Beyond compliance with the basic obligations of human rights, the essential role of individuals and communities in making ultimate decisions on implementation of public health recommendations is underlined by the diverse set of impacts, different in each context, that such interventions can have. Nevertheless, from the mid-1990s, we have witnessed public health mitigations such as the culling of livestock and poultry, and more recently lockdowns, curfews and mandates, that impart significant damage to livelihoods that can far outweigh often inconclusive evidence of benefits, impinging on other aspects of health in the short and longer term. These are compounded when human nature promotes other interests among those giving recommendations due to financial or social conflicts.

Conflicts of interests occur when people in decision-making positions on behalf of the public use the said positions for personal gain. In the public health sphere, conflicts of interests can enable vested interests such as pharmaceutical companies to influence policy development and decision-making in order to enhance markets. It is therefore essential that firewalls against such practices are built into the constitutions or governing documents of public health institutions. They can also be addressed through ensuring accountability of decision-makers, though such accountability must be weighed against the unknowns on which best-guess decisions and recommendations must be made. Of most importance is the method (i.e. scientific method, discussed below) through which such decisions are reached.

As conflicts of interest tend towards concentration of wealth, public health institutions have a role in promoting distributive justice, or a fair allocation of benefits and burdens, undertaken without extraneous considerations such as cultural background, religious convictions, race or economic class. In particular, governments are under obligation to use the resources at their disposal to promote health equity within their jurisdictions. The logic from a health viewpoint is two-fold, firstly social well-being is addressed through reduced poverty, and secondly physical and mental well-being are significantly tied to economic state.

A corollary of distributive justice is the tailoring of interventions to local context – recognition of the diversity of need and preference. As such, any public health measure imposed on the whole of a population or populations, sometimes described as a 'one-size-fits-all' directive, is bound to be a disservice to some. This principle requires community consultation and control in place of a top-down approach to international public health, on a national or international level, consistent with the 1978 Alma-Ata declaration emphasising the role of primary health care.

Public health institutions provide advice through the accumulation of data and expertise. It is essential that this be free of conflict of interest and based on the scientific method in order to ensure objective information is available to enable public decision-making. The scientific method, as articulated by Francis Bacon and subsequent thinkers, aspires for objectivity and replicability. Underlying this aspiration is the conviction that no one possesses absolute knowledge of the operation of nature, so that human knowledge grows in a piecemeal and gradual manner, and is, therefore, always tentative. This, in turn, implies openness to inspection and correction. In the fields of medical care and public health, this also implies the need to be open to diverse approaches to the promotion of health and healing, as long as those who propose the various options are willing to have their proposals submitted to inter-subjective verification.

As such, public health law and policy ought to be developed from a robust discourse that takes serious cognisance of divergent approaches, as long as they are all committed to the imperative to provide evidence for their perspectives.

International public health institutions

The rationale for State sovereignty is grounded in the current international order, which, in line with the United Nations Charter, is founded on the equality of all sovereign States. The WHO's Constitution goes a step further than the United Nations in that none of the members of the WHO has veto power, and, according to Article 59 of its Constitution, "Each Member shall have one vote in the Health Assembly".149 Thus, no government should be in a position to impose health requirements upon another State regarding healthcare matters within that State.

Moreover, according to Article 2 (C) of the Constitution of the WHO, one of the functions of the organisation is "to assist governments, upon request, in strengthening health services". This implies that the organisation is obligated to refrain from imposing public health measures on sovereign States. Accordingly, international public health measures ought to be recommended, and put in place, without any extraneous considerations such as geo-political interests or commercial influence, with ultimately the State, and thereby its citizens, having final say on implementation.

Conclusion

In view of the foregoing reflections, it is evident that an international health organisation which is not based on sound ethical principles runs a high risk of undermining health. Consequently, international public health ought to be viewed primarily as a matter of ethics rather than science, with science serving ethics, and not the other way round. Thus, ultimately, global public health is a matter of human rights grounded in the intrinsic, inestimable value of each and every individual ('human dignity'). Consequently, public health legislation, policy and practitioners ought to promote the health of populations without curtailing the liberties of the individual. Since no public health advice performs fully against all decision criteria (e.g. effectiveness, efficiency, equity, acceptability), there is no optimal policy from a technical perspective, and advice given should generally be time-limited and interpreted in context (see Section II.1.2). Only in this way can the health of humanity, in its broad sense, be consistently and equitably enhanced.

II.1.3. Balancing public health: social determinant versus biomedical approaches

One of the key reasons public health exists is because individuals' health is influenced not only by individual – biological and behavioural – factors and clinical services, but to a large extent by social determinants of health (SDOH). The concept of SDOH was well demonstrated in higher-income countries in the 1970s,150 while long established in low-income countries where health services and ability of populations to access care and good nutrition are still more fragile at a local and national level. More recently, in 2015, it was estimated that the relative contributions of various types of factors to differences in a health outcome composite score between American counties are as follows: 47% for socioeconomic factors, 34% for health behaviours, 16% for clinical care, and 3% for the physical environment. Clearly, public health should be mostly aimed at addressing these determinants and an IHO should give them priority, particularly where a lack of national economic strength and capacity makes poverty pervasive or income inequalities hard to address at a national level.

Contrary to the linear causality underpinning much of clinical medicine, understanding the interplay between social determinants and health necessitates adopting a systemic, complex analytical approach. Indeed, aside from lack of healthcare access and higher environmental risks, a reason behind the translation from health to disease – and its more frequent occurrence in lower-income people – is to be found in the long-term effects of psychosocial stress on the physiological stress response pathways resulting in chronic inflammatory dysregulation. However, as pointed out in Section II.1.2, while a holistic approach aimed at identifying and alleviating the root causes of poor health frequently makes more sense, empirically and theoretically, from a population standpoint, a dominant approach in public health and medicine often consists of addressing individual diseases one by one from a biomedical perspective, with different public health disease streams concentrated on disease diagnosis and specific management, competing for resources rather than collaborating on overall population health outcomes. This has often been termed the 'biomedicalization' of public health, or biomedical reductionism of the public health approach.

Key features of biomedical reductionism within the literature include:

- The growing dominance of technological or scientific solutions to health, particularly biology, biochemistry, genetics, and the use of pharmaceuticals for both treating illhealth as well as the promotion of good health.

- The growing dominance of biomedical solutions as a preferred method of addressing issues of health across an increasing range of social and personal experiences. For example, it is often suggested that the focused use of pharmaceuticals for pandemic preparedness versus focusing on the promotion of basic health to improve immune response is a form of biomedical reductionism.

- A trend toward greater surveillance, diagnostics and biomedical assessment in the reduction of ill-health as well as the promotion of good health.

- A trend towards biomedical solutions for the human body, which treat the body as a machine-like entity that needs 'fixing' and/or as a 'biopolitical' space that requires reengineering towards a predetermined upstanding of health.

This is closely tied to the securitisation agenda in health, aligned with the current WHO pandemic agenda, and a clear influence in WHO from the World Health Report of 2007: a safer future: global public health security in the 21st century. See Section II.3.2 for further discussion.

Over-biomedicalization of public health has four key implications: (i) an over-reliance on technical and biomedical solutions rather than underlying drivers of individual resilience and well-being; (ii) the individualisation of health issues, thus neglecting broader interactions and social contexts; (iii) the marginalisation of community-led and interdisciplinary approaches; and (iv) the emergence of ethical and equity concerns arising from exclusionary practices. This results in a narrowing of public health's scope and effectiveness in addressing root causes of health and health inequalities.

The biomedical or disease-focused model for public health is further promoted by the desire of donors, policy makers and health economists to measure outputs in terms of financial return on investment. While economic analysis is important to ensure the best allocation of (scarce) resources within a health system and to assess health disparities and the distribution of benefits from public health policies, this risks skewing policy toward less good, but more measurable, interventions. In particular, health economics relies heavily on cost-effectiveness analysis (CEA), which compares health interventions based on their incremental benefits and costs. However, CEA is designed to measure the relative value of specific interventions and programmes (e.g. tuberculosis prevalence after a specific screening and treatment programme), but not so well suited to assess cross-programmatic efficiency, Cost-benefit analyses, enabling comparison with interventions in other sectors, are more informative but more difficult to implement. However, prioritising interventions because they are more readily measurable rather than more potentially impactful may lead to inefficiencies and inequity.

Furthermore, the heavy commoditisation of health under the biomedical model, based around drugs, vaccines and diagnostics that are manufactured for profit, often under patent protection, makes the field both attractive to commercial entities and open to influence by such vested interests. Such conflicts of interest have been termed the commercial determinants of health,160 or the political determinants of health where national governments with corresponding geo-political interests become involved.161,162 Again, the diversion of policy priority from population good to commercial profit and narrow political interests risks inequity,163 but is a clear risk where funding streams to an IHO are heavily dependent on such interests (see Section IV.6.2).

Consequently, despite its intellectual and empirical appeal and the urgency of addressing social determinants in public health policies, the ideals of a more holistic approach apparent in earlier decades of WHO, as articulated at Alma Ata in 1978,164 struggle to get political traction and are poorly translated into policy.165 This is regardless of regular calls by many organisations – including some voices within WHO (see below)– to tackle social determinants, to strengthen community health systems and health promotion, to address the neglect of traditional medicine, and to redesign health systems to address complexity and better respond to population needs.

II.1.4. Health Systems and Policy

Improvement of health systems – the modes by which healthcare is delivered, is a core function of public health and a particular traditional focus of multilateral and bilateral health agency support for poorly-resourced countries. However, as with support for the broad determinants of health, health systems support suffers due to the difficulty in measuring its overall impact.

Health Systems

Health systems have been defined by WHO as "*comprising all the organizations, institutions and resources that are devoted to producing health actions*". Health system performance is by nature multidimensional, and there are trade-offs to be made between various goals (e.g. improving average health status vs. equity, efficiency, responsiveness).

The conceptualisation of health systems has evolved. They are generally represented either as carrying out several functions – service provision, resource generation, financing and stewardship – or comprising various pillars or building blocks – service delivery, health workforce, information, medical products/vaccines/& technologies, financing, and leadership/governance. Health system design varies widely (e.g. consumer-financed versus publicly financed-based), and these various characteristics influence their performance. Like other complex systems, health systems are "*a complex of interacting elements*", including several key characteristics:

Self-organising: system dynamics arise spontaneously from internal structure.

Constantly changing: they adjust and readjust at many interactive time scales.

Tightly-linked: the high degree of connectivity means that change in one sub-system affects the others.

Governed by feedback: a positive or negative response may alter the intervention or expected effects.

Non-linear: relationships within a system cannot be arranged along a simple input-output line.

History dependent: short-term effects may differ from long-term effects.

Difficult to measure impact: cause and effect are often distant in time and space, defying solutions that pit causes close to the effects they seek to address.

Difficult to change: seemingly obvious solutions may fail or worsen the situation, or face barriers due to set patterns of behaviour.

Therefore, health and health systems need to be approached through systems thinking, which:

> "*is an approach to problem solving that views "problems" as part of a wider, dynamic system. Systems thinking involves much more than a reaction to present outcomes or events. It demands a deeper understanding of the linkages, relationships, interactions and behaviours among the elements that characterize the entire system*".

Public health policy must consider these complex relationships in order to ensure beneficence and non-maleficence across an entire system, and therefore the entire population (Section II.1.2).

Health Policies

Health policies may be defined as "the purposeful and deliberate actions through which efforts are made to strengthen health systems in order to promote population health". Health policies can influence health (and other) outcomes through various pathways, including through shaping health system organisation and institutions, governing relationships between actors, determining how health services are financed, and directly through specific interventions (e.g. health promotion and prevention activities, or normative guidance to health service providers).

Like any public policy, health policies follow a cycle that starts by the inclusion of a given problem on a political agenda (including problem definition and causal diagnosis) followed by policy formulation (planning), policy adoption, implementation, monitoring and evaluation, and adaptation/succession/or termination. The first stages of policy development are crucial. Indeed, a policy is supposed to be designed to address a given societal problem (or, at least, to prevent problems from arising). At an international level, this must commonly include the interaction of health outcomes (e.g.: through the spread of infectious disease) between countries. A analytical framework commonly used to understand the agenda-setting stage includes a problem stream (a public problem is objectivised and publicised), a solution stream (one or more alternatives) and a political stream (a political willingness to develop a policy); usually, thanks to the intervention of 'policy entrepreneurs'. Again, on an international stage, this requires forums where political discussions can occur between States, commonly with a multilateral organisation (e.g. an IHO) to facilitate.

Once a policy is proposed at the political level, its design stage is also crucial. In the public health sector, this includes both the prioritisation of health problems and needs to address, and the prioritisation of interventions to address these. It is typically done based on criteria including specifically the:

- Disease burden (in terms of size and seriousness)
- Existence of cost-effective interventions
- Acceptability by implementers and beneficiaries
- Effects on fairness/equity.

From Evidence-Based Medicine to Evidence-Based Policy

The medical field, in order to guarantee healthcare quality, emphasises the importance of 'evidence-based medicine' (EBM); a "systematic approach to clinical problem solving which allows the integration of the best available research evidence with clinical expertise and patient values". However, there are also limitations to this approach. First, biology is complex and heterogenous, epidemiology of disease even more so, and individuals have preferences and cultural, religious and social contexts that affect individual decision making. Medicine therefore, applied ethically, cannot consist simply of following guidelines but rather of, ultimately, following a patient's choice (Section II.1.2). EBM in its pure form is also poor at addressing multimorbidity, as disease States interact. Indeed, randomised controlled trials on which EBM is classically based generally exclude multimorbid patients to avoid confounding. EBM can inform on whether a given medical product or intervention "works on average", but application to a specific individual requires a broader approach.

Following the model of EBM, the term 'evidence-based (or informed) policymaking' is widely applied to public health However, compared to the hierarchy of evidence applied in clinical decision-making, public health policy requires a still broader spectrum of sources and considerations. "The translation of research into policy content and practice consequently challenge for researchers and decision makers". Public health policy development is further complicated by the diversity of potential outcomes; relevance, effectiveness, efficiency, overall impacts, as opposed to (at a clinical minimum) relieving a presenting disease. No public health intervention will be optimal on all criteria, and trade-offs are necessary (e.g. reduce efficiency to guarantee equity; sacrifice short term effectiveness to build local capacities and ensure sustainability and long-term impacts) while any investment also has an 'opportunity cost' – that is, it removes available resources from other priorities.

To achieve legitimate public health policy, it is therefore essential to have enough competencies, strategic vision and political will to coordinate and base prioritisation on clear criteria, but also to ensure an inclusive and participatory policy dialogue, enabling the citizens ultimately impacted to exert their voice on final choice. Decision making requires capacity and expertise, but ultimately must take place close to or within the communities involved. This requires a combination of pooled expertise and knowledge, and sufficient subsidiarity to ensure decisions are based on local context.

II.2. HISTORY OF INTERNATIONAL PUBLIC HEALTH PRE-1990s

To understand modern international health cooperation and how the WHO came into being, it is important to understand the prior history of multilateral international cooperation in health, and the context of the WHO's formation just after the Second World War.

II.2.1. Short history of international public health

A collaborative effort to improve general well-being and address threats to health provides a common good, and is necessary for addressing certain threats such as infectious disease spreading across borders. More broadly, most cultures recognise merit in supporting others in building better and healthy lives. The WHO constitution's affirmation that health involves 'physical, mental and social well-being, and not merely the absence of disease or infirmity', implies broad areas of potential cooperation touching on individual, community and State action.

More directly, the spread of infectious diseases or other biological, chemical or radioactive threats across borders raises obvious issues of health and national security. Such threats stimulated the first major efforts to develop international cooperation in public health, through the sanitary conferences and subsequent Sanitary Conventions of the latter half of the Nineteenth Century.

However, these early sanitary conferences also illustrated the dangers inherent in proposing actions or restrictions on one group of people for the perceived benefit of another, and this poses a risk that has dogged public

health ever since. The first international sanitary conference was held in Paris in 1851, being a meeting between colonial powers, some still supporting slavebased economies. The conference therefore aimed to protect the interests of economically or politically dominant groups from diseases perceived to be spread from other societies. The First Sanitary Convention, ratified at the seventh conference in Venice in 1892, addressed the spread of cholera, with a further Convention addressing Plague five years later.

In the first half of the twentieth century, the discipline of public health would expand to conflating health and human potential with ethnicity and hierarchical concepts of human worth, leading to the eugenics approaches and medical fascism prevalent in Europe and North America. Health-seeking and fear of death can be powerful and unifying forces, and so are open to abuse by power structures and political movements seeking to use them to gather support for economic or ideological goals.

The first establishment of an international health office was the International Sanitary Bureau of the Americas in 1902, the forerunner of the Pan-American Health Organization (PAHO) which is currently the WHO Regional Office for the Americas. The Office Internationale d'Hygiene Publique was inaugurated in Paris in 1907 as a first permanent secretariat for international health matters for European nations.

The Health Organisation of the League of Nations was then established in Geneva after the First World War, adding Smallpox and typhus to the list of diseases specified under the International Sanitary Convention. The League was European-dominated but included Japan in its permanent council and a number of American and Asian countries among its members. Much of Africa and Asia at that time consisted of colonised populations supporting the prosperity of others, their lands providing a resource for growing northern industry and consumerism, but their peoples lacking a say in the prioritisation of international health.

With the excesses recognised in World War Two and the broad emphasis on decolonisation, equality and human rights that followed, the concept of cooperation between States to reduce health disparities rather than as a primarily securitising measure became widely accepted. The World Health Organization grew on the concept of wealthier countries funding aspects of health systems and health interventions in countries with less resources, either directly or through multilateral mechanisms, to reduce the major avoidable disease burdens within those lowerresourced populations. Focus on the major infectious diseases of malaria and tuberculosis, and on sanitation and nutrition, reflected this. While smallpox eradication and the campaign against diseases such as polio and measles had global aspects, the main beneficiaries were again lowincome populations where their remaining burden was concentrated.

II.2.2. The WHO: An Egalitarian Birth

On 22 July, 1946, the 51 countries of the recently convened United Nations (UN), together with ten non-Member States, signed the WHO constitution. The WHO arose from the defeat of fascism and the assumed decline of the old imperial world order as the UN's health agency, to guide the application of public health measures for the world's population. Coming into force in 1947 when the twentieth country ratified the agreement, the new body's constitution was based around its broad definition of health:

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".*

The second principle underlined the post-colonial and post-fascist approaches that emphasised equality over hierarchy:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".*

While inevitably building a somewhat centralised structure, the WHO constitution enshrined the idea of individual and community authority within its guiding principles, albeit failing to specify voluntary informed consent:

> *"Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people".*

WHO was to be governed on the basis of one nation – one vote through the World Health Assembly (WHA) – a council comprising all Member States. This council grew as more nations achieved independence from colonial masters, gradually moving the weight of votes towards

lower income countries with higher disease burdens – the post-colonial States. Most funding was through allocations based on gross domestic product of its members, providing core funding which the technical expertise recruited by WHO, guided by the WHA, could direct based on its constitution and perceived need.

WHO consists of six Regions, each with its own Regional Office and a Regional Director (RD) elected by States within that Region. The global office (Headquarters) in Geneva, Switzerland, houses the Director General and is governed by the World Health Assembly (one State – one vote) that meets at least yearly, and an executive board (EB) formed of 34 members nominated by 34 States on a rotating basis, with at least three from each Region (Articles 24-29). Staff have mostly been grouped under technical (disease-related) units, with those in headquarters reflected in the Regional Offices.

While addressing the highest remedial disease burdens within less-resourced Member States was the major focus of WHO's work, many infectious diseases are unlimited by borders, and an outbreak in one country can impact the population of others either bordering or distant. While this usually happens locally or regionally with vector-borne diseases (e.g. malaria, dengue fever) and those requiring close human to human spread (e.g. Ebola, HIV), others spread by aerosolised respiratory viruses can rapidly become global. Influenza and coronaviruses are well-recognised examples. Foreknowledge of such outbreaks and their epidemiology and genetic make-up (e.g. through influenza virus surveillance) influences the preparatory measures that downstream countries may take to reduce impact, and thus addressing epidemic risk also formed an original part of WHO's remit. Therefore, in Article 2 (g), the new Organization's remit included "*to stimulate and advance work to eradicate epidemic, endemic and other diseases*".

Meanwhile the WHO and its Director General were expected to respond on behalf of Member States, with the Executive board (EB) having power (Article 28 (f)) to request the organisation:

> "*to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular it may authorize the Director-General to take the necessary steps to combat epidemics…*"

WHO led the global eradication of Smallpox, and the reduction of polio, through large vaccination campaigns. These have been considerable logistical achievements, and it is hard to imagine efforts of such scale without the ability to coordinate across borders and support technical capacity vested in a supra-national organization. Before the 1940s, vast colonial enterprises could consider such efforts within their empires, but these programmes demonstrated they were possible as collaboration between large numbers of sovereign States. However, they also illustrate the attractiveness of such readily quantifiable interventions in the international sphere rather than programmes that may have still higher impact. We recall mass vaccination and eradication as examples rather than building mass resilience through nutrition or deworming programmes. A danger is that policy then becomes shaped by appearance over substance.

II.2.3. Defining human rights in a decolonising world

The United Nations General Assembly, meeting in Paris on the 10 December 1948, sought to express consensus on the (relatively newly emergent) international principles of equality and individual autonomy through the Universal Declaration of Human Rights (General Assembly resolution 217 A). The original English version begins:

> Article 1: "*All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood*". and:
>
> Article 2: "*Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status*" (in part).

Through 30 articles, the Declaration enshrines freedom of movement within one's own country, and freedom to leave and return to one's country, freedom of thought, of opinion and of religious expression, and rights to basic areas of participation in society including work, education and family life. A series of legally-binding international treaties followed, laying out these Articles into human rights law, discussed in detail in Section II.1.1. While authoritarian rule obviously persisted in many States and wars between them, international agencies such as WHO at least would be expected to emphasise, and base their approach on, these newly codified humanitarian

principles. The Helsinki Declaration of 1964, as example, last updated in 2024,204 built on the Nuremberg Code to define the importance of free and fully-informed consent as prerequisites for health-related trials and the use of experimental treatments. Voluntary informed consent for medical practice in general, though based in many cultural traditions emphasising individual freedom and bodily autonomy, is built on the same principles and has been strengthened through various national and international instruments since the founding of the WHO.

WHO, growing through this period of emphasis on human freedom, built disease-related programmes, particularly targeting infectious diseases of high burden, malaria, tuberculosis, schistosomiasis, soil-transmitted helminth infestations and micronutrient deficiencies. These were mainly based around decentralised approaches, as most sufferers were in lower-income communities with often limited formal health services. Over decades, a growing armoury of antimicrobials and vaccines expanded the scope for large, centralised commodity-based programmes, directed by central expertise. Large programmes dispensing commodities to hundreds of millions of people grow bureaucracies to manage them, with an increasing workforce of career-minded health bureaucrats and researchers who, though likely well-meaning, have priorities in conflict with the distant individuals and communities with whom they have little direct contact or requirement to answer to.

II.2.4. The heyday of primary care in public health

The increase in health commodities and the bureaucracies required to manage them, coupled with fundamental changes in the funding of WHO detailed below, set up a contrast between two broad approaches to international health policy; horizontal programmes centred around community-based approaches addressing the underlying determinants of health, and vertical commodity-based approaches supplying disease-specific management with pre-approved medicines, vaccines, and diagnostics, exemplified by the recent securitisation of public health policy (see Section II.3.2). Though both should be essential components of a system delivering basic universal healthcare, the incentive structures that promote them are very different, and inevitably result in different approaches that have major implications for current international health policy.

It is widely accepted that the primary drivers for increased life expectancy in wealthy countries over the past two centuries are related to improved nutrition, sanitation and living conditions. While the advent of modern antibiotics has been influential, and more recently vaccines have in particular reduced transmission of certain pathogens and helped eliminate one (Smallpox), improving human resilience and reducing exposure through environmental changes underly the major improvements in health following the industrial revolution.

In low-income countries with higher infectious disease burdens, where WHO's efforts have been concentrated, both approaches to health care should naturally be seen as complementary. Mortality from infectious diseases is heavily dependent on the immune resilience of the individual and their exposure. Immune resilience is broadly dependent on nutrition and absence of concomitant chronic debilitating infections, and on prior exposure either through survived infection or vaccination. Exposure is dependent on the environment and behavioural traits of an individual, and on the level of circulation of pathogens within the community in which they reside. Severity and outcome once an infection is established is frequently dependent on the availability of effective therapeutics such as antimicrobials.

In the early decades of WHO's existence, and in keeping with the broad emphasis of international public health, high priority was given to improving nutrition and environment, with relatively few antibiotics or vaccines available that could target a specific pathogen. Examples of primary healthcare innovation such as the 'bare-foot doctor' programme of China from 1968, and community health worker programmes in other countries, greatly expanded basic healthcare and popularised the concept of bottom-up health management. Centred on a basically trained but readily accessible cadre of workers, who were often volunteers working in the communities from which they were recruited. This primary care approach provided basic medical management, vaccination services, and health education. The primary care movement was consistent with the central tenets of the WHO's charter of equality of healthcare access and local participation:

> *"Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people".*

The emphasis on primary care culminated in the International Conference on Primary Health Care at Alma Ata in Kazakhstan (then part of the Soviet Union) in September 1978, and the eponymous Declaration that arose from it.

The Alma Ata Declaration emphasised the centrality of community-based primary care to good public health outcomes. Community consultation stood as a counter to homogenous centralised or vertical approaches, ensuring that policies would reflect local context and priorities. It was an extension of the broad understanding in the WHO constitution that health involves physical, mental and social well-being:

> *"The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".*

Thus, public health policy was considered to operate within a much wider context that went well beyond health, and to achieve good outcomes would have to take those into account. This clearly cannot be achieved from a distance through a one-size-fits-all policy.

The following clauses of the declaration establish the importance of local involvement and control as central to UN and WHO health policy:

> Article IV: "... *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care*".

> Article VI: (Primary health care) "*... made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus ...*"

> Primary care, in Article VII(5): "*... requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, ...*".

The spirit of this democratic and rights-based approach is reflected in the prologue of the Declaration, calling on the international agencies WHO and UNICEF, national governments, non-governmental organizations (NGOs) and funding bodies to follow these principles. There is a notable absence of any mention of corporate or private interests or funding. International public health was to be based on the concept that people, and their communities, would be directly involved in deciding, guiding and managing their own healthcare. WHO and other health agencies were to facilitate this process. Health was a democratic, rights-based area of life encompassing physical, mental and social well-being from which all should derive benefit, rather than an industry geared for financial profit.

II.3. HISTORY OF GLOBAL PUBLIC HEALTH POST-1990s

A changing global health landscape

The period leading up to and soon after the turn of the millennium was a time of great change in international public health, with a rapid increase in resourcing and in the number and size of agencies working in the area. Previously, WHO had dominated public health at the international level, with support from other UN agencies, particularly UNICEF, while bilateral assistance agencies and a few foundations such as the Wellcome Trust and Pasteur network focused on incountry research and support. During the years immediately before and after 2000, WHO suddenly became one of several large agencies wielding influence. The Bill and Melinda Gates Foundation (now Gates Foundation) brought unprecedented private money into the field, working with WHO, through NGOs or direction with countries. The World Bank began increasing its interest in health, while the Global Fund was formed by donor countries as a conduit for funding for recipient countries, working under WHO's technical guidance but also through the power of its grants taking a role of considerable influence.

The large public private partnerships (PPPs) were gradually inaugurated, starting with Gavi, the vaccine alliance, again taking resources and influence over an area once almost the exclusive purview of WHO and UNICEF. Others followed, including UNITAID (addressing market development for health commodities), and in 2017 CEPI (the Coalition for Epidemic Preparedness Innovations, focussed exclusively on pandemics, mainly vaccines). PPPs are different in structure to WHO in that, while including funding from governments, they include the private sector – both private foundations and corporate interests – on their boards. Thus, they are supported by public money but are directed in part by private interests that can

benefit directly from this, particularly those representing the pharmaceutical sector. PPPs have brought private sector direction into what was a relatively public-only policy space, providing increased funding that can add considerable benefits but with inevitable implications for the policy environment within which WHO works. Some (e.g. Gavi and CEPI) work closely with the Gates Foundation, which was a co-founder of both and remains involved in directing them.

II.3.1. The shift from international health to global public health

The 1990's witnessed a discernible shift from international health governance (IHG) to global health governance (GHG), paralleling a rise in globalization generally after the end of the Cold War. This brought about a widening scope of health issues addressed collectively during the 1990s as well as an increase in the number and type of actors involved in shaping global health policy. For example, prior to the 1990s, international health governance historically focused on State-to-State cooperation to control cross-border disease, while GHG started to encompass a broader, more complex network of state and non-State actors addressing health challenges.

The shift to global health governance is largely understood as the result of three factors. First, the end of the Cold War offered new opportunities for cooperation and collective action against a range of persistent development issues and new needs associated with the collapse of Soviet Union. Second, whereas ODA had been used strategically as a form of 'soft' and 'normative' power during the Cold War by Western and Soviet powers, the end of the Cold War required renewed justifications for the use of ODA in the promotion of national interest and humanitarian causes, in which health traditionally had high acceptance rates by Western taxpayers. Third, the rapid acceleration of global interdependency and globalization in the 1990s raised awareness of the need for better coordination as well as the need to include a wider set of global actors and stakeholders. Events such as the 1997 Asian Financial Crisis demonstrated amplified risks of interdependency as well as the need to address these new collective action problems.

However, the shift to GHG resulted in several new challenges. First, the expansion of new actors and global institutions increased governance transaction costs, fragmentation, blurred jurisdictions and accountability, policy misalignment, and competition between actors (including beneficiaries). For example, in terms of transaction costs, in 1909 the total number of intergovernmental organisations in existence was thirty-seven. By 2014, the global health sector alone accounted for 3401 registered international institutions, associations and associated organisations. Moreover, this number excludes bilateral health programmes, such as those offered by the United States or other traditionally large donors and excludes many specific programmes by international bodies that may have significant baring on health policy, i.e. the World Bank and UNICEF. Second, whereas the WHO was once considered the epistemic authority in global health prior to 1990, its authority gradually became challenged by a host of new global health initiatives (GHIs) who were seen as more efficient and effective than WHO, especially by powerful donors such as Group of Seven (G7). Third, GHG was accompanied by a new global health 'partnership agenda' in which NGOs, CSOs, foundations, and other private entities were included in global health policy decision-making and its financing. Despite the clear benefit of having new financial streams for health and fresh potential for wider consultations and expertise, the key side effects of this agenda has included conflicts of interest, a lack of transparency, an offshoring of State responsibility to private entities (by both donors and recipients), the expansion of management and financial consultancies in health, claims of private-public profiteering, revamped aid dependency-cycles, and the use of problematic results-based one-size fits all programming.

Although GHG once held the promise of decolonising international health and democratising policy away from the traditional 'Great Powers' towards multistakeholder partnerships, this promise has gone mostly unfulfilled, with influence remaining concentrated in a handful of powerful and wealthy State and non-State actors.

II.3.2. A shift towards securisation of health

The securitisation of WHO's approach to health

Securitisation is a concept used to examine public policy when an issue is elevated to an "existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure". The securitisation of policy can be both ideational and performative, influenced by dominant discourses and the positional power of securitising actors, which includes

intentional tactics and strategies to elevate issues to the level of a security threat, so as to change the way those issues are perceived, thus motivating action. With a professional global health workforce highly dependent on donors, a perception that grants and salaries are better secured by emphasising a certain narrative – in this case the biosecurity agenda – can readily build an impression of expert consensus.

Processes of securitisation have traditionally emerged from national security narratives, yet can also be driven by other sources. For example, there can be forms of expert led securitisation, which "occurs when experts dominate an administrative process that translates a securitizing speech act into extraordinary public policy". Moreover, it is common for perceptions of "collective securitisation" to transcend national borders, where various interests intentionally securitise an issue at the international level to "push their concerns up the political agenda, recognizing that security gets to the top levels of decision-making in national, regional and global forums". One historical example in global health policy involved the inflated public health security threat assigned to HIV/AIDS in the 1980s and early 1990s to increase policy engagement from key global actors (what has been referred to as "the noble lie").

In many ways health is an ideal area for securitisation processes, since health represents the existential foundation upon which all human activities rely. In other words, a threat to health represents a potential risk to our individual existence. In this regard, "global health security stands out because it begins to transform the inner biological workings of our bodies into additional sites of security concern". Thus, 'health security' becomes a collective idea, prioritising population health over the health of the individual, since the one cannot exist without the other. Within this logic, securitising health can allow for emergency narratives where it is appropriate to declare war on a virus and to stigmatise the sick as an enemy.

There are several relational concepts involved in the securitisation of health. In connection with an increased 'biomedical reductionism', global health organizations have increasingly engaged in processes of "medicalising security", "pharmaceuticalizing security", "healthifying security", and the "riskification of health", whereby security issues are increasingly framed in biomedical terms and where uncertainty is ever more constructed as risk. Importantly, within these processes health experts and public health authorities gain importance in the security field, with pharmaceutical interventions becoming important instruments for security policy.

To be clear, the relationship between health and security has long historical roots with the control of infectious disease playing a large role in international health policy. In fact, the very beginnings of international health governance and WHO's evolution as a coordinating agent are rooted in prior health security concerns involving sanitation and hygiene regulations, protecting imperial interests, and with combating international infectious diseases such as smallpox and polio. However, there has been a clear acceleration and securitisation of health over the past twenty years, with an additional acceleration and solidification of health security into global health policy during Covid-19.

To understand a basic trajectory, it is possible to identify key milestones in the increasing securitisation of health:

- **1892 International Sanitary Convention (ISC) and the start of International Health Policy:** First international health treaty. Response to cholera outbreaks associated with maritime trade. Standardised quarantine procedures. Set the stage for increased coordination for international health security.

- **1918 Spanish Flu:** A series of H1N1-A influenza outbreaks between 1918 and 1920 responsible for 25 to 50 million deaths globally. Coincided with First World War, spreading quickly and dangerously under the crowded and poor conditions of trench warfare and associated economic decline in civilian populations. The outbreak had serious impacts on military operations and thus fused health with national security and military strategy. A feature of the outbreak was death by secondary bacterial infection, which in the pre-antibiotic era, drove mortality rates, showing the crucial relationship between hygiene, infection, and mortality.

- **1951 International Sanitary Regulations (ISRs):** The first set of global health regulations from WHO that focused on preventing the international spread of six quarantinable diseases: cholera, plague, relapsing fever, smallpox, typhoid, and yellow fever. The ISRs were revised and renamed as the International Health Regulations (IHRs) in 1969.

- **1969 International Health Regulations (IHRs):** The goal of the IHRs is to standardise preparedness of core public health capacities to enhance security

against the international spread of diseases while minimising interference with international traffic and travel. The IHRs were revised in 2005 (introduction of the PHEIC, increased monitoring of infectious diseases, and improvements in information sharing) and again in 2024, with the 2024 revisions providing greater focus on pandemic preparedness and response, including managing infodemics, coordinating international funding (Coordinating Financing Mechanism), increasing surveillance and diagnostic capacities, and improving commitments to medicine access and supply chains.

- **1980 HIV/AIDS:** The discovery of HIV/AIDS was a pivotal moment where health security became a dominating narrative in the international health lexicon. The securitisation of AIDS has been attributed to a significant mobilisation of financial and medical resources including the mass production and roll out of life saving drugs, global anti-stigmatisation campaigns, and the emergence of new bilateral (PEPFAR), multilateral (UNAIDS, Global Fund), and private institutions (Gates and Clinton Foundations) dedicated to the prevention and control of HIV/AIDS.

- **1995 Tokyo Sarin Attack and the fusing of bioterror and health security:** A chemical attack in the Tokyo subway, from which concerns about biological and chemical terrorism became increasingly linked with preparedness and response protocols for epidemics and pandemics. International health security became increasingly militarised as security officials involved with bioterrorism became more involved with wider health security threats, creating a nexus between global health and military response.

- **1997 H5N1 influenza as global risk:** Although it killed only 18 people the case fatality rate was exceptionally high, causing an increased level of concern. The outbreak also highlighted poor levels of preparedness, especially for influenza. US president Bush declared influenza “a danger to our homeland” with the United Nations creating the International Partnership on Avian and Pandemic Influenza (IPAPI). Several programmes for influenza have been launched since 1997, such as the Global Outbreak Alert and Response Network (GOARN), which was revitalised with additional resources after the H1N1 Swine Flu outbreak in 2009.

- **2001 USA Anthrax Attacks:** A case of domestic terrorism in the United States where anthrax spores were mailed to public officials, the media and politicians. The attacks caused 5 deaths and 17 infections. Importantly, the mailings occurred shortly after the September 11 terrorist attacks, causing increased panic and speculation of a greater threat. Although unrelated to those attacks, and the act of a single person, the incident elevated the threat of bioterrorism into 'high politics' with considerable resources mobilised for prevention and preparedness, leading to an 'all hazards approach' to health security.

- **2003 SARS and the rise of 'microbial anxiety':** Although it killed less than 800 people, the SARS outbreak highlighted several global health policy failures and raised fears of under preparedness. The suitability of existing processes was diminished by China reporting the outbreak late, and with countries imposing ad-hoc travel bans and aggressive non-pharmaceutical interventions. It led to a global strengthening of influenza surveillance systems such as GOARN, the adoption of the revised 2005 International Health Regulations, and an increase in national preparedness plans.

- **2007: WHR:** The World Health Report 2007: A safer future: global public health security in the 21st century. With this report, emphasising a theme the WHO frequently uses today - “*At a time when the world faces many new and recurring threats…*” - the WHO sought to strengthen its place in the global health security agenda.

- **2009 Swine Flu and the pharmaceuticalisation of health security:** An H1N1 viral infection from swine. Mortality numbers are inexact, but estimates range from 18,000 confirmed deaths to 500,000 excess deaths. The outbreak is controversial in that WHO quickly labelled it a pandemic despite a lower-than-normal influenza risk profile. The outbreak saw a rapid stockpiling of pharmaceuticals by the global north, acting as a precursor to Covid-19 'vaccine nationalism'. Some critics suggested that the outbreak was elevated to emergency status because westerners and western elites were susceptible.

- **Ebola 2014:** Despite a relatively low mortality rate and confined geographic risk compared to other infectious diseases (by far the largest recorded outbreak, in 2014 in West Africa, had 11,325 recorded deaths), the securitised narrative around Ebola dominated global health, with the use of military personnel, rapid flooding of funds, and images of dead

bodies and biohazard suits. In response, the G7 launched a series of 'never again' health security initiatives including the Pandemic Emergency Financing Facility (PEF) and the Global Health Security Agenda (GHSA). Both initiatives where explicitly designed to act outside of the UN system and WHO in line with growing concerns about their effectiveness.

- **2018: Introduction of 'Disease X'** in the priority diseases for R&D (R&D Blueprint).

- **2020 SARs-CoV-2 & the Covid-19 response:** Largest pandemic since the 1918 Spanish Flu with 7.1 million reported deaths associated with the virus and over 20 million excess deaths including those associated with the public health response since the outbreak began. Post-Covid policy has accelerated global health security narratives with a host of new policies, institutions, and unprecedented investment (see below).

- **2022 The post-Covid moment of pandemic anxiety:** The post-covid moment represents an acceleration of an already existing trend in the securitisation and biomedicalization of global health. New initiatives based on the narrative that pandemics are an 'existential threat' have emerged in a very short period, including the revised 2024 International Health Regulations, the Pandemic Fund hosted by the World Bank, the new WHO Hub for Pandemic and Epidemic Intelligence (Pandemic Hub), the '100 Days to Vaccine mission' (GAVI), the WHO mRNA Biohub, and the WHO Pandemic Agreement and ongoing negotiations on its annexes. Critics suggest that a potentially inflated risk profile for pandemics has led to resource diversion to pandemic preparedness, which will have high opportunity costs and diminish health outcomes.

In this context WHO as a centralising agent in international health has become both a receiver and reproducer of an ongoing securitisation of health, a condition that has accelerated after SARs-CoV-2. As noted in Section IV.6.2, the estimated budget associated with the General Programme of Work Fourteen (GPW14) for 2025–2028 is predominately focused on health security and health risks, which allocates scarce resources to a specified list global public health priorities. Moreover, since the emergence of SARs-CoV-2, WHO has adopted a highly securitised language of 'existential threat' regarding climate change and pandemics, resulting in a current restructuring of WHO that disproportionately favours health emergencies, particularly responding to those frequently labelled as emerging infectious diseases (EIDs).

In the case of the pandemic preparedness, WHO begins most of their recent statements and policy recommendations with the assertion that pandemics are increasing in frequency and severity. This securitised language has dominated discussions around the Pandemic Agreement and revisions to the International Health Regulations with the intent to mobilise political and resource support for these WHO initiatives. Most global health actors have followed suit, seeking to securitise the current global health landscape to capitalise on 'the post-Covid moment', which has resulted in an accelerated political process and rushed policy making. The narrative of high-risk continues even though many risk claims are based on underwhelming evidence, including cases where the cited evidence actually fails to support WHO claims.

WHO's role in the securitisation of health is evident in their promotion of a security agenda with increased institutional capacities. After the 1997 outbreak of H5N1 in Hong Kong, WHO issued its first influenza pandemic plan encouraging Member States to follow suit. In 2005, the United Nations and WHO launched the International Partnership on Avian and Pandemic

Influenza (IPAPI), which required participating countries to share samples with the WHO. In that same year, the United Nations System Influenza Coordination (UNSIC) was established with the WHO to coordinate "multiple UN agencies engaged in strengthening pandemic preparedness", while WHO updated its guidance to incorporate an "all-of-societies approach" or "whole-of-society pandemic preparedness" to health security.

Through the securitisation approach, public health is in effect being transformed from a supportive function within society to a cause in itself, to which other areas of society and of human endeavour must subvert themselves – at least when public health authorities deem this necessary. Public health becomes an end in itself, rather than a means to an end (e.g. such as human flourishing or a good life). This in turn is justified through a series of demonstrable fallacies regarding risk. The world, prompted by WHO, is placing itself in a dangerous position where fundamental human rights – expressed as individual sovereignty – are suppressed by a misguided collectivist flight from a mirage.

II.3.4. Other actors: NGOs, foundations, CSOs, PPPs

The commoditisation of global health has been accompanied by an increase in the funding available and the number of organisations that have arisen to work alongside WHO. While UNICEF has acted as a UN agency for children's welfare for most of WHO's existence, WHO had relatively few other major partners or competitors in the international public health. The rise of the Global Fund to fight AIDS, Tuberculosis and Malaria in the year 2000 acted as a major new conduit for government (and private) overseas health aid, but the Global Fund also closely followed WHO as its technical agency. Today, however, the WHO finds itself as one agency in a broad and often competitive environment.

The evolving international landscape

The foregoing discussion has outlined the evolution of international public health and the principles and policies that should govern the work of an IHO such as the WHO. However, an IHO also works within a much wider context of other actors seeking to address the same concerns. Efforts to promote institutionalised cooperation among sovereign States and to reduce and manage friction between them has led to a proliferation of international organizations.

As mapped by the Yearbook of International Organizations, the number and types of intergovernmental organisations (IGOs) increased rapidly in the second half of the twentieth century. Their number climbed from 37 in 1909 and 123 in 1951 to about 7,000 in 2000. The number of non-governmental organisations (NGOs), discussed later, also increased from 176 to 48,000 in the corresponding period. The combined total of inter- and non-governmental organisations currently stands at over 78,500. They have added greatly to the institutional complexity of international relations. In previous centuries the essence of relations could be distilled into war and diplomacy symbolised by the soldier, the diplomat and a merchant class tied to a specific colonial power. Today, alongside the horde of diplomats and soldiers, a new multinational merchant class exists essentially above national jurisdictions or loyalties (e.g. as represented within the World Economic Forum), together with international financier, WHO technocrat, UN peacekeeper, NGO humanitarian worker, and IT specialist jostle for space on the increasingly crowded international stage.

Not all IGOs deal with health, but a large overlap exists between health-related work, wider development, and other IGO areas that extend within and across borders. Within the wider UN system, the WHO acts as the lead technical agency and standard-setter for health, but organisations such as UNICEF and UNDP and even the IAEA include large health portfolios, while a few such as UNAIDS and the World Food Programme (WFP) are dedicated to specific aspects of health. A further tier of financing institutions has arisen (e.g. The Global Fund, UNITAID) specifically to support health programmes or health commodity market shaping respectively, and the World Bank has become increasingly active in global health, housing as example the Pandemic Fund.

PPPs and foundations

One of the major changes in the WHO's global health environment has been the rise of publicprivate partnerships (PPPs) and large foundations (particularly the Gates Foundation), as discussed above in Section II.3. Gavi and CEPI in particular have greatly influenced the commoditisation of international health and driven the focus on vaccines and (particularly CEPI) pandemics., The unprecedented specified private funding from the Gates Foundation directly influences WHO policy by requirements on the use of the funds, and indirectly through funding and direction of PPPs and NGOs (below) that WHO must work alongside, in addition to direct government contacts.

PPPs arose with the idea that private sector expertise, and more money, could only benefit underfunded aid programmes. This could be seen as naïve, as private corporations (e.g. Pharma) are also answerable to boards who require corporate activities to result in profit, whilst private individuals may come with vast financial resources but very limited experience and expertise in the broad array of health and development issues in which they wish to invest. Clearly, neither could be said to be representing, or have "lived experience" as, the population with the highest remediable disease burdens. Private sector involvement in global health was not new – the USbased Rockefeller Foundation was involved in the early years of the WHO and the UK-based Wellcome Trust has funded healthcare for many decades,, but the scope and level of funding from the year 2000 onward was unprecedented.

Private foundations

Private foundations have long been active in international public health, with the Rockefeller Foundation having an

early role in the shaping of the WHO itself. The Wellcome Trust based in the United Kingdom and the network of Pasteur institutions have played roles since before the inauguration of WHO in sponsoring and running research in health and supporting laboratories and external initiatives. However, perhaps the most fundamental influence on WHO has come from the Gates Foundation (formerly Bill and Melinda Gates Foundation), launched in 2000. This US-based organisation, through the sheer weight of the finance at its disposal from its wealthy founders, has shaped all levels of global health. The foundation funds research in low- and high-income country laboratories and academic institutions, sponsors NGOs, supports modelling institutes, has been instrumental in developing and supporting public-private partnerships (see below), directly invests in pharmaceutical and diagnostic developers and manufacturers, and as of the end of 2025 has become the largest single funder of WHO. The Gates Foundation's work and influence is discussed elsewhere in this report. Its influence on the WHO needs to be understood both through its impact on determining priorities of WHO partner agencies and Ministries of Health in LMICs through the funding it provides, through sponsorship of major media global health and development pages, and through its direct funding to WHO, which is specified and therefore restricts WHO to acting in ways with which the Foundation agrees (see Section IV.6.2).

PPPs and corporate partnerships

Public-private partnerships gained popularity as a model for implementing international public health policy around the turn of the millennium, in parallel with the beginning of the Gates Foundation and increasing corporate interest in global health. Technological development in pharmaceuticals (especially vaccine development) and in diagnostics expanded the role of disease-specific commodities in healthcare, and with it an interest from the for-profit corporate sector who manufactured such products. While LMIC markets required low pricing, the size of such markets (e.g. there are now roughly 1.4 billion people in sub-Saharan Africa) offers economies of scale and potential for significant profit if a commodity such as a vaccine can be recommended across populations irrespective of illness.

PPPs offer a promise of gain for all. Public health programmes such as those of WHO and UNICEF were interested in expanding reach, while manufacturers were interested in expanding markets. Wealthy philanthropic foundations and donor country aid agencies with expanding ODA were interested in purchasing such commodities, but reticent about international public health bureaucracies being the ideal model to implement such programmes. The idea of pairing public health experience and knowledge with private sector entrepreneurial spirit seemed an attractive answer, with governments able to claim they were bringing private sector efficiency to the use of taxpayer funding. The prospect of greater funding for healthcare, together with job security and higher salaries (as discussed regarding NGOs below and WHO in Sections IV.6.2, 6.3) counters concerns regarding conflict of interest.

Gavi, the vaccine alliance, was thus inaugurated in the year 2000 to bring private sector approaches to improve access to, and thereby the use of, vaccines. The board consists of the founding partners (The Gates Foundation, World Bank, UNICEF and WHO) and direct representation from vaccine manufacturers, donor countries and others. With a pharmaceutical investor, the Gates Foundation, being one of the largest donors, and direct support from the pharmaceutical industry in both donations and board membership, Gavi's large budget would inevitably skew international public health, for better or worse, towards the vaccine sales that some of its benefactors benefit from.

UNITAID, formed later and aimed at stimulating markets for useful health commodities, acts as a public-private partnership addressing a wider range of health commodities than Gavi. It aims to address an intrinsic market failure stemming from the difficulty of establishing markets for diseases associated with poverty – most major endemic infectious diseases in LMICs. The board includes representatives of countries, NGOs and the Gates Foundation.

A particularly significant PPP to recent international public health direction has been CEPI, the Coalition for Epidemic Preparedness Innovations. CEPI was inaugurated at the World Economic Forum annual meeting in Davos, Switzerland in 2017 by a coalition including the Gates Foundation, The Wellcome Trust, and countries including Norway and India. Started a century after the last major acute pandemic, Spanish Flu in the pre-antibiotic era, CEPI focusses exclusively on epidemics and pandemics, and almost exclusively on vaccines as a response. CEPI lists the West African Ebola outbreak as a stimulus or justification for this, though mortality was under 12,000 people or equivalent to less than 4 days of global tuberculosis mortality. CEPI, together with Gavi, have been instrumental in shaping vaccine-based responses to the

Covid-19 pandemic (e.g. through COVAX), and CEPI leads the 100 days vaccine initiative to rapidly produce mRNA-based vaccines in a future pandemic or threat thereof, reducing manufacturing, regulatory and testing barriers and thereby time to market.

The Covid-19 outbreak showed how the PPP model can direct the use of public money to benefit private companies. A resultant rise in inequality could be anticipated. Ideally, such organizations, claiming to exist for the benefit of populations in LMICs, would have boards and governance that reflect their target populations, with recipient countries driving prioritization as envisioned in the Paris Declaration; as in Paragraph 15 of the Paris Declaration's Statement of Resolve, donors will:

> *"Respect partner country leadership and help strengthen their capacity to exercise it"*. This was strengthened further in the Accra Agenda for Action, (e.g. Paragraph 12):
>
> *"Developing countries determine and implement their development policies to achieve their own economic, social and environmental goals. We agreed in the Paris Declaration that this would be our first priority..."*.

The PPP model appears poorly compatible with this, with a predominance not only of donor countries but the inclusion of private foundations and companies from the same countries in positions to determine policy. An exception in the financing world is perhaps the Global Fund, which provides funding for agreed agendas that are developed and submitted by the recipient State (or group of States). The risk to the private backers of PPPs would clearly be that recipient country priorities may be incompatible with the requirements of the company to generate return on investment for its shareholders through participation in structures such as PPPs.

Whether one supports or questions the general concept of prioritising sudden outbreaks and pandemics over alternate and larger disease burdens, the conflict of interest concerns remain when priorities are set under a PPP. It inevitably skews public health policy, as no equivalent heavily funded vehicles exist for nutrition supplementation, sanitation or general health service strengthening. Though existing PPPs and the Global Fund (as the main external funder of endemic infectious disease management) do include capacity strengthening as part of their narrower remits, the historic drivers of longevity in higher income countries remain relative orphans in the global health ecosystem. There is no large workforce with a vested interest in strengthening individual and health system resilience.

NGOs

The term non-governmental organisations (NGOs) is generally intended to refer to a subset of IGOs that are officially independent of governments in their management structure but not falling into the category of private foundations or trusts. However, some are structured as nonprofit entities, some as private companies but competing with other NGOs for grant funding as go-betweens implementing donor-directed work. They may work within a certain country only, or internationally.

The number of international NGOs within the total of 78,500 IGOs and NGOs is notoriously difficult to estimate, with a suspected bias towards those with headquarters in wealthy donor States and a serious undercounting of NGOs based in low-income countries. Another difficulty in gauging their numbers accurately is that receiving funds from government sources is not generally considered a disqualification from NGO status. The World Association of NonGovernmental Organizations identifies around 54,000 NGOs that operate in more than 190 countries. For example, in the health field, Médecins Sans Frontières (MSF) operates in more than 70 countries. It has around 68,000 employees, partners with local organisations, and recruits local staff to provide medical services. Among other prominent international NGOs, Save the Children operates in almost 120 countries with nearly 12,000 employees, with a structure that includes regional and country offices. Oxfam operates in over 90 countries through a confederation of 20 independent organisations. Its international secretariat has only 300 staff globally, but Oxfam affiliates have around 10,000 employees plus almost 50,000 interns and volunteers.

As NGOs are dependent on directed donor money for their work and survival, they will inevitably be shaped by donor interest. Where support is broadly based this may simply mean that donors with interests common to the NGO are attracted to give support. However, where NGOs are mostly dependent on a single or very few donors, they are clearly under pressure to implement donor requirements or go out of business. With a workforce of tens of thousands globally, this also constitutes a very large lobby for major donors, such as the Gates Foundation and certain governments, upon whom many of their salaries and job security depends.

IGOs and NGOs have added greatly to the institutional complexity of international relations. A set of rules developed by WHO to guide collaboration, FENSA, is discussed in Section IV.3.1.

II.3.5. Official Development Assistance (Development Assistance for Health)

International public health occurs in an environment of donor and net recipient countries. Inevitably, the policies of donor countries in directing their assistance, termed Official Development Assistance (ODA) or more specifically Development Assistance for Health (DAH) inevitably shapes the public health policies of lower-income recipient countries, with programmes often dependent on external funding. Where this is tied to specific programmes, it can become very directive, including when targeted to multilateral organisations such as the WHO as specified funding (see Section IV.6.2).

Concepts

Official Development Assistance (ODA) is defined by the Development Aid Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) as the:

> *"financial support from official providers to aid recipients (low- and middle-income countries) in areas such as health, sanitation, education, and infrastructure. It mainly consists of either grants or 'soft' loans, and it makes up over two thirds of external finance for least-developed countries".*

The OECD-DAC collects data on ODA from donors through a Creditor Reporting System (CRS). The definition – and calculation – of ODA has evolved over time, notably to take account of the 'grant equivalent' of some loans provided by State donors to LMICs. ODA, as discussed in Section IV.2, has three critical characteristics: (1) it is provided by official agencies of State and local governments; (2) its main objective is the promotion of the economic development and welfare of low-resource countries; and (3) it is concessional in character,289 being available as a grant or a loan at better than commercial terms and may be coordinated with funds from private foundations or individuals.

Development assistance for health (DAH) comprises the share of ODA targeted to the health sector, but also other funding sources such as private foundations and charities not qualifying as ODA but aimed at improving health in LMICs (or operating at the global level). The Institute for Health Metrics and Evaluation (IHME) in the USA collates data on DAH and its features and evolution. Its latest report, 'Financing Global Health 2025: Cuts in Aid and Future Outlook', focuses on funding for LMICs, while it also provides a public database visualising DAH flows from donors to LMICs based on health focus.

Aid (in)effectiveness

ODA effectiveness has been scrutinised and questioned for decades. In the late 1990s, many evaluations assessed development aid projects using theoretical analyses of the political economy inherent to the donor-recipient relationship. The World Bank, in its 1998 report 'Assessing Aid: What Works, What Doesn't, and Why', analysed the relationship between aid and economic development. Overall, findings led to donor agencies being encouraged to reform aid delivery modalities in order to shift from predominantly stand-alone projects and conditionality-led structural adjustment programmes toward partnerships and mutual (donorrecipient) accountability.

In the first decade of this century, the OECD-DAC's Working Party on Aid Effectiveness and several high-level forums aimed at improving aid effectiveness led to several declarations:

The Rome Declaration on Harmonisation in 2003.

The Paris Declaration on Aid Effectiveness in 2005; crystallising five aid effectiveness principles:

- Ownership, by recipient countries, of their own development agenda.
- Alignment, by donors, on national policies and systems.
- Harmonization of their aid management practices between donors (e.g. planning, financial management, monitoring and evaluation).
- Results-orientation, instead of micro-management or process.
- Mutual accountability for results between donors and recipients.

The Accra Agenda for Action in 2008.

The Busan Partnership for Effective Development Co-operation | OECD in 2011, after which was created the Global Partnership for Effective Development Co-operation.

In parallel, the European Union (EU) issued in 2007 the EU Code of Conduct on Division of labour in Development Policy aimed at improving coordination and reducing fragmentation of development assistance among EU actors. All in all, the hope of seeing emerge a "new paradigm of development assistance" was cherished, despite some inherent incoherences in this paradigm. Concentrating on the health sector, the OECD-DAC set up a Task Team on Health as a Tracer Sector (TT HATS) which issued in 2012 a report 'Aid Effectiveness in the Health Sector'.

Donor proliferation has mixed effects on recipient countries, posing challenges in transaction costs, programmatic fragmentation and stakeholder coordination, negatively affecting performance. A solution has been advanced since the end of the 1990s under the form of sector-wide approaches (SWAPs). Its principles were reappropriated through the International Health Partnership and related initiatives (IHP+) in 2007, which subsequently became the International Health Partnership for UHC 2030 (UHC2030).310 The latest initiative aimed at improving health aid effectiveness is to be found in The Lusaka Agenda (and now the 2025 Accra Reset), emanating from the Future of Global Health Initiatives Process, promoting the adoption of five key shifts:

(1) make a stronger contribution to primary health care by effectively strengthening systems for health;

(2) play a catalytic role towards sustainable, domestically-financed health services and public health functions;

(3) strengthen joint approaches for achieving equity in health outcomes;

(4) achieve strategic and operational coherence; and

(5) coordinate approaches to products, research and development, and regional manufacturing to address market and policy failures in global health.

Despite these efforts of the past 30 years, demonstration of the effectiveness of these principles on development outcomes is not straightforward, unless one adopts a theory-based approach, reconstructing the chain of effects from the implementation of these principles to improved national policies, plans and systems, then to improved health services at operational level, and finally to improved health outcomes and status. Perhaps consequently, donor coordination remains limited. An IHO such as WHO has an important role in promoting coordination and efficiency, but it operates in an environment of multiple bilateral and multilateral initiatives over which it has limited influence, dependent on directed funding from donors it might wish itself to direct (see Section IV.6.2). In the context of coordination, the recent US America First Global Health Strategy stands as an interesting case, reducing multilateral coordination with other donors but directing resources more specifically toward mutually-accountable bilateral partnerships concentrated on building national capacity. With a reducing ODA budget (Section IV.6.2), the importance of coordination, but also of capacity building to reduce longterm dependency, is likely to become imperative.

II.3.6. Global disease burdens and challenges

Measuring disease burden and well-being

An understanding of disease burdens is essential to developing international health policy and allocating resources, but the limitations of such metrics are also considerable. These arise particularly from the frequent difficulty in assigning a single 'disease', or cause, to illness and death, the multitude of factors that promote ill health versus well-being, and the interactions between different diseases. The spectrum of causation between endogenous and exogenous factors, very relevant to infectious diseases but also many non-communicable diseases (NCDs), is discussed in Section II.1.3. Disease burdens can also be misleading during policy prioritisation unless a broad understanding of public health and disease causality is employed. An infectious disease may be preventable through a vaccine, or treatable with antimicrobials, but the greatest reduction in risk may be found through improving individual resilience to infectious diseases via improved nutrition and reduction in environmental threats.

One way around this problem is to consider all-cause mortality. This provides an overall metric for assessing the entire range of conditions that support life. For example, reducing measles is of limited benefit if the vaccinated children are then likely to die of malaria, diarrhoea or some other malady. However, all-cause mortality is a poor indicator of physical disability, and even poorer of mental and social well-being, equally relevant aspects of health. A related metric to all-cause mortality is years of life lost (YLL), which assumes a certain expected life expectancy (from birth or from a certain age) and consequently calculates years lost due to premature death. This can allow useful comparisons between countries, assuming that, under the same set of conditions, all humans would live to the same age. This, like all-cause mortality itself, provides a rough guide to health equity, though more directly physical rather than mental or social.

Commonly used metrics incorporating poor health in addition to mortality, generally applied to specific diseases or pathogens but also applicable to overall health, include an estimate of disability combined with mortality (Disability-adjusted Life years DALYs), or a related measure stressing impact of interventions on disease and well-being (Quality-adjusted Life Years – QALYs).

As with the relationship between disease states, an understanding of what these metrics mean is essential to understanding, and using, comparative estimates of disease burden. For an IHO, this is essential for policy development and requires metrics that are standardised between countries in the way they are measured, but then also interpreted dependent on local context. They are useful guides for international resource allocation (assuming there are practical preventive or mitigating strategies available), but their effective use requires a degree of subsidiarity.

Major burdens of disease

The ability to measure disease burden varies widely between countries and regionally within them, due to factors including the completeness of illness and death recording, notification or registration, the capacity to make diagnoses, and incentives and legal requirements to register one cause versus another. This limits the accuracy of overall data and comparisons. Two major global sources of disease data are the WHO itself, and the Institute for Health Metrics Evaluation of the University of Washington (a mostly-privately funded effort supported by the Gates Foundation and working with a broad range of international collaborators). WHO and IHME use many of the same sources. Both use modelling to fill data gaps and address uncertainties, in addition to actual reported data.

Comparing disease burden

Major burdens of disease assessed by DALYs and mortality (deaths) are illustrated in Figure II.2 and Figure II.3, based on 2019 numbers – pre-Covid-19 – for reasons discussed below. As is clear, NCDs dominate both at a global level (two hundred years ago, infectious disease would probably have greatly dominated). Of note, neonatal disorders are significantly greater when measured in terms of DALYs rather than deaths, as non-fatal disorders often leave life-time disability. Similarly, falls, strokes and ischemic heart disease cause considerable long-term disability as compared to mortality.

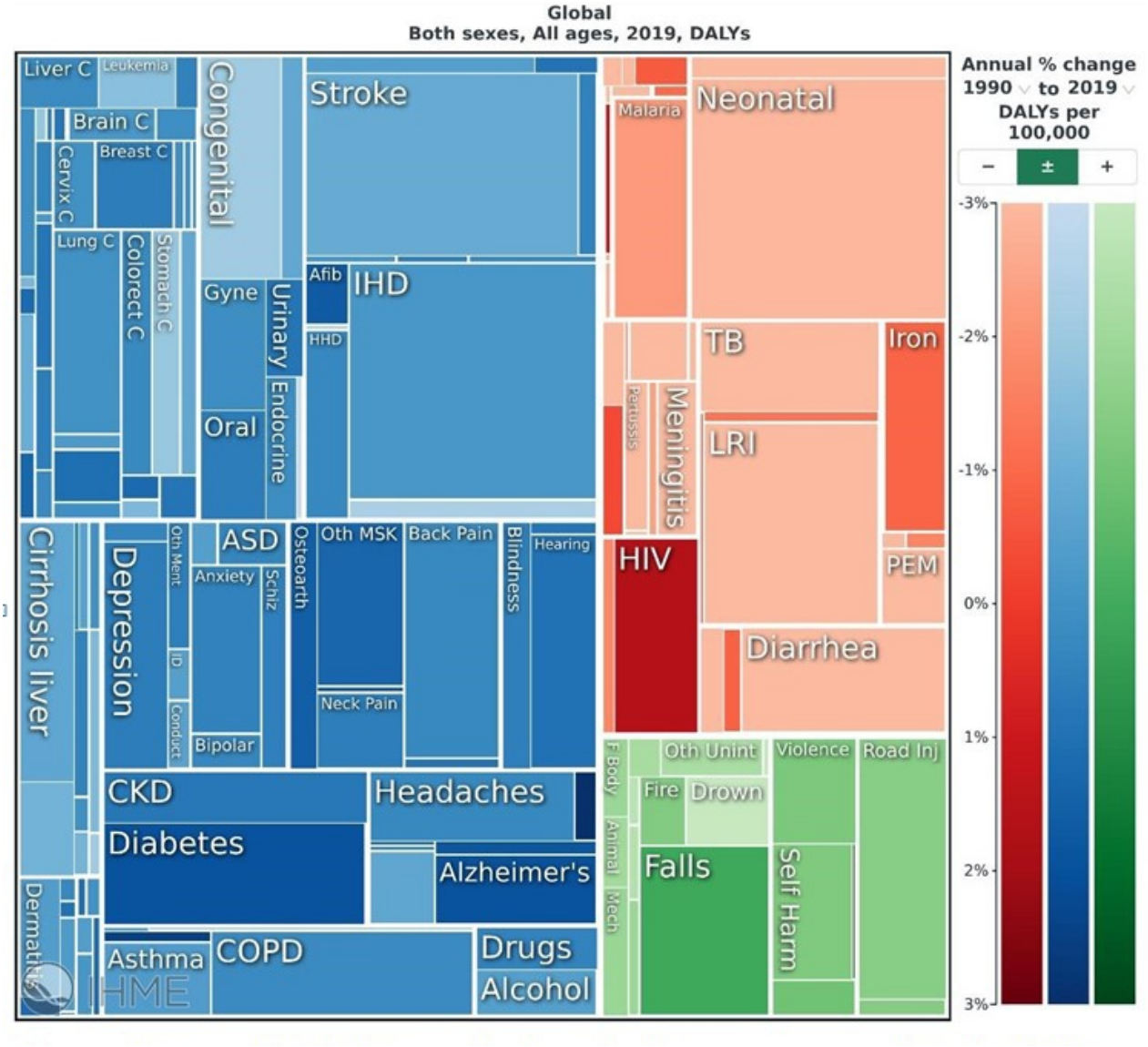

Figure II. 2 – Global disease burdens by disease, expressed in Disability - ajusted Life years (DALYs).
Source: Institute for Health Metric and Evaluation (IHME), https://vizhub.healthdata.org/gbd-compare/

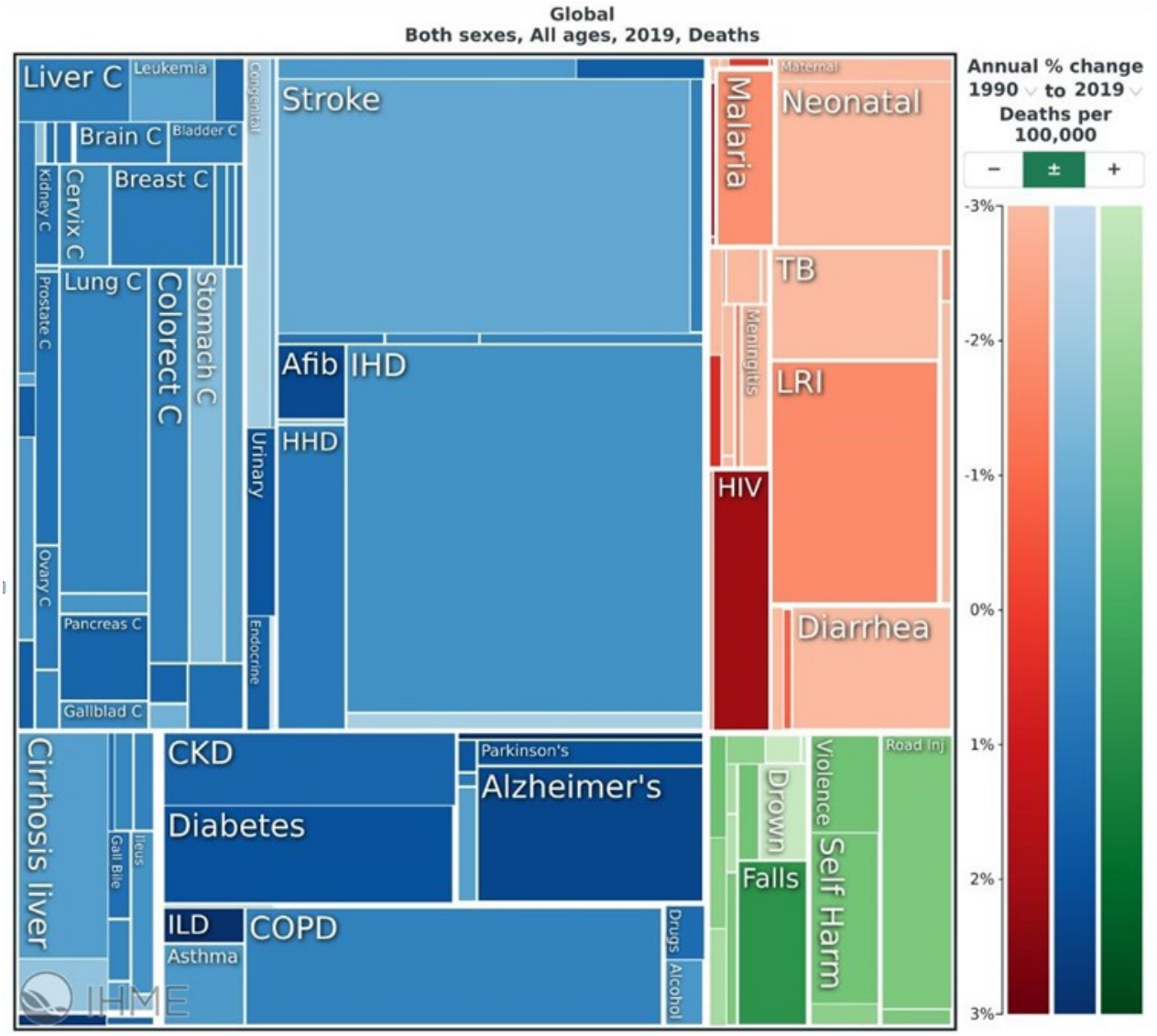

Figure II. 3 – Global disease burdens by disease, expressed in deaths.
Source: Institute for Health Metric and Evaluation (IHME), https://vizhub.healthdata.org/gbd-compare/

Comparing mortality alone in Figure II.4, a major difference is seen between countries. Infectious disease still greatly dominates as a cause of death in Nigeria, while NCDs are now dominant in India and very much so in the United States. As seen from Figure II.5, this trend is strongly associated with national wealth (i.e. population income and capacity to invest in healthcare). Historically, infectious disease mortality follows a very similar pattern to life expectancy with the predominant reduction in mortality at young ages being the reduction in infectious disease burden.322 Thus, though NCDs dominate mortality and disability in higher income countries, this is largely due to the elimination of most burden of infectious disease that was killing people at a much younger age.

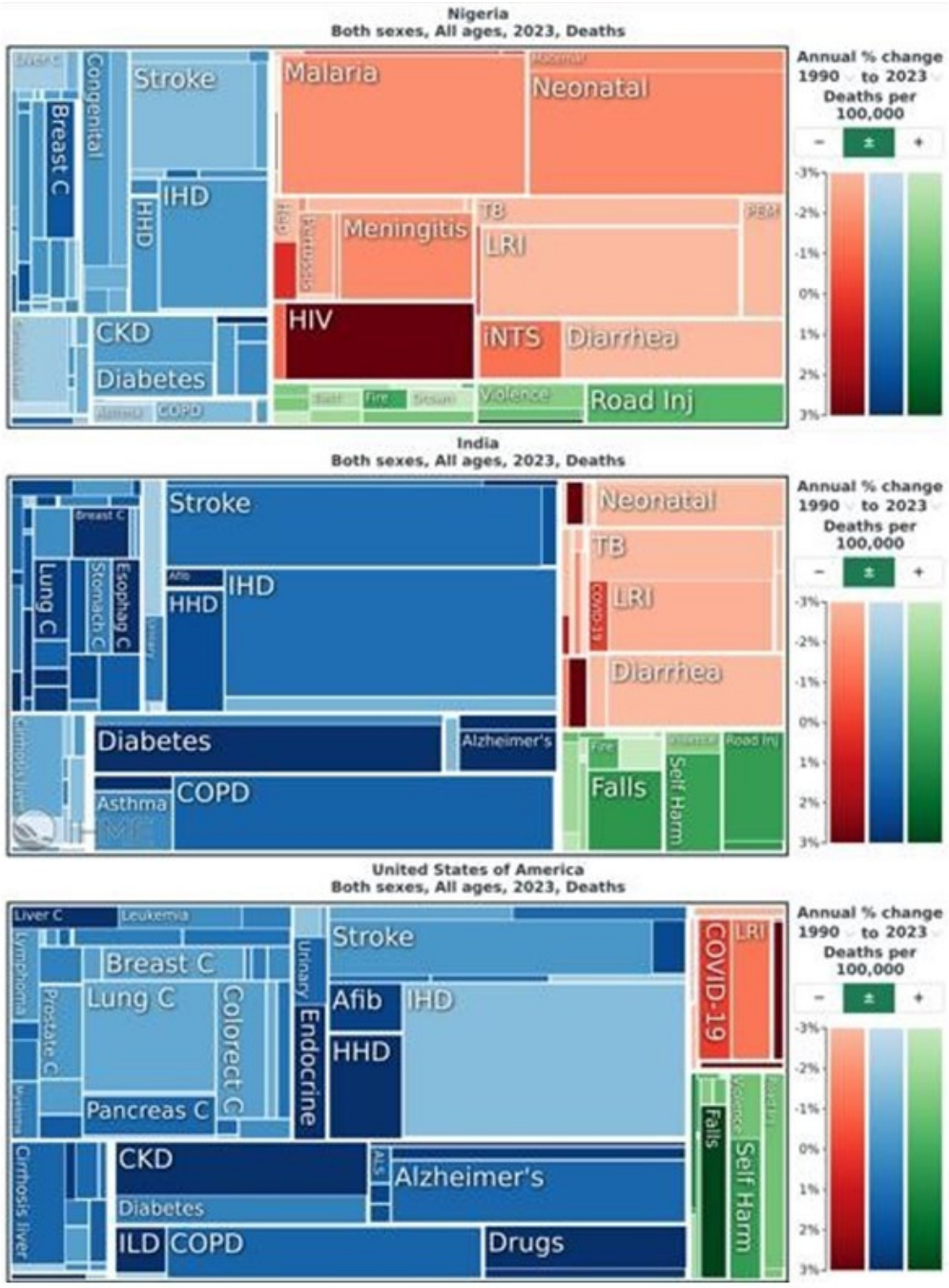

Figure II.4 – Comparison of major causes of mortality by country (Nigeria, India and the United States).
Source: Institute for Health Metrics and Evaluation (IHME), https://vizhub.healthdata.org/gbd-compare/

To promote both equality in health outcomes and overall health and well-being, measured at least by reduction in premature mortality and DALYs, Figures II.2 - 5 indicate that most gains are clearly to be found if lower income, high infectious disease burden countries reduce their neonatal and infectious disease burdens. How this is achieved, by disease-based approaches, prioritisation of underlying drivers of resilience against infectious disease mortality, or a sensible combination of the two, is discussed in Section II.1.3. For Nigeria and similar countries, the role of disease-specific approaches in the immediate term seems clear – reducing neonatal disorders, malaria, lower respiratory tract infections (LRIs) and HIV/AIDS will reduce immediate mortality and disability, improving the population conditions for economic growth that improve underlying capacity and drivers of well-being more quickly than ODA may do in capacity building alone.

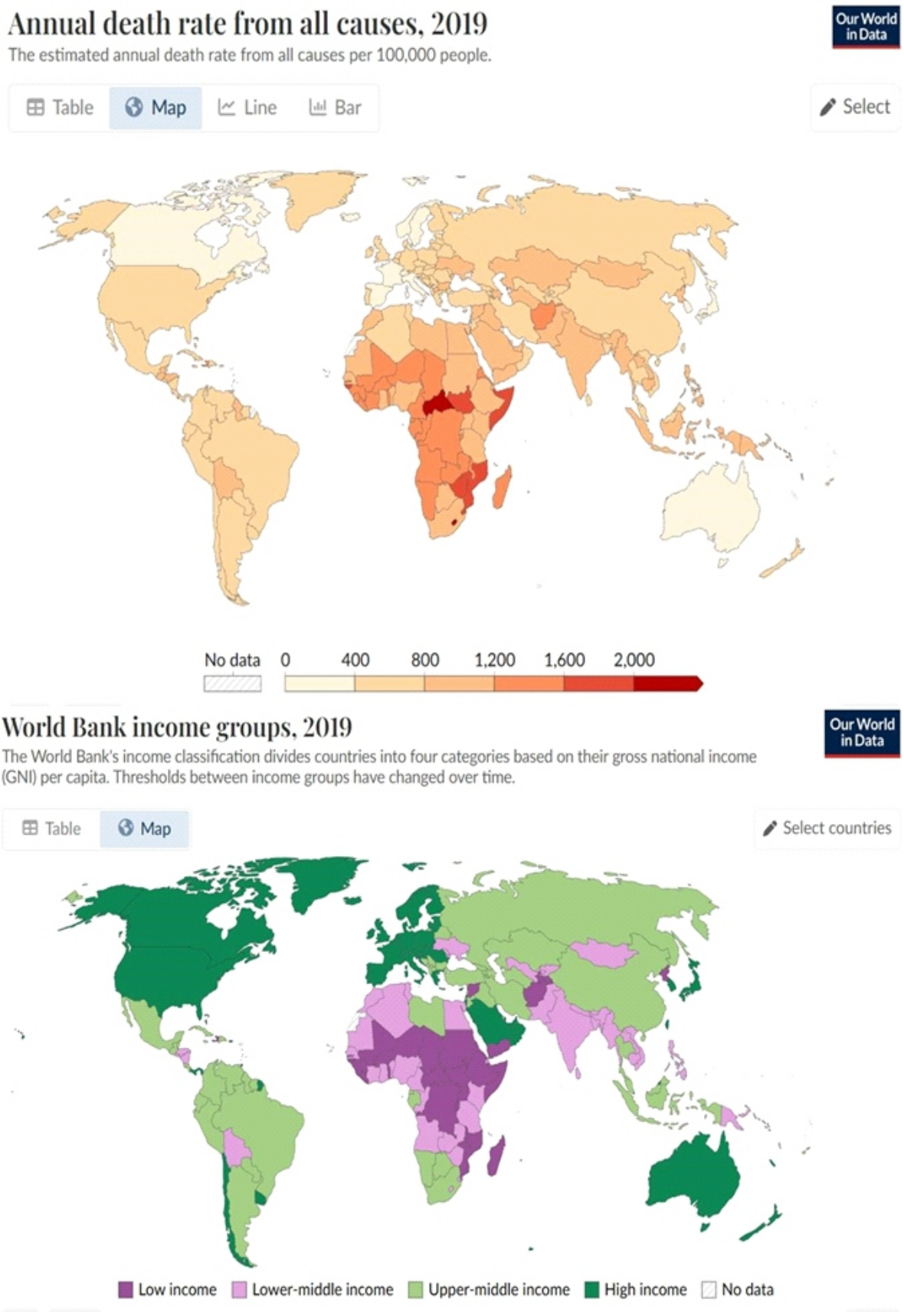

Figure II.5 – Association of death rates with poverty (as measured by World Bank country income status), 2019. Source: Our World in Data, www.ourworldindata.org. Data derived from IHME and the World Bank.

Policies including dietary advice and micronutrient management will bridge the gap across both infectious diseases (through individual resilience and immune competence) and aspects of the NCD burden (much of it) that is related to poor diet (e.g. diabetes mellitus, which is rising in India and other middle-income countries). However, it is reasonable to question whether such middle-income countries need the help of an IHO in addressing these (e.g. need the help of foreigners) or whether such concerns are best addressed, whenever sufficient capacity exists, entirely from within the national context. The apparent rise in NCD burden globally, though widely associated with rising rather than declining life expectancy, is an invitation for missioncreep of an IHO such as WHO but not necessarily a useful or efficient use of global resources. This rise of NCDs further raises the importance of contextualised approaches rather than onesize-fits-all programming, as NCDs are frequently more strongly life-style related and strongly subject to cultural, social and behavioural characteristics within a population.

The relationship between income and life expectancy is well established, and clear historically, and geographically (Figure II.5). Policies on fair trade and economy building may therefore be the most effective long-term mechanisms for improving health, and particularly for infectious disease reduction. An IHO's focus should be on health system strengthening, building resilience and disease burden reduction to promote equality through short-term improvement in health outcomes, but this must consider the need to avoid measures that entrench poverty and restrict long-term economic health, as emphasised in pre-Covid recommendations on pandemic management.

Relatedly, the association of infectious disease mortality with lower national income makes it clear that an IHO concentrated on moving countries to self-sufficiency in healthcare should be concentrating on low -income countries (Figure II.5). Countries in higher income brackets are ODA donors rather than recipients. Having already achieved considerable gains in life expectancy (including the underlying environmental conditions and healthcare capacity to maintain this), the real added value to their own healthcare systems of an IHO, beyond data sharing and standard setting, is arguably very low.

Covid-19, pandemics and disease burden

The advent of Covid-19 and subsequent published estimates of global disease burden illustrate the difficulties in assigning burdens to diseases and basing policy solely on them. Severe or fatal Covid-19, a respiratory infection caused by the SARS-CoV-2 virus, has overwhelmingly been in people in old age with a number of other severe, life-shortening co-morbidities such as obesity and diabetes mellitus, chronic renal failure and chronic obstructive pulmonary diseases – many of the major causes of death in the United States exampled in Figure II.4. This highlights a number of issues. Firstly, assigning death to Covid-19, versus other life-shortening co-morbidities, is problematic. Secondly, incentives to report Covid-19, such as subsides to healthcare facilities and families in case of hospitalization death, may inappropriately raise assignment of cause. Thirdly, lack of diagnostics or healthcare access may reduce recognition of causation. Fourthly, in common with many diseases, large areas globally still have very incomplete death registration. Fifthly, the public health response to Covid-19, including poverty-promoting policies such as workplace and market closures, reduction in clinic access and use of new classes of pharmaceuticals, may all have affected all-cause mortality and so reduced its usefulness in estimating direct pathogen impact.

IHME attempted to address these limitations through the use of modelling to estimate potential true mortality in areas where available data was considered to be poor. However, this included acceptance of data where incentives to report Covid-19 as cause-of-death were in place whilst using modelling to increase mortality rates in other areas. This will inevitably run the risk of inappropriately inflating overall burden. Assumptions driving IHME's model included claims that masks were "incredibly effective" at stopping Covid contrary to data elsewhere, and vaccine efficacies that are at odds with studies of waning and population-level impacts. Applied to countries with lower use of non-pharmaceutical interventions and more targeted vaccination, these methods risk driving Covid-19 burden estimates well above true levels. As the ceiling of all-cause mortality is a relatively reliable number, inflating Covid-19 deaths within this ceiling results in underestimation of non-Covid excess mortality attributed to the public health response.

Increasing indications that the SARS-CoV-2 virus may not be of entirely natural origin but modified through gain-of-function laboratory procedures also makes the more recent (post2020) IHME data less reliable as a guide for ideal IHO policy. Biosecurity and even biowarfare threats are generally considered national security priorities rather than international, though multinational organizations could clearly play some role.

Recent burden estimates of total pandemic impact create similar difficulties. Figures of 2.5 million deaths as an annualised average per year, repeated in major journals such as Lancet, arise from modelling that use pre-antibiotic era data, including burdens not seen since Medieval bubonic plagues in Eurasia and mass-die-offs of populations in the Americas and Pacific, which were immunologically isolated in the early years of European colonialism. Applying these to populations today and ignoring the absence of such large immune-naive populations, of changes in nutrition, sanitation and modern healthcare is unrealistic. Based on data from confirmed natural outbreaks over the last 100 years, or even including Covid-19, annualised average pandemic mortality from pandemics is dwarfed by other endemic infectious disease burdens.

In summary

Disease burden estimates are essential to planning and allocation of resources and for understanding longer term impacts of interventions and progress, even though reductions such as those of infectious disease mortality are multifactorial in terms of cause. Disease burden estimates are also problematic both in their estimation and their use, as they are not necessarily direct guides to where resources should be applied for best impact, and they are subject to error both through incomplete or inaccurate reporting, and in inappropriate modelling to fill such gaps.

Certain trends are clear, however. Infectious diseases, most readily addressed by direct interventions (e.g. diagnostics and antimicrobials) and by improvements in underlying drivers of well-being and health system strengthening, are predominantly associated with lower income populations with the lowest life expectancies. NCDs, while amenable to many of the same interventions, are a relatively bigger issue in countries already having greater healthcare capacity and therefore less in need of, or likely to benefit from, external assistance. NCD prevalence and management is also often more strongly subject to local behavioural and cultural factors.

In terms of capacity building, improving global equality in health outcomes and promoting selfsufficiency, it is clear that the work of an IHO is best concentrated in lower-income countries and on endemic infectious diseases. Recent trends within WHO and in PPPs towards an emphasis on outbreaks of non-endemic infectious diseases, through concentration on pathogen-specific approaches such as mass vaccination rather than primarily building individual and health system resilience, are consequently concerning.

II.3.7. The growing pandemic agenda

Over recent years, and particularly since the global spread of Covid-19 in 2020, pandemic prevention, preparedness and response (PPPR) has dominated much public health discourse. Pandemic risk is characterised as an "existential threat to humanity", and is accordingly used to justify recent amendments to the International Health Regulations and ongoing negotiations over parts of the Pandemic Agreement. These involve unprecedented annual financial requests including over $10 billion in new ODA and over $26 billion projected as required investment by LMICs.339 The World Bank proposes a further $10 - $11 billion for related One Health interventions.

With some countries opting out of the IHR amendments, and negotiations on sticking points of the Pandemic Agreement continuing into 2026, there is concern from various WHO Member States regarding the direction and impact of proposed PPPR measures. These include costs of the programme and resultant funding diversion and opportunity cost regarding other health and economic priorities, and the ownership of samples and intellectual property, including rights to vaccines developed for pathogens of interest identified by country-level surveillance systems and covered under the proposed Pathogen Access and Benefit Sharing (PABS) system which is currently under negotiation.

The PPPR agenda is promoted as urgent, and broad in scope. It includes the Pandemic Fund managed by the World Bank, Global Bio-Hub (WHO-Germany), and the CEPI 100 days vaccine initiative, alongside a number of programmes within WHO. This emphasis is based on the assumption of a rapidly increasing pandemic frequency and burden. However, analysis of the reports on which these assertions of risk and return on PPPR investment are based by the REPPARE project at the University of Leeds have been shown in recent work to be poorly supported by the evidence and citations put forward. This includes reports of the WHO, the World Bank, G20 High Level Independent Panel (HLIP) and other institutions promoting this agenda. The likelihood that much of the increase in recorded natural outbreaks over the past 60 years is explained by technological advancements in diagnostic testing, communications, and funding for both is poorly addressed in risk assumptions. The main methods by which outbreak pathogens are distinguished

from background, including PCR, genetic sequencing and point of care antigen and serology tests, have been developed and rolled out geographically in close association to the increase in reported outbreaks.

Putting Covid-19 aside, a downturn in reported outbreaks from around 2010, noted in the GIDEON database,, may indicate that this increase in surveillance and response mechanisms, and environmental changes are now driving down risk of major natural outbreaks.

Other public health interventions will also have contributed to successfully reducing this burden in the past 10 to 20 years. Covid-19, if indeed of natural origin, appears as an outlier rather than part of an underlying trend, with Marani et al. (2021), cited by the World Bank, estimating a naturally-derived Covid-like event to happen less than once per century.

Actual mortality excluding Covid-19 has been very low for acute outbreaks over the century since the 1918-19 Spanish Flu. High estimates of annualised mortality applied to current global populations, such as 2.5 million deaths per year, rely heavily on pandemics and epidemics from many centuries ago such as the European Black Death, which occurred in a vastly different healthcare, technological and environmental context. Other annualised estimates include pre-antibiotic era Spanish Flu, and the HIV-AIDS outbreak for which surveillance and response issues are quite different.

The costing for PPPR developed by WHO and the World Bank, which forms the basis of G20 messaging, has been demonstrated to be based on a poor evidence-base that is self-referential and uses problematic baselines for comparison with other health priorities that fail to properly examine wider economic impacts and disease burdens. The opportunity costs in terms of building population and health system resilience through broader emphasis on the determinants of health, rather than focused surveillance-response approaches, are not elucidated by WHO. However, as proposed budgets equal 25% to 55% of current global development aid for health. As a result, the PPPR investment case appears questionable in terms of policy legitimacy and potential for overall positive public health outcomes.

Thus, while outbreaks occur and will continue to, and form an important area of work for multilateral health approaches, the current emphasis on PPPR, in common with the securitised health agenda of which it forms a part, discussed earlier, is poorly evidenced. Drivers such as zoonotic spillover events are complex, and the University of Leeds reports are recommended as background to understanding the overall risk and return on investment approaches on which the current PPPR agenda is based.

The term 'One Health' is frequently used within PPPR. In terms of underlining a holistic approach to improving health outcomes, it is well aligned with traditional public health thinking, particularly regarding management of zoonotic spillover risk and building of individual and community resilience. However, when used to imply equality of importance between species or a vague planetary health concept beyond human health (and the effects on this of wider ecology), it becomes problematic in terms of human rights (primacy of the individual), cultural beliefs and public health priority setting. It also raises concerns, discussed in Part IV, if it becomes an end or necessity in itself, preventing a more balanced approach. Within the pandemic agenda it is an important concept regarding the importance of building resilience, but raises concerns when it is considered that over-emphasis on it diverts funding from more important health priorities.

PPPR approaches are currently highly commodity-based and amenable to measurable system metrics such as threats identified or vaccines given that are attractive to private sector interests, and the rise of these approaches parallels the increasing influence of private sector and PPPs in global health over the past two decades. What has arguably been lacking from WHO and other multilateral entities is a clear role in moderating such influence to ensure a balanced and proportionate approach. The PPPR agenda includes areas of real public health need but also considerable private profit, while the less commercially attractive but none-the-less vital areas of global health need where burdens are higher, and so return on investment in terms of lives saved or well-being improved may be more attractive, are relatively orphaned in current discussion.

The pandemic agenda illustrates the major challenges facing global health, and the need for proportionate, evidence-based approaches that prioritise population well-being in the context of an increasingly crowded and often conflicted environment. Parts III and IV of this report will examine the need for an IHO intended to provide leadership and coordination within this evolving context, and the suitability of the WHO's performance and structure to fulfilling this role.

II.4. INTERNATIONAL INSTITUTIONS

Having discussed the human rights and ethical principles that underlie public health, and the scope and intent of public health itself, it is useful to lay out some basic understandings that define international institutions such as an IHO that would help coordinate, or implement, public health policy. This is then expanded in detail in Section III, where ideals of an IHO are discussed.

II.4.1. Central tenets of a Constitution

A constitution is the rule book that outlines the mission and purpose of an international organisation, determines how the organisation is to be structured and how it will work, and distributes powers and responsibilities between the various organs of the organisation. It is simultaneously a social declaration, a political instrument, and a legal instrument that prescribes the distinctive structures and the authority and powers that are necessary to carry out the organisation's mandated functions.

The social purposes of the organisation are expressed in the preamble or an introduction that sets out the vision, mission, and organising principles that underpin the community concerned. The operative articles specify the principal and subsidiary organs of the organisation; their membership, composition, and terms of office; their rules of procedure; their powers and limits in relation to one another and to the members of the community; the rights and obligations of Member States; and so on. At the same time, the constitution also defines the limits on the organisation's powers over sovereign Member States and their citizens.

In joining the organisation, Member States agree to accept the outcomes of decisions made according to the prescribed rules. At the same time, those who are entrusted with international public power are required to conduct themselves as the representatives of Member States. As noted in Section II.2.2 and Sections IV 3.1, 6.3, in the case of the WHO secretariat and indeed all international civil servants in the wider UN system, this implies representing all Member States collectively (the "international community"), rather than specifically their State of nationality. This is implemented in practice within WHO by working within the hierarchical structure of the organisation, under the authority of the Director General appointed by the World Health Assembly.

II.4.2. States and international institutions

Juridically, sovereign States are the primary actors and units of the international global order. At the same time, interdependence in security, financial stability and prosperity, health, environmental sustainability, food and energy security and so on creates the need to promote collaboration in shared goals to maximise the gains for all States, and also to ameliorate tensions and mute conflicts at points of friction when States compete for the same resources amidst scarcity. Thus, interdependence also creates mutual vulnerabilities and shared fragility, so that the costs of not cooperating with one another according to agreed rules and procedures are unacceptably high. Therefore, to provide regularity, predictability, and stability to their interactions, whether in cooperative ventures or in efforts to minimise conflicts, States establish organisations and institutions in which they "pool" sovereignty to achieve all-round mutual benefits. The latter act as agents of, by, and for States who remain the principals and owners of the international institutions. However, such bureaucracies set rules for internal and external transactions, because negotiating anew for everything would be too cumbersome and costly, thereby also asserting a certain level of independence and also rigidity (or legalism) regarding interactions with their principals (States).

II.4.3. Self-interest, and mutual interest and collective action

Whether in a series of actions undertaken when States are entrapped in an escalatory spiral that culminates in a major war, perhaps even a world war, or in adopting selfish protectionist measures that cause global recession and depression, unilateral policies can produce catastrophic consequences. Multilateralism refers to collective, cooperative action by States – at times in concert with non-State actors – to deal with common problems and challenges when these are best managed collaboratively at a level above the State. Recognising this empirical reality, States have created an international system that rests on a dense network of treaties, international organisations, and shared practices that embody common expectations, reciprocity, and equivalence of benefits. On balance, every Member State stands to gain more through collective than unilateral action. Even the most powerful and richest States cannot achieve security nor maintain prosperity and health as effectively when acting unilaterally or in isolation.

II.4.4. State responsibility and humanism

In the words of the UN's most illustrious Secretary-General Dag Hammarskjöld, the United Nations was "not created in order to bring us to heaven, but in order to save us from hell". The UN Charter begins with the grand words "We the peoples of the world". The reality is that it functions as an organisation of, by, and for Member States. Realism as a philosophy of international order locates morality in maximising the security, prosperity, and welfare of members of an exclusive political community inside territorially demarcated sovereign entities. An ethical definition of world order places considerable emphasis also on international solidarity. It is not just the balance of power that provides order and stability and keeps anarchy at bay, but also a common set of values and international practices appropriate to them. National rights entail corresponding international obligations towards others' rights, sovereignty as privilege is inseparable from sovereignty as responsibility in both domestic and international spheres. International organisations embody and articulate a common vision of the global good life uniting all human beings. That vision – and the ethical principles underpinning them – find their most authoritative and eloquent articulation as the purposes and principles enunciated in Article 1 of the United Nations Charter. Following from that, every international organisation must strike a balance between interests-based realism and solidarity-encapsulating humanism.

For all its flaws and shortcomings, the United Nations system remains the focus of the hopes and aspirations for a future where men and women live at peace with themselves and in harmony with nature. The idea of a universal organisation dedicated to protecting peace and promoting welfare has survived the death, destruction, and disillusionment of armed conflicts, genocide, persistent poverty, environmental degradation, and innumerable assaults on human dignity. Yet, "*national governments retain the authority to disable international policy making, but not the capacity to resolve problems on their own*".

Most international organisations lie at the intersection of interests and values. As such, they are both a stage for State-based realism, and actors in their own pursuing ideals of solidarity that bind the scattered members of the human family across the divides of borders, race, religion, gender, and other attributes. They act as bridges between the global North and South. They reject the notions that might is right and that millions of people should continue to be condemned to a life of poverty, illiteracy and ill-health.

PART III:

AN IDEAL INTERNATIONAL HEALTH ORGANIZATION

PART III
An ideal international health organization

The first quarter of this report provided important background information on health ethics, global health policy, global health financing, the principles of global public health, as well as major policy themes within global health governance. From this background, Part II then outlined the history of the WHO (pre and post 1990) as well as explored key themes in its development, including an increase in the biomedical securitisation of health and its political and financial relationship with non-State entities.

The second half of the Technical Report aims to do two things. First, Part III outlines what an ideal International Health Organisation (IHO) should do, detailing a series of ethical and global public health standards from which to measure the WHO. Second, in Part IV, the WHO will then be measured against the standards outlined in Part III. The aim of this exercise is to identify gaps between the IHO standards and WHO practice so as to determine key areas that need to be addressed by any reform or replacement strategy.

Yet, before doing so, it is useful to revisit the analytical framework underpinning this report.

III.1. ANALYTICAL FRAMEWORK AND ORGANIZATION OF ANALYSIS

Given its role as the central actor involved in global health, the WHO has historically attracted significant levels of scrutiny and calls for reform. As briefly outlined in Part I, a systematic review of the academic literature on the WHO conducted in 2022 located a wide range of critical reflections and reform recommendations. The review analysed 139 articles published between 2008 and 2018 to identify, categorise and articulate key WHO performance issues. Importantly, the timescale of the 2022 Fabian and Bump review excludes the WHO reform debates stemming from later SARs-CoV-2 response, which a rapid review conducted by IHRP reveals to have at least doubled the number of articles analysed in the 2022 review.

Despite this limitation, the 2022 review reveals several key insights and research challenges involved with academic debates on WHO reform.

First, there were no standard methods for assessing an IHO such as the WHO. Thus, a key finding of the review was that there is a need for a more "rigorous and inclusive" research agenda on how to assess the WHO performance and resulting recommendations for reform. This problem persists within the post-2018 WHO reform literature, suggesting that despite the growth of the WHO reform debate, these methodological shortcomings remain, undermining the potential for academically based insights to impact upon WHO reform debates.

Second, most articles (88%) were short commentaries without specified methods, while 76% of the articles originated from only three high income countries (USA, UK and Switzerland). An identified problem included a general lack of analysis at "ground level" from those most impacted by disease burdens and associated global health policies. This raises questions about the role of confirmation, selection and funding bias within the research, while reinforcing the oversized role institutions in high income countries play within global health debates.

Third, a dominating theme within the literature focused on outbreaks (25%), which corroborates the claim that there exists an over-securitised focus in global health (see Sections 3.2, 3.7).

Fourth, there is a direct correlation between outbreaks and WHO reform articles (Figure III.1) with the highest number of publications appearing during and immediately after the 2014 Ebola outbreak (outside of Covid-19).

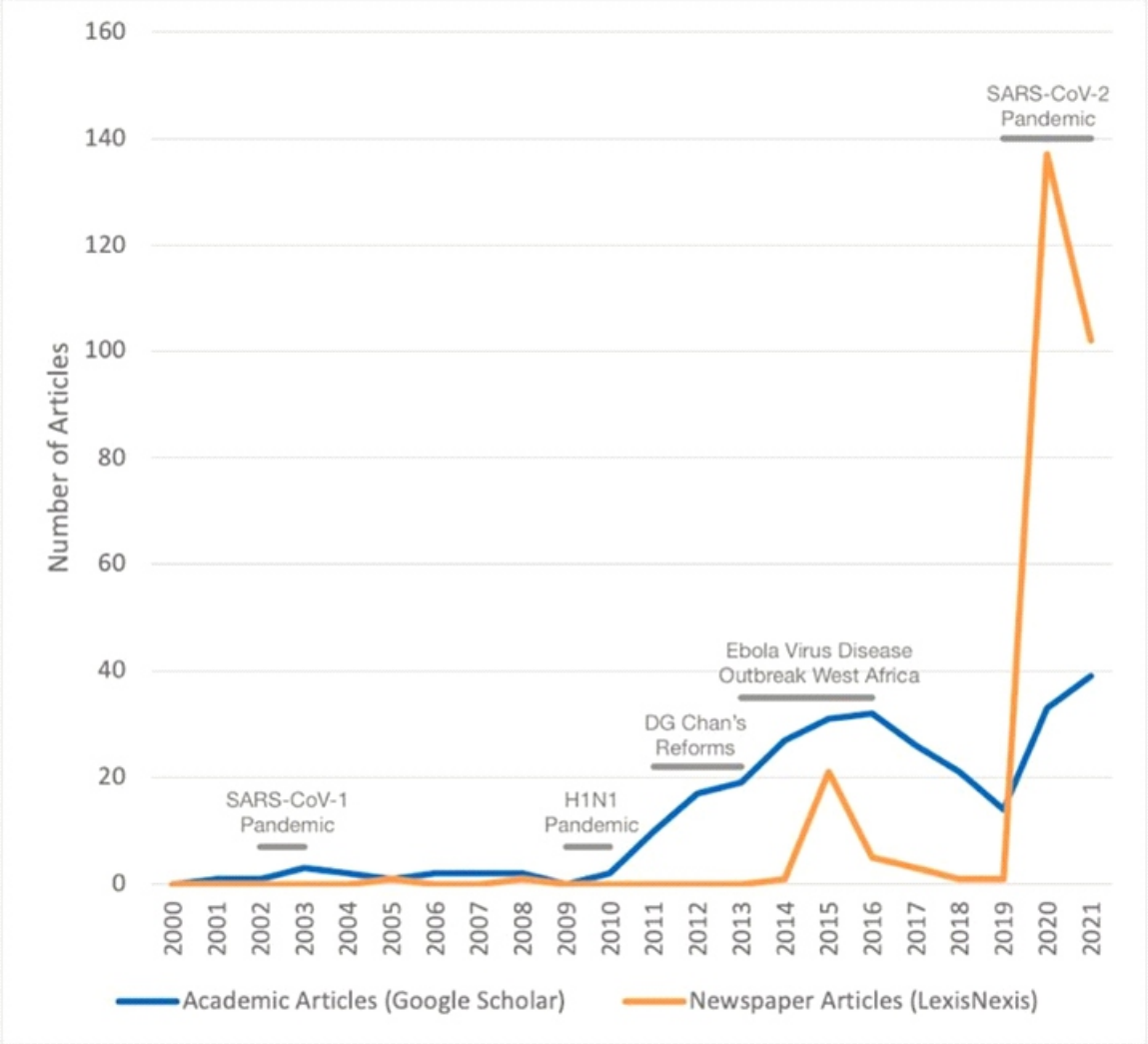

Figure III.1 – Frequency of News and Academic Articles Mentioning World Health Organization Reform 2000–2021.
Source: Fabian Moser, Jesse B. Bump, https://doi.org/10.1016/j.socscimed.2022.115456

This again shows that health security and infectious disease outbreaks play an oversized role within the academic literature on WHO reform and assessment of its performance, a finding again confirmed by a review of WHO reform publications post Covid-19.

In many ways this emphasis on outbreaks makes sense, since outbreaks garner considerable public, media and political attention, involve an acute emergency, and test the performance of existing institutional response structures. Yet, it also demonstrates the inappropriately elevated status of low burden infectious disease outbreaks within global health. A regionally isolated outbreak like Mpox (the Democratic Republic of Congo had approximately 60,000 deaths last year from malaria versus under 300 total deaths from Mpox), can absorb considerable academic research bandwidth, .sidelining WHO reform challenges associated with endemic or non-communicable disease of far higher burden.

As outlined in Part I, this report adapted the analytical framework used by Moser and Bump which categorised five primary target areas for WHO reform discerned from the academic literature on the WHO. These organisational categories and effectiveness sub-questions included: Goals and Strategy; Identity; Legitimacy and Governance; Structure and Performance, and; Authority and Relationships. Again, as outlined in Part I, this report makes four alterations to the framework and its use in the organisation of this report:

1) The category of Identity has been moved to the top of the framework due to its importance in how an IHO prioritises its programme of work. This allows the report to identify disparities between theory (normative values) and practice (how it performs) thus providing useful insights about the need for institutional normative shift and/or the need to realign the WHO with these normative foundations.

2) This report includes sub-categories that were not prevalent or were undervalued within the academic literature at the time of the Moser and Bump review, particularly predominant debates regarding post-Covid WHO reform and new matters arising from cuts in Overseas Development Assistance (ODA).

3) This report adds a specific subcategory of WHO financing under the category of Structure and Performance due to the important role it plays in WHO's organisation, performance and ultimate sustainability.

4) This report places a greater emphasis on external relationships. This is because the WHO operates within an increasing cooperative and competitive global health policy landscape with unique outcomes.

Based on this framework, the report will now outline what an ideal IHO should look like in response to key ethical and public health foundations presented in Parts I and II. By doing so, it provides a baseline from which to identify gaps and measure how WHO operates. Moreover, by identifying these gaps, it is possible to provide specific recommendations for how to improve the WHO as an IHO, and to further determine the feasibility of whether WHO can be reformed against the standards set in Part I, II and III of this report.

III.2. IDENTITY

III.2.1. IHO elements of public health

As explained in Part II, public health policies should address heterogeneous populations with varied needs and preferences. Therefore, it is essential that they do not consist in 'one-size-fitsall' measures, but are tailored to the various needs and preferences of various people. This does not mean that there should be no norms or standards in public health – on the contrary, they may be useful as targets or process guidelines, and to guarantee quality services – but these norms should neither be 'universally binding', nor applied without adapting to local contexts. Indeed, health systems worldwide are extremely different and vary even among countries with relatively similar socio-economic, political and demographic contexts (such as member countries of the OECD), since they have very different features (e.g. health personnel ratios, service provision organisation, health financing indicators, etc.). In particular, total health spending is extremely different between low-income and high-income countries (resp. US$36 and US$5,702 per capita, on average, in 2019). It would therefore be untenable to develop the same norms – e.g. as for recommended health personnel ratio per inhabitant, antenatal care, etc. – for such different contexts.

III.2.2. International health norms and the State system

The international order is based on a system of sovereign States as a means of organising the world to discharge the States' responsibility to their people. Namely, to protect their lives and livelihoods and to promote their well-being and freedoms. However, States' ability to exercise national sovereignty has been increasingly circumscribed in the decades since 1945. The steady erosion of the principle of sovereignty is partly rooted in the reality that all States face mutual vulnerabilities. The world is interdependent in areas as diverse as financial markets, infectious diseases, climate change, terrorism, nuclear peace and safety, product safety, food supply, water availability, fish stocks, ecosystem resources, and so on. In addition to their potential for provoking interstate military conflicts, these are all drivers of human insecurity due to the threat they pose to individual lives and welfare. In recognition of this empirical reality, the international system rests on a network of treaties, regimes, intergovernmental organisations, and shared practices that embody common expectations, reciprocity, and equivalence of benefits.

Multilateralism refers to collective, cooperative action by States – at times in concert with nonState actors – to deal with common problems and challenges when these are best managed collaboratively at the international level. Areas such as maintaining international peace and security, economic development and international trade, human rights, functional and technical cooperation, harmonization of regulatory requirements and markets, and the protection of the environment and sustainable

use of resources require joint action to promote collaboration, reduce costs, and bring order and regularity to international relations.

Furthermore, multilateralism now operates in a world much changed since the creation of the United Nations. There are four times as many State actors, a significant rise in the number of non-State actors, and a tremendous diversity in the types of State and non-State actors compared to 1945. There has been a matching proliferation in the number, nature, and types of threats to national security and world peace alike. Consequently, the growing number and types of actors in world affairs must grapple with an increasing number, range, and complexity of issues in a networked, deeply intertwined, but also more fragmented world. The sense of community that might once have bound together the Member States of the United Nations has been attenuated over the decades.

As a result, an IHO should be a specialised agency, ideally closely aligned to the UN system, to avoid duplication and redundancy, with the capacity to address collective health concerns on behalf of its Member States. Thus, the role of an IHO would be to advocate for collective concerns in global public health, monitor public health risks, preparing for emergencies by identifying, mitigating, and managing risks, and coordinating responses to health emergencies. An IHO would set international health standards and guidelines and provide technical assistance to countries. The organising principle is that an IHO represents countries, recognising their citizens as rights bearers with agency and the capacity to make decisions concerning their own welfare.

As argued in the accompanying Policy Report, a key feature of enhancing a State's ability to discharge its responsibility to its people is the organising principle of subsidiarity where health decisions reflect the desires and intent of those closest to where they will have their effect. Subsidiarity is a concept about the level of governance (local, provincial, national, regional, global) and the sharing of powers among levels to determine the point at which action should be taken to adopt and implement public policy. Regarding an IHO, it empowers the individual members and not the organisation to make decisions on issues that affect them.

III.2.3. General international legal norms

It is assumed here that an IHO would be a stand-alone intergovernmental organisation created on the basis of a constitutive treaty, have a legal personality different from its Member States, and thus the ability to enter into agreements with nation States and other international organisations, including those of the UN system (or as a UN body itself). General international law, which is made of customary international law and general principles (Art. 38, Statute of ICJ), would logically govern the IHO's workings and relationships with other stakeholders. Such a position should not cause much contestation since States who form the organisation are generally already bound by these rules. However, the complex issue on whether an international organisation might or might not be bound by international treaties - both lex generalis and lex specialis (general rules and rules specific to its functions)- that the organisation has not accepted, should be discussed among the IHO Member States in order to generate some consensus or understanding. In the international health realm, it is illustrated by proposals on the applicability of certain economic and social rights (i.e. the rights to health, water, food, development) recognised by the ICESR and affecting operations of the International Monetary Fund, the World Intellectual Property Organization, and the World Trade Organization.

It is also necessary to establish some privileges and immunities for the organisation and its staff to ensure independence and effective functioning. Generally, they may be established by the constituent treaty establishing the organisation, general multilateral treaties (for example, the 1946 General Convention on the Privileges and Immunities of the United Nations and the 1947 Convention on the Privileges and Immunities of the Specialized Agencies), customary international law and national law (for example, the UK 1968 International Organization Act). In practice, a set of privileges and immunities are conferred to the organisation itself (see Sections IV.3.1), the staff and/or short-term contracted individuals, as well as representatives of Member States. They include immunity from the judicial jurisdiction of States (usually not absolute depending on the nature of the acts), immunity from prosecution, inviolability of premises and archives, and fiscal privileges. As example, immunities of WHO staff are discussed in Sections IV.3.1 and IV.6.3.

III.2.4. Public health ethics

Public health ethics are discussed at length in Part II. Fundamentally, post-World War Two norms are based on the understanding that all individuals have self-sovereignty, and consequently bodily autonomy, and are equal and not of quantifiable (i.e. limitable) value. From

this understanding four fundamental medical ethical principles are derived: the Hippocratic understandings of beneficence, non-maleficence, confidentiality and, accordingly, voluntary informed consent (Section II.1.2).

Shifting these to a public health sphere, as discussed in Part II, the primacy of the individual and their fundamental rights must remain, but considerations of those rights related to the actions of, or effects on, others become important. The rights or sovereignty of communities or countries, as an expression of the rights of the individuals therein, then come into the process of decision-making. Such communities of countries also have an obligation to uphold the potential for individuals to exercise their rights through maintenance of health and well-being, expressed within the concept of the 'right to health' (see Sections II.1.1, III.2.5, IV.2.1).

An IHO must therefore work within this framework if it is to have legitimacy as an organization supporting health within the concept of individual sovereignty and equality. These are expressed in this report as the thirteen principles of an IHO, as outlined in Part II.1.2. An IHO has a requirement to support nations and communities within them to further the right to health but cannot dictate to these communities, as this would infringe upon the right of self-determination of the individuals they represent. It is therefore governed by the principle of State sovereignty, while supporting States when requested.

This defines an important hierarchy of power in priority-setting and decision-making, based on the individual, whose power is expressed through the governance mechanisms that represent them (Member States) and allow expression of their sovereignty within a broader population, with the IHO being subsidiary to these governments as a support mechanism managed by and for them. This implies a structure emphasising subsidiarity within the IHO, to ensure clear representation and control by national governments. Those working within an IHO therefore must be representative and answerable to the structures through which individual sovereignty is expressed. While there is no ideal mechanism for this, as national and community structures themselves vary widely in their representatives, the practical alternative is subverting such sovereignty and imposing structures determined by central/global authorities, which is clearly inconsistent with the fundamental or negative rights on which modern human rights law is based (Section II.1.1).

The focus on sovereignty and subsidiarity raises an important point in need of clarification. The literature on WHO reform often identifies "entrenched sovereignty" by Member States as the primary driver of gridlock in global health policy making. As a result, criticisms of the WHO tend to argue that it requires more centralised authority with the power to enforce compliance.

This report argues the opposite. Namely, if States are the main beneficiaries and stakeholders which an IHO is designed to serve, then the emphasis should be on legitimate political processes and not maximising centralised efficiency. Moreover, subsidiarity creates smaller and more effective sites of political interaction while increasing the potential for greater institutional legitimacy, contextualised policy, and national ownership, thus creating higher levels of selfdetermination and compliance. In other words, the aim of an IHO is not to get things done fast in accordance to rules designed in the Secretariat, but to assure that rules reflect the will of its constituents, that processes and their outcomes are deemed legitimate and relevant, and that the rules that are created capture a form of self-legislation in concert with others under a law making process. Although this results in slower policy making, it will increase legitimacy and compliance due to its adherence to its own values, making for a more effective and reputable IHO in the long-term.

III.2.5. Right to health

As discussed in Part II, many countries recognise the right to health in their constitutions and legislation, and have obligation to progressively implement this right, being parties to the ICESCR. The IHO and its staff should have a duty to operate in accordance with generally accepted international human rights and humanitarian principles and norms. This can therefore include a right to health, but as discussed in Part II, this must be included as a State-based responsibility, and subsidiary to the fundamental (inviolable) negative rights on which all activities of an IHO must be based. Overall, the IHO should not dictate to its members how to interpret and implement a right to health. This implies staff commitment to be politically neutral and free of biases and conflicts of interest. As a result, it is important to have such guiding principles enshrined in the IHO's constitution.

III.2.6. IHO internal culture and identity

Research demonstrates that organisations with positive workplace cultures have higher average annual returns whether that is measured in outputs, profit, or

programme effectiveness. As a result, an ideal IHO should strive to maintain a positive workplace and internal culture to sustain a high level of efficiency, effectiveness and employee well-being. In its ideal form, a positive internal culture of an IHO would maintain the following baseline conditions:

- **Trust and psychological safety.** An internal operating condition where people are not afraid to discuss ideas and share opinions free from retribution, silencing or suppression, especially when those opinions may be different from their managers or popular paradigms. This includes the maintenance of transparency in decision-making and allowing for the recognition of mistakes or 'lessons learned' without undue punishment, retribution or silencing.

- **Professional development.** Clear and transparent professional advancement procedures and opportunities based primarily on merit and performance versus by quota, political manoeuvring, or cronyism. Professional development includes training and upskilling opportunities, clear advancement benchmarks, and promotion of worklife balance.

- **Countering inertia.** An ideal internal culture would strive to reduce role stagnation, job entrenchment, and jurisdictional fiefdoms. This includes maintaining collaboration, communication and feed-back loops between departments and thematic areas to drive innovation, problem solving, and adaptation, while controlling for overly dogmatic top-down structures.

- **Inclusiveness and belonging.** Respect for individuals and their ability to be part of a larger operational whole. Practices that are discriminatory or single out individuals should be eliminated. Inclusion of individuals as decisionmakers and not just decision takers is particularly effective in fostering ownership, motivation, and employee satisfaction.

- **Tackling professional misconduct.** An ideal internal culture would have clear, fair, and responsive procedures for handling claims of professional misconduct that equally protect all parties while a swift, yet thorough, investigation is performed. Misconduct investigations should be free from conflicts of interest and conducted independently, especially in cases where senior management officials are under review. Procedures should be equally applied and subject to the highest standards of due process.

- **Appropriate capacities.** An ideal internal culture would have sufficient personnel to undertake its organisation's remit, including proper levels of expertise, experience and ability. Role appropriation should be based on capability and suitability.

- **Stability**. Stability and job security are frequently considered beneficial but are subject to constraints in an IHO, where task-oriented employment and term limits are desirable (See Part IV.6 Workforce) and there is also a need to avoid permanently draining national workforces through higher salaries and benefits. This can be addressed in other ways through support for subsequent employment and recognition of achievement and good standing.

- **Workplace Environment.** An ideal internal culture maintains a minimum level of bureaucracy required to fulfil its organisation's remit and to optimise performance. Management cultures should not be seen as removed or separate from day-to-day operations. Multidirectional communication channels and accountability mechanisms are crucial for the maintenance of trust and shared vision. Heavily top down or politicised structures should be avoided to foster multidirectional cooperation, feedback loops, subsidiarity, and organisational transparency and accountability.

An important feature of an IHO is the maintenance of a positive workplace culture. This not only creates a better workplace environment for its employees but also helps to assure higher performance in terms of outputs, programme effectiveness, and health outcomes. As will be discussed in Part IV, the maintenance of a positive workplace culture will also improve the perceived legitimacy of an IHO.

III.3. LEGITIMACY AND GOVERNANCE

III.3.1. Participation

Following the acknowledgement of the lack of an inclusive and transparent policymaking style during the Covid-19 pandemic in many countries, a WHO team developed a handbook on voice, agency, empowerment and social participation for universal health coverage. The handbook reckons that:

"One crucial but challenging aspect of strengthening governance is systematically bringing in people's voice into policy- and decision-making. [...] For people's views to be aired and heard requires an environment where people feel empowered to speak their voice; doing so gives populations agency over their own health and lives, a key step in fulfilling the human right to health".

The above quote captures a crucial element required for IHO governance and legitimacy. Namely, because international politics is multilateral, and because States are the primary stakeholders and beneficiaries of an IHO, an IHO must be designed to serve the interests of its Member States as a multilateral organisation by creating legitimate political processes that allow equal access, deliberative opportunities, and collective public policy. When coupled with the principle of subsidiarity, the aim is to create a smaller and more tightly focused international site for multilateral political interaction that promotes the responsibility of States to improve the health of their populations.

III.3.2. National ownership

An ideal IHO should by no means be entitled to exercise decision making powers in countries or to impose undue influence upon them. Its role should be limited to policy advice and technical support. As explained in Section II.1.3, it is impossible for public health policy to be perfect for all people, and to be able to reflect all performance criteria. Hence, even if evidenceinformed, trade-offs are to be made, and decisions must be made based on clear criteria and transparent negotiations between equals, ensuring participation by all domestic constituencies (including vulnerable and marginalised groups). Decision criteria must be set by countries based on their own values and priorities, even if it somewhat runs against international norms and/or the policy interests of powerful actors.

III.3.3. Accountability

Accountability refers to the extent to which an organisation is answerable to relevant external stakeholders for its actions and impact. This can include overall success, but in case of an IHO success is not always readily measurable, at least in terms of overall health indices. Improved nutrition, as an example, can occur for many reasons including dedicated micronutrient supplementation but also economic health and agricultural output etc., and can impact in a broad range of categories of well-being and disease states that are themselves also subject to change through other influences. The delivery of the micronutrient may be measurable, but any further metrics of impact are based on assumptions rather than fact.

However, it is possible to make judgements on how well an IHO's advice conforms with known data and trial outcomes, and known variation in target populations. The quality of advice, at least, can be assessed and health metrics measured, where a direct correlation between intervention and impact is established (e.g. insecticide-impregnated bed net use and malaria incidence). Since an IHO receives public finances, and its actions are intended to impact life and death, accountability is essential.

Varying models exist to build accountability into international organisations (IOs) at a governance level. The WHO has the World health Assembly (WHA - a council of all countries) and an Executive Board (Section IV.3.1). The Bank of International Settlements, though impacting many countries, has a council of six founding countries, while the International Labour Organization (ILO) has a governing body comprising Member States, employer and labour representatives. The OECD is self-governing but limited only to giving recommendations (and so may be considered to have lower accountability requirements). A discussion of accountability models can be found here. Governing bodies are, however, only as effective as their insight into the inner workings of the organisation allow them (degree of transparency), and the objectivity of their representatives.

International organisations may also include semi-autonomous internal audit panels or mechanisms to respond to both internal and external concerns regarding accountability, such as The Global Fund's Office of the Inspector General. Internal panels, however, can be subject to similar pressures as general staff in protecting organisational reputation over ensuring transparency and accountability. As a result, they can play an important but limited role. External independent bodies also exist to audit and rank accountability and transparency, such as Transparency International and AIDData. Yet, the independence of the organisations conducting the audit, especially when hired by the organisation under audit, requires scrutiny. This is because one can ask who owns or audits the auditor and what mandate they pursue, thus effecting the legitimacy of them to make objective judgments. AIDData's ranking is interesting in that privately-funded international organisations rank higher

in transparency than many UN bodies, but this may reflect their purpose – such as to increase access to health commodities, versus broader (and difficult to measure) capacity building for healthcare and development.

Accountability, as stated, is essential to build trust and legitimacy. A danger inherent in any organisation that is not answerable directly to a specific population is that a disconnect can develop between recommendations given, and awareness of and impact by, the results of those recommendations. This risk will grow greater the more centralised the organisation becomes, and is of clear relevance to a multilateral IHO housed in a country far removed geographically, economically and culturally from impacted populations. Harm can result from solidly-based advice that fails in certain unforeseen contexts, advice that is inadvertently poor which may result from either honest mistakes or neglect (e.g. based on incorrect data or inadequate analyses), or through malfeasance (e.g. as a result of conflict of interest or malicious geopolitical intent).

Requiring accountability of staff for outcomes of decisions and recommendations of an IHO should increase the diligence with which recommendations are formulated and disseminated. However, the nature of an IHO's work, often requiring decisions made on incomplete data and hypotheses rather than assured knowledge, makes the risk of inadvertent harm unavoidable. The nature of health recommendations themselves adds to this uncertainty, as any intervention at a population level is expected to impact each individual within the population differently due to inherent biological, environmental and other variables. To hold staff, or an IHO itself, directly responsible for all outcomes of its recommendations could stifle decision-making and may lead to institutional paralysis in areas where a dynamic response is needed. This would be exacerbated if accountability was extended to members of expert committees and panels convened to assist the IHO. Such reasoning is the basis of the immunity clauses within Chapter XV Articles 65-68 of the constitution of WHO and Annex 7 of the United Nations Convention on Privileges and Immunities, discussed further in Section IV.3.1.

So, how should accountability be ensured, and recipients of IHO advice be protected?

First, most would accept a need for sanctions on staff or others who deliberately provide poor health advice in order to achieve personal gain. This should to some extent extend to advice that is poor through neglect where such neglect broke an understanding or contract to provide advice that reflected expertise and good intent. Such sanctions would be expected to ensure increased effort on the part of staff and basic honesty in their work, and could clearly include at least cessation of employment. A multilateral IHO faces challenges in imposing more severe penalties as the IHO is not (cannot be) subject to an individual State's jurisdiction. Mechanisms for international jurisdiction, such as the ICC, are not accepted by all States.

Second, mechanisms can be built into the IHO constitution and operating procedures to minimise potential harm. At an IHO level:

- Pressure toward institutional conflict of interest can be mitigated by ensuring assessed contributions and non-specified contributions as a basis for supporting operations and avoiding or tightly controlling private sector contributions.

- Staff and panel members can be selected based on strict criteria including transparency of potential conflicts of interest, and prioritising appropriate expertise and experience.

- Discussions and evidence can be available, ensuring "radical transparency" (see Sections III.5.2, IV.5.1) – full transparency is in theory ideal, but this raises certain restraints on frankness or completeness of discussion and may therefore limit quality of output.

- Discussions and committees should be open to external participation. However, this may limit depth of discussion, may make decision-making bodies too large to be effective, and may allow conflicted or biased external entities to influence decision making. Even "civil society" groups are often funded from sources that themselves may have vested interests, and not remotely representative of typical or target groups in the community.

- Importantly, recommendations must be filtered through regional and national mechanisms (or further) to ensure that they are implemented only when, and in a way that, they are likely to produce the outcomes intended.

This latter principle of subsidiarity is fundamental to dealing with the heterogeneity of risk, epidemiology, cultural and economic contexts that impact on any public health intervention.

III.4. AUTORITY AND EXTERNAL RELATIONSHIPS

III.4.1. Relationship to United Nations

The UN system contains a multitude of institutions and bodies across all sectors. At the regional level and in specific fields (i.e. finance, trade, agriculture), many organisations have been established outside the UN system. They all enjoy some relationships with the UN, usually formally through agreements, representations and liaison offices.

Article 55.b of the UN Charter states that the UN shall promote "solutions of international economic, social, health, and related problems; and international cultural and educational cooperation", and Article 56 describes a Member State's commitment "to take joint and separate action in cooperation with the UN" to achieve the goals enumerated in the previous provision. Therefore, in the event that a new IHO emerges from a multilateral agreement outside the UN system to co-exist with the WHO, cooperation with the UN system would still be central (see costs of parallel institutions below).

As previously discussed in Section III.3.1., the establishment of a new IHO may be seen either as competitive to the WHO or a complementary or alternative option for international health cooperation. In both cases, collaboration would be useful for both, especially regarding disease and outbreak surveillance and notification.

Regarding other matters, collaboration with the UN system would also be unavoidable. The UN system has been creating a giant corpus of international treaties and bodies in all sectors. In the case of a new IHO being established contra to major WHO reform, it would have to decide to what extent it affiliates with the UN system and abides by existing international treaties and bodies, versus developing a more independent approach.

However, it is important to note that the former option of an IHO operating outside the UN system or in parallel to the WHO would foreseeably increase fragmentation, duplication, transaction costs, inefficiencies, and opportunity costs. These costs might not be insignificant. Thus, there are enormous benefits to having an IHO as part of the UN system in terms of authority, legitimacy and policy efficiencies and effectiveness, that must be weighed against restrictions regarding areas such as culture and staffing policies discussed elsewhere in Part IV. These need to be weighed against recent arguments around the US withdrawal from WHO and the establishment of alternate multilateral organisations or bilateral agreements.

Relationship to Global Health Initiatives (GHIs)

The global health policy ecosystem consists of multifarious multilateral organisations and nonState initiatives in which an IHO will undoubtably have to engage and potentially coordinate, including private-public partnerships. According to the Wellcome Trust report "*Reimagining the Future of Global Health Initiatives*" (FGHI), global health reform will require changing how major GHIs such as the Global Fund and Gavi engage and promote health at the local level. In line with the findings of this report, the FGHI report argues that the GHI ecosystem must better complement and strengthen health system capacities to deliver health impacts aligned with local priorities. Moreover, the spirit of the FGHI report suggests that the main aim of GHIs is to ultimately make themselves redundant by promoting localised self-reliance and sustainability of programmes. As a result, the FGHI report is largely in-line with the principles laid out clearly within the Lusaka Agenda, which is an agenda that also informs this IHRP Technical Report and its corresponding Policy Report.

In this context the role of an IHO is to promote international collective action that is reflective of the needs of States and local communities, to champion States in their responsibilities for the health of their peoples, to protect and serve the health rights of individuals, and to act as an overarching coordination umbrella assuring that GHIs are facilitating programmes that are based on local needs and that are nationally owned. As a result, an ideal IHO acts as the mandated health authority via the collective will of its constituents, while maintaining independence from external influence. In the case of GHIs, an ideal IHO would be free from undue influence from GHIs via reliance on their donor contributions, programme dependencies, conflict of interest, and political patronage.

III.4.2. Constitutional principles and legal standing

Multilateral organisations have a wide range of denominations, such as group, association, or cooperation. Regardless of the name chosen, they must be built on a constitutive agreement agreed upon by more than two States, that lay out at the minimum the reasons

why it is created, the cardinal principles of its workings, its mandates, and internal institutions developed to achieve these mandates.

The WHO's constitution lays out a list of "basic principles" in its Preamble necessary for any generalist IHO, such as the definition of health, the basic importance of the child's healthy development, the responsibility of a State toward its people, and the "utmost importance" of informed opinion and active co-operation. However, as discussed in Section IV.5.2, their placement has not always translated into WHO upholding their value. WHO's Covid-19 response and post-Covid-19 concentration on its pandemic agenda shows an organisation drifting away from these principles and ignoring its own definition of health. Therefore, any new or reformed IHO's sponsoring States would have to consider establishing new principles in a manner that ensures they underlie policy making and implementation. These must encompass the well-known principles established in medicine and public health discussed under Section II.2 1-4 and reflected in The Right to Health Sovereignty Policy Report. Sections IV.5 and IV.7 discuss the WHO's constitution, structure and weaknesses that may have led to apparent failures to uphold its original mission.

The lack of jurisdictional oversight makes enforcement of a constitution difficult, and eventually it is up to Member States (of the WHA in WHO's example) to insist on written principles being abided by. However, this makes enforcement subject to the diplomatic and geopolitical machinations of international relations that vary with time and the priorities of certain powerful national administrations. It is thus perhaps unrealistic to assume continued internal integrity of an international organisation, raising the importance of control by individual Member States through subsidiarity to ensure smaller States are not disadvantaged through centralised drift and influence.

III.4.3. State sovereignty and IHO Member States

The military conquest of one country by another through the use of force determined the geopolitical map of the world from the mists of antiquity until the twentieth century. The First and Second World Wars enshrined the notion of national self-determination that completely delegitimised the change of borders by means of military force. The post-1945 liberal international order was embedded in and underpinned by a vast latticework of institutions centred on the United Nations. The newly independent nations of Asia and Africa that emerged from the yoke of European colonialism became the most passionate champions of national sovereignty and among the fiercest defenders of the existing territorial borders, using the weight of their numbers throughout the UN system to offset their lack of military power, financial muscle, and geopolitical heft.

Yet, the empirical reality of the unequal distribution of resources, wealth, and power among nations, has set the scene for continuing contestation between powerful and weak countries for control and influence of foreign actors inside sovereign jurisdictions. In addition to this historical continuity, however, there was a new development: the growth of intergovernmental actors intruding with increased visibility into domestic affairs of sovereign States in the name of the international community. One of the most recent domains in which this has occurred is health, the subject of this report.

Sovereignty: Meaning, Origins, Evolution

The Peace of Westphalia (1648) comprised two European settlements that changed forever the geopolitical map of Europe. It is generally held to be the foundation of the modern State system built around the concept of territorial sovereignty. Internally, sovereignty refers to the exclusive competence of the State to make authoritative decisions of government with regard to all people and resources within its territory. Externally, it means the legal identity of the State in international law, an equality of status with all other States, and the claim to be the sole official agent acting in international relations in the name and on behalf of those within its borders.

However, just as constitutional arrangements and distribution of powers between different branches and levels of government qualify the absolutism of domestic sovereignty, so international constitutional arrangements through agreements entered into voluntarily – such as the United Nations Charter, the statutes of the World Court and the International Criminal Court (ICC), the World Trade Organization (WTO), the network of European Union (EU) level treaties – qualify external sovereignty.

The traditional view holds that State sovereignty is based on power. An alternative conception holds that popular sovereignty must derive from the active choice of the governed. Over time, concomitantly with greater sensitivity to the inherent dignity and rights of individuals, sovereignty as the philosophical underpinning of the State system was redefined in terms of a social contract between citizens and rulers. By the end of the 19th

century, legal sovereignty as vested in parliament was distinguished from political sovereignty that resided in the electorate. In the 20th century the trend was taken further with the notion of popular sovereignty. With the rise of 'liberal democracy', State sovereignty was challenged by popular sovereignty, first conceived of as the consent of the governed, and then their active choice.

Internal power relations experienced an inversion of authority. Subjects were no longer answerable to sovereigns; rather, States were accountable to citizens. Rights-bearing citizens did not owe duties to sovereigns. In 2001, in response to the so-called challenge of humanitarian intervention in the 1990s, the International Commission on Intervention and State Sovereignty (ICISS) concluded that it is necessary and useful to reconceptualise sovereignty as responsibility. The principle of the Responsibility to Protect (R2P), unanimously endorsed by the UN World Summit in New York in 2005, adapted this change to the international level, shaping both relations between citizens and States domestically, and between States and the international community represented by and acting through the United Nations globally. Individuals are rights bearers and States have the primary responsibility to protect all peoples on their territory, but the UN has a fallback responsibility when States are manifestly failing to do so. In relation to the role of an IHO, its existence is to assist States so that they can fulfil their responsibility for the advancement of the health of their citizens.

Contrasting Approaches to Sovereignty: Major Powers

As an ex-colony that itself won independence on the back of a revolutionary war, the United States has always been a jealous defender of national sovereignty against international encroachments. In the twenty-first century, "America First" sovereigntists have launched three lines of attack against what they call "globalism": the emerging international legal order is amorphous, unclear, contested, often contradictory, and illegitimately intrusive in domestic affairs; the international law-making process lacks democratic foundations, is unaccountable, and the resulting law is unenforceable. As a result, the US has argued that it can opt out of international regimes as a matter of constitutional duty, legal right, and power.

Unlike LMIC countries that have historically had little to back their defence of sovereignty beyond the strength of numbers, the US has been the world's preeminent geopolitical heavyweight since the inception of the United Nations in 1945. The former Soviet Union was equally firm in the defence of its sovereignty as the second superpower during the bipolar Cold War. Both bloc leaders also illustrated, although not to an equivalent degree, Thucydides' ancient wisdom that justice does not apply to relations among nonequals. Instead, strong powers do what they can and weak States suffer as they must. Hungary in 1956, Czechoslovakia in 1968, and the many instances of US intervention are milestones on the relevance of Thucydides' insight to post-1945 international history. Since the end of the Cold War and the implosion of post-Soviet Russia, China has also emerged as the most formidable US rival and global champion of sovereignty. India is also a powerful advocate, as it too emerges as a consequential power.

Contrasting Approaches to Sovereignty: Low-and Middle-Income Countries

As noted above, the principle of sovereignty and the attribute of sovereign statehood are distinctively European in origin and conceptualisation. The Westphalian system oversaw the imperial expansion of the European great power rivalries and the resulting global rise of European colonialism. The export and universalisation of the principle of sovereignty, and its expression as nationalism by colonial subjects, paved the way for the emergence of powerful independence, self-determination, and national liberation movements culminating in the worldwide decolonisation process. Having emerged from colonial conquest and rule, the newly independent countries proved to be fiercely jealous about protecting their sovereignty against external exploitation and foreign interference. In effect they domesticated what had been a European export.

Membership of the United Nations has been historically a symbol of sovereign statehood for freshly independent countries and their seal of acceptance into the community of nations. The UN Charter and the UN General Assembly became their preferred constitutional tool and political organ to this end. The UN also became the principal international forum for collaborative action in the shared pursuit of the three goals of State-building, nation-building, and economic development.

At one level, LMIC attachment to sovereignty is deeply emotional, reflecting the history of Europe's encounter with Arabs, Africans, and Asians. The parties and leaders at the forefront of the fight for independence helped to establish the new States and shape and guide the founding principles of their foreign policies. The anticolonial impulse in their worldview was instilled in the

countries' foreign policies and survives as a powerful sentiment in the corporate memory of the elites. At another level, the commitment to sovereignty was also functional. As the foundational organising principle of the postcolonial international order, sovereignty has provided order, stability, and predictability to what otherwise could have produced international anarchy.

Challenges to Sovereignty

Yet, absolutist conceptions of sovereignty are not unchallenged. While national sovereignty locates the State as the ultimate seat of power and authority, unconstrained by internal or external checks, constitutional sovereignty holds that the power and authority of the State are not absolute but contingent and constrained. Domestically, power sharing between the executive, legislature, and judiciary, at federal and provincial levels, is regulated by constitutional arrangements and practices. Internationally, States are constrained by globally legitimated institutions and practices.

The international order is based on a system of sovereign States and acts as a means of organising the world in order to discharge the State's responsibility to protect the lives, livelihoods, well-being and freedoms of their people. The steady erosion of the principle of sovereignty is associated with neoliberal views on the reality of global interdependence. In a globalising seamless world, political frontiers became less salient both for international organisations, whose rights and duties can intrude inside national borders, and for Member States, whose responsibilities within borders can be held to international normative benchmarks and external scrutiny.

A second set of challenges comes from the apparent inability of some States to maintain the internal order that is central to sovereignty. Westphalian sovereignty was predicated on the effective control of territory. International law recognises States and governments on the basis of who exercises effective political control over discrete territories. However, the objective disconnect between the legal fiction of effective control and the empirical reality of fragmented power structures means that the substantive reality is one of quasi-sovereignty. State failure and breakup may mean the end of viable central public authority and control so that the rights of citizens cannot be upheld and inter-State relationships cannot be meaningfully pursued.

State sovereignty is also challenged by the realities of the twenty-first century, in which there has been a rise and recognition of new actors playing significant roles and wielding considerable power. These include transnational corporations, regional and global international organisations and agencies, and even powerful and mega-wealthy individuals.

Another set of challenges lies in the formal end of professed indifference to the internal governance of other States and attempts to formulate norms for internal governance that are intended to be internationally scrutinised and enforced. There were increasing attempts to generate formal mechanisms for protecting human rights, from the UN Human Rights Council to the European Court of Human Rights which can give binding orders to sovereign States. As well, aid and trade can be tied to what is considered to be acceptable internal behaviour of States on human rights, gender equality, and climate sustainability goals.

A further set of challenges arises because many issues cannot be dealt with within traditional boundaries, for example environmental and health problems. The most pervasive set of challenges arises from the movement of people, ideas, and goods. International communications crosses borders while commerce is boundary-less. Moreover, the lucrative businesses of the illicit trade in drugs and human smuggling have grown exponentially as examples of the dark side of globalization. Transnational criminals use weak or failed States as bases and safe havens as well as sources to fund their operations.

Accordingly, the sovereignty recognised by the United Nations is far from being absolute, and instead has generally been considered to be contingent. The more significant change in recent times is that it has been reconceived as being instrumental. Its validation rests not in a mystical reification of the State, but in its utility as a tool for the State serving the interests of citizens, or in some cases wider geopolitical interests. Internal forms and precepts of governance are expected to conform to international norms and standards of State conduct.

Multilateral Curtailments of State Sovereignty

Sovereign statehood remains the defining attribute of the international system. The international system rests upon a network of regimes, treaties, international organisations, and shared practices that embody common expectations, reciprocity, and equivalence of benefits. As is often noted in the literature on globalisation, their combined effect has been to

circumscribe States from exercising many practical aspects of national sovereignty. The legalist model of international politics – premised on the primacy of sovereign autonomy and equality, noninterference, and the low relevance of domestic forms of government – is demonstrably out of touch with reality in a number of respects. In the Westphalian model of international relations States are the principal actors, and the preservation of independence and territorial integrity, along with the prevention of aggression, are the primary objectives. However, this construct has conceptual and practical limitations. States are not necessarily all viable. Weak capacity and institutional fragility afflict many States. State incapacity is an underlying source of a wide range of pressing problems. Many threats to national and international security today are rooted, not in conquering States in the Westphalian paradigm, but in failing States from the preWestphalian world.

Legal sovereignty notwithstanding, all states face mutual vulnerabilities arising from intensifying interdependence. Even the most powerful States cannot achieve security, environmental safety, and economic prosperity as effectively in isolation or unilaterally. Areas such as maintaining and promoting international peace and security, economic development and international trade, human rights, functional and technical cooperation, and the protection of the environment require joint action to reduce costs and to bring order and regularity to international relations. Such common problems cannot be addressed unilaterally with optimum effectiveness.

The International Order Rests on Global Governance without World Government

Multilateral solutions beyond State borders are necessary in what the late Secretary-General Kofi Annan called "an age of problems without passports" in a speech to African-American civil society leaders on 7 October 2003. Global governance is not synonymous with world government. There is no world government: Secretary-General Guterres is not the world's president, the General Assembly is not the world's parliament, the Security Council is not the world's political executive, and the UN Secretariat is not the world's administration. Instead, global governance refers to the workings of the international system of authoritative rules, norms, institutions, and practices for managing world affairs. The organising principle of global governance, including the multilateral system of mandated international organisations, is State sovereignty, which is the exact antithesis of world government. Consequently, global governance never has and never can fully escape the tension between the need and demands for the internationalisation of rules, on the one hand, and the powerful push to retain national control, on the other. To date, reconciliation between the two competing pressures on instruments of global governance has proven elusive.

The UN system lies at the centre of the Westphalian system of global governance and multilateral order. This has two core features.

First, it was created and still functions essentially as a State-centric system: an organisation of, by, and for Member States. The only international public interest that commands authority and legitimacy is the accommodations among the Member States pursuing their individual national interests. They are the sole decision-makers, rule enforcers, and also the only subjects and primary objects of international decisions. Individuals, corporations, and armed militias become the objects of international bodies only through the prism of States.

Second, the Westphalian order comprises territorially demarcated political, economic, and social units as they engage in international transactions. International rules, institutions, and practices developed both to promote collaboration among State actors and to reduce frictions and mute conflict where their interests clash. This is the template enshrined in the 1945 UN Charter that pervades the entire UN system. Article 2.7 explicitly proscribed the United Nations from intervening "*in matters which are essentially within the domestic jurisdiction of any State*".

Under the impetus of globalisation, however, the machinery of global governance slowly rebalanced the Charter division of authority and jurisdiction between States and international organisations. This happened not through any formal denunciation of the Article 2.7 stipulation, but by stretching the boundaries of State sovereignty to accommodate the emerging new issues like weapons of mass destruction, environmental threats, international terrorism, and infectious killer diseases that were global in origins, reach, and impacts and required multilateral collaboration for resolution.

Consequently, even while still firmly anchored in a system of States, international forums and sites became the primary vehicles for setting global agendas, framing global issues, and adopting international standards. To accomplish these tasks, they often prescribed requirements for international permission structures, monitoring, and reporting. Moreover, in order to drive the

processes of global governance there has emerged a cadre of professional and managerial elites who run the national public sector and international secretariats. There was a parallel proliferation in the number and types of actors playing some role in the implementation, delivery, and monitoring of these globally-driven norms and efforts. Major NGOs and civil society actors such as Amnesty International, Human Rights Watch, the International Committee of the Red Cross, Greenpeace, and Transparency International have proven worthy competitors to the UN's human rights mechanisms, while actors like Doctors Beyond Borders and many others have challenged the epistemic authority and practice of the WHO. As a result, over the decades since 1945 when the UN was established and the liberal international order came into being, the thin overlay of global governance was spread on the dense web of interstate interactions. Geopolitical changes, gaps in and failures of global governance, and a newly conscious assertion of identity politics have begun to reinfuse statism into the liberal internationalist web of global governance. In terms of an IHO, this resurgent anti-globalism in combination with the experience of Covid-19 has placed the saliency of global health governance and WHO directly in its crosshairs (See Policy Report).

III.4.4. Compliance and enforcement

Compliance Pull

Norms can be understood differently by scholars of international law and international relations. Legal norms impose binding legal obligations. Political norms create moral obligations. The latter can still be encased in a wider legal context and have legal effects. In regulating State conduct, both laws and norms serve enabling (licence) and restraining (leash) functions. The history of human rights movements (suffrage, anti-slavery, anti-colonialism, anti-apartheid) shows that while social movements are motivated to enact moral norms into law, the moral authority of the norms by themselves exert a powerful 'compliance pull'. In general, legal norms are more effective in regulating State behaviour. But in specific instances, a particular law may be breached while a political norm shapes a decision – on an act of commission or omission – through a calculation of reputational costs. The State weighs the costs of breaching the law against the advantages it expects from doing so.

On mass atrocity crimes, for example, the 1948 Genocide Convention imposes legal obligations on States to act. By contrast, the 2005 Responsibility to Protect (R2P) is a global political norm that creates a moral responsibility but no legal duty on outside States to prevent and halt atrocities. However, even R2P must be interpreted and applied in the broader context of binding obligations on States under national, international, humanitarian, and human rights laws. For great powers in particular, R2P makes it more costly, on one hand, to resort to self-interested unilateral interventions, including so-called 'humanitarian interventions' as Russia discovered in South Ossetia in 2008. On the other hand, it also makes it more costly to resist disinterested UN-authorised calls to collective action to save strangers from mass atrocities. In 2011, for example, the power of the R2P norm overcame China's and Russia's instinctive opposition, and they abstained rather than veto Security Council Resolution 1973 that authorised a human protection intervention in Libya. But the stealth transformation of the NATO-led operation from civilian protection into regime change provoked a backlash that allowed the two powers to veto subsequent efforts to manage the unfolding humanitarian crisis in Syria.

The nuclear ban treaty (The Treaty on the Prohibition of Nuclear Weapons, 2017) is legally binding, but only for signatories. The Preamble notes that it is based on the "*principles and rules of international humanitarian law*" including the distinction between civilians and combatants, proportionality, and the prevention of unnecessary suffering. It is not relevant to jus ad bellum – the law of going to war – but it aims to apply to *jus in bello*, how a war is conducted. Of course it may not impose binding legal obligations on non-parties such as the nuclear-armed States and their allies, as per the Vienna Convention on the Law of Treaties (1969), but it does have legal implications for them. By changing the prevailing normative structure, the ban treaty shifts the balance of costs and benefits of possession, deterrence doctrines, and deployment practices, and will create a deepening crisis of legitimacy. It removes the NPT-rooted fig leaf of international legitimacy that the five formal nuclear weapons States have used to cloak their nuclear weapons, while insisting that the pursuit of nuclear weapons by anyone else is both illegal (a violation of the international law of treaties) and illegitimate (a violation of the global norm).

In a matching vein, the pandemic accords' legal effect will lie in strengthening the Pandemic Agreement and One Health as global norms. In combination with the amended International Health Regulations (IHR) that came into force in July 2025 for most States unless they had opted out, and which must and will be read in parallel with the Pandemic Agreement, the political reality is that Member

States will be enmeshed into the international pandemic management framework led by international technocrats. But the latter lack the legitimacy of democratically elected political leaders, are not in practice accountable, and have been given this enhanced directive role without meaningful parliamentary scrutiny and public debate by citizens (Section IV.3.3).

Furthermore, nothing in the Covid-19 experience inspires confidence about the willingness and capacity of political leaders to resist or use for political expediency WHO recommendations in this global institutional milieu (as discussed further in Section II.3.7). Rather, a de facto realignment of chairs at the decision-making table will see the experts take up positions at the head of the table instead of merely being present at the table (or along the walls at the back of the room) to aid and advise. This is why the pandemic accords are the latest waystations on the journey to an international administrative state that consolidates what Garrett Brown, David Bell, Jean Von Agris, and Blagovesta Tacheva call the globe-spanning 'new pandemic industry'.

Of course, WHO recommendations are not legally binding obligations on treaty signatories. In addition, the Pandemic Agreement explicitly states that nothing in it gives the WHO or the DG "*any authority to direct, order, alter, or otherwise prescribe*" any policy; "*or to mandate or…impose any requirements*" that states parties "*take specific actions*" like travel bans, vaccination mandates, or lockdowns. However, the very first function of the WHO is described in its constitution as "*to act as the directing and coordinating authority on international health work*". The Pandemic Agreement's preamble recognises that the WHO "*is the directing and coordinating authority on international health work, including on pandemic prevention, preparedness and response*".

In sum, the genuflection to national sovereignty is formal and abstract. The encroachments on sovereignty are real and concrete. The normative structure created by the amended IHR and Pandemic Agreement will be nearly impossible to resist for most States parties. They could also exercise a powerful compliance pull on non-States parties. Thus, national bureaucrats, nongovernmental experts, and international officials will be able to draw on the authority of the pandemic accords to reinforce their technocratic legitimacy.

III.4.5. Relationship with Private Entities

The broad range of private actors, NGOs and international agencies influencing or dependent on the global health ecosystem is outlined in Section II.3.4. The hypothetical IHO discussed in this report, and WHO as its current incarnation, must work within this complex environment, but stand as a quite different entity. As an intergovernmental agency tasked with fostering cooperation and facilitating technical support strictly on request of a State, it cannot primarily be an implementer, which would put it in positions of subverting the State whose capacity it is supposed to build, and raises issues of decision-making and partnering with external entities that inevitably remove independence. Implications of this regarding WHO are discussed in Section IV.3.1, IV.4.3.

Rather, an IHO based on the principles discussed in Section II.1.2 has a role to provide leadership in international policy development and standard setting as a representative of States and their people. To achieve this, it must be seen clearly to avoid conflict of interest – treading a line between cooperation with other agencies while avoiding being influenced by them beyond the requirements of the States Parties to which it is accountable. International NGOs are generally based in high-income countries and must reflect the priorities of their donors, while an IHO must, if it is to serve all countries rather than States or external entities with the greatest wealth, be divorced from such influence. As noted in Section IV.6.2, this is not currently the case with WHO.

The model of Public-Private Partnerships (PPPs) and its inherent risks is discussed in Section II.3.4. They tend to have State support but from a limited number of States, while also including direct private sector influence on their policies and operations. An IHO must deal with them as it will operate in an environment in which much of its work will overlap with PPPs such as Gavi, Unitaid and CEPI (see Section II.3.4). However, being based on the principles derived from individual sovereignty and subsidiarity in decision-making, an IHO cannot be significantly influenced by a PPP. A danger if the IHO accepts private specified funding, as WHO currently does, is that it essentially becomes a PPP itself.

In dealing with external actors, an IHO in the form envisioned here must therefore remain strictly independent and act as a standard-setter and provider of technical guidance to countries in which other entities are working. Centralisation and co-habitation, which seem convenient to the workforces involved, will work against such independence. Co-habitation with the countries the IHO is intended to serve, through subsidiarity and geographic inclusion, will promote this model.

III.5. GOALS AND STRATEGY OF AN IHO

III.5.1. Mission

The Preamble of the 1946 WHO constitution states:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"*.

As stated earlier, this is unattainable, unless taken in the context of it being an ideal condition, given competing economic and social priorities and, most importantly, the desire of an individual to do what promotes good health in themselves. Within this context, it establishes a firm basis for an IHO's mission. For a supra-national organisation working within the principles of national sovereignty and public health ethics, this means aiming to address this through support of, and on request of, the governance structures established to enable expression of individual sovereignty – i.e. nation-States.

This implies that an IHO cannot aim to dictate, but only to suggest or recommend. To achieve this effectively, its mission must be to acquire and maintain a level of knowledge and expertise higher than individual States can commonly or proactively maintain, and make this available as technical support or recommendation for action.

An IHO tasked with being the primary body in international public health, such as the WHO within the UN system, should therefore maintain data collation, normative and, potentially, research functions, or access such capacity efficiently through Member States. As a body derived from all countries with subsidiarity built into it, the recommendations of the Paris Declaration on Aid Effectiveness should not have to be restated, and as such an understanding is built into an IHO's mission and thus supports capacity development to reduce dependency intrinsic to its mission.

What should an international organisation on health aim for?

As introduced in Part I, there are several theoretical justifications for public health interventions. This is also the case at the global level. Based on the theoretical explanations provided in Part I, we foresee several roles for an IHO. Intervention from an IHO is justified to: (i) invest in – and ensure fair distribution of – global public goods (also called 'common goods for health'); (ii) to ensure transparency and to correct market dysfunctions and information asymmetries; (iii) to encourage the production or consumption of those goods and services creating positive externalities at the international level – and to limit the production or consumption of those goods and services creating negative externalities at the international level; and (iv) more generally, to promote equity and social justice.

As a policy instrument, the following tools can be envisaged:

- Negotiating international regulations (e.g. IHR, tobacco control treaty).

- Delivering and controlling international permits and accreditation (e.g. accredited laboratories).

- Setting norms – not necessarily 'one-size-fits-all' rules, but guidance.

- Management and distribution of international subsidies.

- Support development and provision of public goods, for instance, through research, knowledge management and translation (e.g. managing global databases on health and health system statistics), conceptual and normative work on health systems and health services, evaluation and capitalisation of experience, and public information – including through hosting global alliances such as Global Alliance for Health Policy & System Research, UHC2030, etc.

- In-country technical support for policy analysis, elaboration, implementation, monitoring and evaluation – ensuring that vulnerable and marginalised populations are included.

- In aid-dependent countries, an IHO should be in the best position to pilot donor coordination in the health sector, in order to reduce fragmentation, ensure alignment with national policies and ensure that donor – including GHIs – funding largely contributes to health system strengthening. Moreover, in complex emergencies where governance has disintegrated, an IHO may be in a good position to support health protection for the most vulnerable as an interim measure, to avoid "*malignity in policymaking*".

In particular, a huge market failure in the health sector lies in the oligopoly situation of large pharmaceutical companies (known as 'Big Pharma'). It has been advocated for long that it would be necessary to publicly fund and conduct medical research in order to correct the distorted market and ensure equity.

By contrast, an IHO's role should not be to manage specific donor programmes as their implementing agent.

III.5.2. Learning and innovation

Adaptive and effective organisations require an ability to learn, innovate and alter internal processes and policy. According to management studies research, doing so results in more efficient and effective outcomes as well as a more positive internal culture with the ability to sustain performance.396 In terms of an ideal IHO, it is possible to identify several elements that would benefit the organisation and its ability to meet its remit while adapting to new circumstances. Although recognised as a more difficult condition to sustain within public sector institutions than in private enterprise, these elements are nevertheless held as important components in most institutional settings.

- **Stakeholder-centric design.** An ideal IHO is built around stakeholder needs, in this case, the needs of Member States. Policy is co-designed with, and reflects, the needs and priorities of Member States rather than internal administrative convenience or funder preferences. (see The Right to Health Sovereignty - Policy Report for further discussion).

- **Agile and adaptive culture.** The internal culture seeks to be agile and responsive to adaptation rather than beholden to rigid structures and long-term strategies, which may no longer reflect empirical conditions or be able to produce reasonable results.

- **Radical Transparency.** Research on innovation and organisational learning suggests that "radical transparency" both vertically and horizontally is crucial for institutional learning, problem solving, policy legitimation, and the vetting out of poor constructs.398 Radical transparency seeks to increase access to information, reason-giving, and accountability claims, rendering them as open as possible to dialogue and potential contestation toward constructive and adaptive resolution. Processes of radical transparency are also linked to better scientific innovation and reliability.

- **Constructive dissent and the acknowledgement of failure.** Institutional learning and innovation require sufficient levels of "constructive dissent" and communicative action within a positive internal culture. This requires a culture that promotes alternative approaches without explicit and implicit forms of suppression. Moreover, it requires a willingness to embrace failure as an institutional learning opportunity versus something that needs to be politically managed. Embracing failure as a recognised element of reflective policy making can increase institutional trust, legitimacy, and long-term stakeholder buy in.

- **Intolerance for incompetence.** Although the recognition and acceptance of failure is an important aspect of institutional learning and reflective policymaking, this is not to be conflated with incompetence. An ideal IHO must operate in good faith, aware of its shortcomings and failures while demonstrating high levels of competence. Areas of incompetence must be addressed as a priority of improved performance.

- **Deconstructing siloes.** Departmental fiefdoms and structural rigidities hamper collaboration, institutional learning, innovation and policy effectiveness.

- **Decentralised decision making and subsidiarity.** A reported aspect of an innovation culture is the existence of more decentralised decision making with appropriate levels of subsidiarity to assure that decisions are taken at the lowest possible level and closest to where they will have their effects. Although a degree of overarching standardisation and quality control are necessary structural elements for an organisation to properly function, overly top-down bureaucracies with rigid hierarchical structures are noted as often lacking adaptivity, efficiency, effectiveness, and equity. They are also noted for creating poor internal cultures.

- **Risk-awareness versus risk-aversion.** Innovative institutions are risk-aware without being risk-averse. An ideal IHO would strike a necessary balance between understanding relative risks while also pursuing ambitious policies or defending trusted policies. Although a level of political manoeuvring is a natural part of any international organisation, institutional self-promotion at any cost, despite its performance or policy appropriateness will result in

institutional inertia, compromised policies, distrust, and long-term ineffectiveness.

- **Evidence driven decision-making.** Knowledge is constantly evolving with new social and scientific discoveries continuing to bring new insights for health. New knowledge is key for the creation of 'best fit' policy making based on the latest and best evidence available. This requires invention as well as the testing of embedded paradigms. A key requirement is therefore open communication, a commitment to scientific inquiry, and practiced humility.

- **Multi-perspective staffing.** A key element of innovative cultures is collaboration between multiple perspectives and approaches within an open and communicative environment. Staffing practices based on political patronage or ideological fit can undermine institutional performance, producing sub-optimal results.

- **Leadership by example.** An important aspect of institutional learning is the ability of leadership to lead by example embracing practices of open communication, selfreflection, adaptation and innovation as outlined above. Leading by example includes actively removing administrative barriers and letting experts and stakeholders "help to lead from below".

III.6. STRUCTURE AND PERFORMANCE

III.6.1. Organization

International organizations were established in the nineteenth century in order to conduct international relations. They have quickly evolved from an ad hoc convening, such as after war events or in response to specific disease outbreaks (see Section II.2,1-4, and discussions in The Right to Health Sovereignty Policy Report), to a more permanent status through their specific mandates. The late twentieth and twenty-first centuries was characterised by a proliferation of international organisations in almost every sector. They were either established by and within governments (intergovernmental organisations) or through associations of entirely or predominantly private entities operating in more than one country (international NGOs, international public corporations). Whatever the form, their role has greatly increased in developing international law, fostering cooperation and resolving disputes among nations.

The UN system recognised the importance of international organisations by mandating the International Law Commission to develop governing rules, which resulted in the 2011 International Law Commission's Draft Articles on the Responsibility of International Organizations. The Draft Article 2 of the text proposes the following definition:

> *"International organization refers to an organization established by a treaty or other instrument governed by international law and possessing its own international legal personality".*

Since an IHO would operate on trans-border public health issues, its organisational format would involve dialogue among governments, with voting powers deemed acceptable to the first members. Generally, members of intergovernmental bodies have equal voting powers (one member - one vote), but there are notable exceptions like the UN Security Council and the International Monetary Fund.

Sponsoring States must then decide and codify, in the organisation's constituent treaty, the most suitable type of organisation of the IHO through the type of membership (open, closed, States, other international organisations), member's privileges and duties, and how the organisation is best structured to perform its mandate, in accordance with the principles and available resources. The following sections will discuss the principles on which this structure must be based.

Underlying institutional principles

Institutional principles refer to the set of formal and informal rules shaping the behaviour and relationships between groups and individuals within an organisation (see Section II.1.2) as well as with external constituencies. Whereas organisations are comprised of individuals who each have their own competences and interests, it is essential that organisations, through their institutions, ensure congruence between these individual competences and interests on one hand, and organisational needs and goals on the other.

The institutions ruling an ideal IHO should ensure:

- Clear definition of organisational goals – even if they are multiple, as is necessarily the case in health.

- Adaptation to “clients' needs” through the principle of subsidiarity.

- Clear definition of roles and responsibilities of departments and individuals within the organisation, avoiding duplications.

- Clear lines of accountability both within the organization and towards external constituencies.

- Appropriate competences to fulfil the organisation's mission.

- Alignment of members' values and interests with the organisation's values and interests.

- Appropriate staff motivation – through a coherent motivational system comprising both positive incentives and sanctions.

Bureaucracy

As explained in Part I, bureaucracy is a way of running an organisation based on rules and hierarchy. It aims to be rational, effective and efficient, yet in practice, it faces several risks among which are being too rigid to adapt to changing environments and priorities, to stifle creativity, to become oppressive (following rules strictly instead of “the spirit of the rules”), to be “hijacked” by individuals exploiting “zones of uncertainty” for their own interests, and to become too complex and controlling, resulting in a loss of efficiency (Section III.5.2).

While a certain degree of bureaucracy is inherent to any large organisation – even an ideal IHO – some safeguards should be designed to ensure the risks pointed out above are avoided. In particular, radical transparency on decision-making processes, individual accountability and democratic control should be enforced.

Institutional implementation

A first essential step in designing an ideal IHO's institutions is to clearly define its roles, mandate and functions, including the level where each of these shall be performed (global, regional and in-country), to respect the principle of subsidiarity.

Main functions should be performed as follows:

Global level:

o Conceptual work on health systems and health system performance o Knowledge management (including global health statistics databases)

o Policy dialogue between all Member States on health priorities and needs in terms of global public goods o Overall accountability of the IHO towards its Member States o Management and distribution of international subsidies o Sharing and capitalisation of experience between regions

o Public information on worldwide health priorities (including through hosting global alliances such as Global Alliance for Health Policy & System Research, UHC2030, etc.)

Regional level:

o Negotiating regional regulations

o Delivering and controlling international permits and accreditation (e.g. accredited laboratories) o Setting norms (guidelines) o Evaluation (action-research) and capitalisation of experience at regional level o Public information

o Maintaining up-to-date competences of a pool of expertise

In-country:

o Technical support for policy analysis, implementation, monitoring and evaluation.

In aid-dependent countries, an IHO should oversee donor coordination in the health sector and support to health system strengthening.

Financing

An IHO's effectiveness is dependent on its ability to plan, while its responsiveness and consistency to mission is reliant on its freedom to operate with integrity in this regard independent of its sources of funding. It is critical to the rules and constitution on which the IHO is based, whilst transparency of this area is critical to ensuring it is held accountable. An IHO would ideally operate under the following financial conditions:

- Have reliable financing that is sufficient to allow the organisation to fulfil its mission and corresponding remit set by its Member States.

- Have reliable financing that allows the organisation to fulfil the whole of its remit effectively.

- Have reliable financing that allows the organisation to engage in long-term strategic planning in concert with, and directed by, its Member States.

- Have reliable financing that allows the organisation to have significant discretion in how money is allocated and budgeted.

- Have robust accounting mechanisms to assure financial contributions are used appropriately and deliver value for money.

- Have robust transparency mechanisms to assure that the sources of all financial contributions are made publicly available and are free from conflicts of interest.

- Have robust transparency mechanisms to track how budget allocations were made and by whom.

- Have robust oversight and independent evaluative procedures to assure that its budget and financial allocations reflect the policy parameters set by its Member States.

III.6.2. Workforce

As an organisation whose mission is to support countries rather than its own enhancement, and working as an organ jointly owned by sovereign States as the WHO does within the UN system (see The Right to health Sovereignty Policy Report), an IHO has workforce requirements very different to a private organisation, health sector NGO or multilateral development bank (MDB). Loyalty of its workforce must be to its mission (Section III.4.1) rather than to its institution or even leader (as is somewhat unclear within the WHO – Section IV.3.1).

This requirement is unusual to many workforces, and not simple to implement. For an IHO to function, it requires a common way of working, hierarchy of power and accountability, as well as sufficient internal flexibility to enable staff recruited with specific expertise to have an impact on its direction, within the parameters that its governing body (the WHA in the case of WHO) allows. However, it must be structured to avoid the intrinsic problem of bureaucracies becoming entrenched and an end unto themselves. To enable subsidiarity to function, staff must also be connected sufficiently with the States that the IHO is requested to assist.

A private company will commonly prioritise staff retention, and encourage a work environment and benefits that make it more attractive than rivals. To an IHO, long-term staff retention should not be a priority if it aims to provide state-of-art support to Member States (see Section IV.6.3). Competing against advantages of retained knowledge through staff retention are:

1. The need to ensure technically current expertise within a rapidly changing field

2. The imperative to understand the diversity and cultures of countries requesting support

3. The need to avoid the development of a culture of loyalty to institution over mission (Section III.3.3).

While some requirements for efficient liaison with other agencies (e.g. of the UN) may require an office located where such organisations are based (commonly near the UN headquarters in New York or its Geneva offices), efficient and effective support of Member States requires colocation or proximity to where most work is required to be performed. Other priorities such as data collation do not require centralised locations in the era of modern communications – the new WHO Hub for Pandemic and Epidemic Intelligence, as an example, is in Berlin, Germany, and could equally be in Asia or Africa (barring, perhaps, commercial or political incentives).

Because much of an IHO's work is by necessity in LMICs, location of the bulk of its workforce in these locations as a decentralised structure would facilitate effective collaboration and ensure relevant States have strong opportunity for input. It would also work towards reducing incentives to staff retention based on the attractiveness of high salaries in high income countries such as Switzerland, which work against a good understanding of LMIC needs and cultures while encouraging efforts to maximise length of time at the same location. There is an inevitable tension in recruitment between ensuring a high level of technical expertise that can be offered as a service to countries, and a high level of cultural and contextual understanding that allows such expertise to be effectively shared. Local

context needs to enter central policy-making, and policies developed centrally need to be shaped to address local context.

A further fundamental expectation of a successful IHO should be to reduce the requirement for capacity building as economies, technical skills and technology progress, and infectious disease continues to decline (Section II.3.6). This implies that staff have a role, at least in large sections of a current IHO, to develop their own redundancy. This is difficult to achieve, as staff develop dependency on benefits such as education allowances and healthcare support, if provided in common with current UN agencies. It can, however, be built into contracts as term limits and, potentially, performance incentives to achieve clear objectives of raising country capacity.

In summary, an IHO workforce will clearly depend on how the organisation's mission is defined, but in general, will require:

- Term limits and staff rotation
- Diversity of background with relevance to geography and cultures of work required
- High and current technical expertise
- Independence from influence of external entities and individual States.

Section IV.6.3 discusses these requirements in the context of WHO.

PART IV:

THE WORLD HEALTH ORGANIZATION

PART IV
The World Health Organization

Part III of this report outlined the normative and institutional principles that should underwrite an IHO. Here, in Part IV, the report will now compare existing WHO practice against those standards to identify gaps and required areas for reform and improvement. The analysis is informed by a series of rapid scoping reviews within each of the categories, surveying both primary and secondary sources as well as grey literatures. It is from this analysis that recommendations and discussions about reforming or replacing the WHO will be presented in Part V.

IV.1. SOME COMMON THEMES ASSOCIATED WITH THE LITERATURE ON WHO REFORM

The 2022 review by Moser and Bump identified several key issues involving WHO operations and reform within the existing academic literature. This IHRP report has found similar results and thus explores many of these themes in detail within the subsequent sections below. Yet, it is also useful to outline some of the key findings from the Moser and Bump review, since these compliment the findings of this report and illustrate a level of consensus within the literature.

The review by Moser and Bump found several themes requiring WHO reform:

- Disjointed and ad hoc strategic vision based on donor preference or current interest.
- Overstretched programmes of activities that are "too numerous, too large, or too diffuse".
- Numerous problems with how WHO is financed and how financing can shift priorities and global health policy.
- Poor compliance from Member States effecting implementation of WHO strategy (circumvented by poor resourcing or short-termism from implementing agents including Member States).
- A lack of clear frameworks for facilitating cooperation between actors.
- Internal WHO budget competition, jurisdictional turf wars, and undermined transdisciplinarity (lack of joined up thinking).
- Poor staffing based on budget fragmentation and/or political processes favouring inclusivity versus competence.
- Competitive environment between WHO Headquarters and Regional Offices resulting in diminished cooperation and lower morale.
- WHO tendency to stray from its technical assistance / expertise role.
- WHO authority undermined by Member State consent / voluntary compliance.
- A lack of enforcement mechanisms and a reliance on soft-power / naming and shaming.
- Increasing external competition from global health initiatives (GHIs), most notably GFATM and GAVI.
- A loss of epistemic and practical authority resulting in a shift to other non-governmental agencies to fill perceived WHO failures (e.g. Doctors Without Borders during Ebola 2014).
- Distrustful working conditions between WHO, major GHIs and local actors.
- Unequal influence of certain Member States within WHO processes, including within the WHA and Executive Board.
- Poor inclusivity of LMICs to affect WHO policy.
- An overwhelming WHA in which low resource countries are unable to equally participate.
- An WHO Executive Board that lacks accountability for its decisions.
- A lack of regular and independent evaluations.
- Claims that WHO obscures evidence that counters the policy directives of powerful Member

States and donors.

- A weak operational commitment to its purported rights-based approach.

- Inconsistent application of transparency regulations.

These themes are examined more thoroughly below. Yet the 2022 review by Moser and Bump draws a crucial conclusion from its analysis, which deserves to be quoted in its entirety:

> *"WHO's goals and strategies were unclear and in dispute. Its legitimacy and governance were found lacking. Its authority and relationships appeared to be weak and susceptible to non-democratic interference. The structure and performance of WHO seemed to be antagonistic to its mission and its workforce appeared to be overly specialized and inadequately adaptable. Weaknesses in all these areas underpin questions of identity, which appears to be compromised by disagreements over norms and values, unresolved cultural differences, and various inconsistencies".*

We will now examine many of these and other themes more fully.

IV.2. IDENTITY

IV.2.1. Is the WHO promoting international public health?

As explained in Section II.1.4, health is a complex system and healthcare systems contribute only to a minimum extent to health outcomes, among numerous socio-economic and environmental factors. Furthermore, real-life contexts are characterised by a multitude of concurrent interventions and the absence of "virgin areas" that could be used as control groups.

Therefore, it is extremely difficult – if not impossible – to attribute observed results to a particular health intervention. Existing tools can compare the effectiveness of very specific interventions, but cannot sufficiently measure the benefits of health system strengthening interventions and health system reforms. Finally, except for a very limited number of binding treaties and regulations, none of WHO's outputs are directly applicable in countries; however influential WHO guidelines and experts may be, implementation is always done under the responsibility of local governments. Therefore, it is theoretically impossible both to measure outcomes of WHO's work, and to attribute observed outcomes to WHO, through traditional evaluation approaches.

Nevertheless, the 14th General Programme of Work expects to measure WHO's results through outcome and impact indicators. This has been labelled by WHO as a results framework (Figure IV.1).

Figure IV.1 – 14th GPW's results framework
Source: World Health Organization, https://iris.who.int/server/api/core/bitstreams/46cc7cace35e-451b-808e-1f0e4ad5f68c/content

However, the framework fails to address obvious attribution issues. In fact, the only way through which WHO's results could be assessed is through theory-driven evaluation approaches, either based on theories of change or so-called realist (or realistic) evaluation.

Instead of attempting to attribute a result to an intervention, these approaches "open the black box" of complex interventions (understanding how programmes work, for whom, why, and in what circumstances) and to take context into account. Using such approaches requires strong evaluation capacities. That said, as developed below (Section IV.5), the evaluation culture and practice is still poorly developed at WHO.

Since only theory-driven evaluation approaches can reasonably be used to evaluate WHO's results, WHO will have to rely on theory of change methodologies to guide possible change pathways and to assess the range of effects any policy may have on public health practice in Member States. For instance, the 14th General Programme of Work (GPW) indicates that WHO's "change pathways" and general theory of change are linear and causal, but in reality they are too general to guide evaluation. As a result, its application serves merely as the first basis for elaborating a more detailed theory of change.

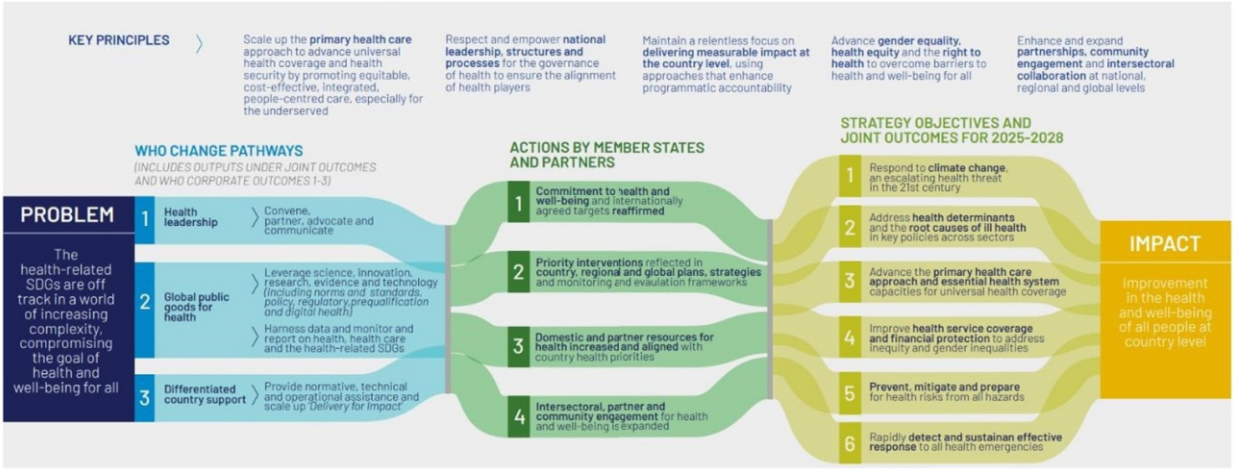

FigurE IV.2 – WHO Change pathways (according to GPW 14 pp. 44-45)
Source: World Health Organization, https://iris.who.int/server/api/core/bitstreams/46cc7cac-e35e-451b-808e-1f0e4ad5f68c/content

Another way of identifying plausible "change pathways" for actions taken to improve specific health system capacities through investments in essential public health functions and common goods for health, is through using the Health System Performance Assessment (HSPA) framework.

Lastly, another type of theory-driven evaluation is to be found in realist evaluation, which requires specific capacities in evaluation. This approach has notably been used by WHO and partners to evaluate the role of the Universal Health Coverage Partnership – a complex intervention, involving a multitude of actors, with diverse activities and outcomes – in strengthening policy dialogue for health planning and financing in a selection of beneficiary countries.

WHO and international legal norms

As an international organization, the WHO is bound chiefly by its constitution, customary international law and jus cogens norms, as well as other treaties it has concluded. Nevertheless, when it comes to treaties to which an international organization is not a party, that organisation does not have an obligation to implement them. For example, since the WHO is not a party to the ICESCR, it is not bound by the ICESCR. This principle would not however stop the WHO from using the contents generated by the Committee on the interpretation of the human right to health.

International organizations also generate laws through their workings. Hence, it is expected that the WHO respects its own treaties, regulations, rules and norms created by its bodies. This is the essence of the rule of law at the international level. It relies, however, on the willingness of organisations to maintain its obligations, since international law often lacks robust accountability and rule-of-law mechanisms.

An unfortunate recent example of WHO not adhering to its norms, and in the process putting less resourced States with smaller WHA delegations at a considerable disadvantage, was laid bare in recent negotiations on amendments to the IHR. In short, the WHO and the WHA failed to follow the rule of procedures prescribed in Article 55.2 of the IHR(2005), which required all draft amendments to be "communicated to all States Parties" at least four months before a WHA meeting. As Article 55outlines:

> *"Article 55 - Amendments (International Health Regulations)*
>
> *1. Amendments to these Regulations may be proposed by any State Party or by the Director-General. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.*
>
> *2. The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration".*

WHO regulations adopted under Article 21 of the Constitution have an extraordinary status: they "shall

come into force for all Members" after due notice is given and providing that Members did not exercise the ability to opt out within a timeline (Art. 22, WHO Constitution). In other words, the regulations are treaties without bearing that official name. As treaties, the final text should be normally discussed and approved by relevant ministries and national parliaments before national delegations commit. The public may have their say through consultations of civil groups and communications with their representations. The 4-month requirement of Article 55.2 should be understood according to this democratic principle.

The matter was discussed at the 5th WGIHR meeting in October 2022. During the public discussion, the WHO's Legal Officer stated that Article 55(2) would not apply to the WGIHR as a subdivision of the WHA, disregarding the fact that Article 55(2) didn't make such distinction, and that the WGIHR had initially intended to respect the Article by giving itself the January 2024 deadline. One Co-Chair of the WGIHR invoked a false precedent, stating that the negotiations of the previous package of amendments adopted in 2005 had continued until the morning of the 58th WHA session. But the 1969 version of the IHR, amended in 1973 and 1981, had not contained any such procedural provision on amendment submission. The 4-month requirement was only added to the 2005 version approved by the WHA at that meeting, and so became applicable after that time. It was therefore obvious that what happened in 2005 did not violate Article 55(2) since it did not exist.

Regrettably, the WGIHR decided that the specific procedural requirements of Article 55(2) were not to be respected and that negotiations had to continue up until May 2024 (the WHA), as noted in the meeting report.

> *5. The Co-Chairs noted that, in reference to decision WHA75(9) (2022), it appeared unlikely that the package of amendments would be ready by January 2024. In that regard, the Working Group agreed to continue its work between January and May 2024. The Director-General will submit to the Seventy-seventh World Health Assembly the package of amendments agreed to by the Working Group.*

To make the matter worse, the WHO claimed in Q&A that it had fulfilled the requirements of Article 55(2) by circulating a compilation of 308 proposed amendments in November 2022 – those that had been largely modified or deleted through multiple rounds of negotiations.

At the 77th WHA meeting (June 1, 2024), negotiations continued into in the late evening (with delegations due to leave Geneva a few hours later) until a consensus text was reached. The procedural requirements of Article 55.2 IHR were clearly and intentionally breached by the WHO as the meeting convener.

IV.2.2. WHO and public health ethics

In 2015, the WHO published 'Global Health Ethics: Key Issues', within which WHO includes medical ethics and public health ethics under 'health ethics', as it indicates that:

> *"Health ethics is the interdisciplinary field of study and practice that seeks specifically to understand the values undergirding decisions and actions in health care, health research and health policy, and to provide guidance for action when these values conflict".*

The risk of such an approach involves subjecting medical ethics to public health ethics by subordinating the principles of beneficence, non-maleficence, patient confidentiality and informed consent to 'the common good'.

Indeed, in *Global Health Ethics: Key Issues* WHO already seems to replace Patient Confidentiality with 'trust' when it lists non-maleficence, beneficence and 'trust' as "*fundamental ethical principles at the heart of clinical care*", and refers to "*privacy and confidentiality*" as "*other important ethical issues in clinical care*" (see Section II.1.2). Trust, in reality, is an outcome of the patient's perception of the doctor or wider health system, while patient confidentiality unequivocally focuses on the doctor's obligation to the patient. As such, 'trust' cannot possibly be a cardinal principle of medical ethics. Patient confidentiality has been acknowledged as a cardinal principle of medical ethics for over two millennia, and the WHO's disregard for this principle has concerning implications.

Subsequently, in 2023, the WHO published the *'WHO Code of Ethics'* – a document which lays out the conduct expected of WHO employees, consultants and others who work with the organisation. However, the code mainly addresses the issues that typically arise in large institutions, and emphasises the staff's obligation to be loyal to WHO. For example, under Independence and Impartiality, it states:

> *"We conduct ourselves with the interests of WHO only in view and under the sole authority of the Director-*

General. We exercise the utmost discretion in our actions, refrain from participating in any activity that is, or may be perceived to be, in conflict with the interests of WHO, or that might damage the reputation of the Organization…".

This, clearly, is not a focus on public health ethics, but it does raise interesting potential conflicts for WHO staff where they may perceive direction from the organisation as contrary to the requirements of their profession; i.e. public health ethics (See Section on Internal Culture).

In sum, it is most important to mitigate the effects of external influence and control on the basic rights of individuals to determine their own healthcare, as defined through the doctor(practitioner)-patient relationship, and on the rights of communities and populations through the extension of such principles to public health. Centralisation of medical care has been gaining momentum since the formation of professional bodies in the medical field in the nineteenth century, beginning with the inception of the British Medical Association (BMA) in 1832 and the American Medical Association (AMA) in 1847. This has extended with the development of modern public health and the formation of national and international institutions in this field. Such associations and institutions can promote respect for the rights of patients and populations by upholding the principles of human rights expressed in the Hippocratic Oath and subsequent codes and declarations. Yet they can also undermine these rights by abrogating the basic right of decision making invested in each person. Pressure to act in the latter manner rises when associations act as guilds to enhance income or form relationships with for-profit entities with conflict of interest in the field, or when public health institutions do the same or simply become absorbed in their own survival and enhancement over that of their mission. It thus becomes critical that a code of ethics and guiding principles are agreed, based on the fundamental rights of each person, that governs and restricts the potential for public health to become corrupted in such a way.

While the WHO began within an era of active rethinking of human rights and medical ethics in the years after the Second World War, there is little explicit expression of ethics within its constitution. As an agency of the UN, however, it is reasonably assumed that the major international human rights conventions discussed in Section II.2.1 apply to its work, alongside the normative understanding of individual sovereignty encompassed within the UDHR, together with codes directed to medicine and medical research (e.g. the Nuremberg Code and Helsinki Declaration).

The WHO has attempted to increase emphasis on ethics within the organisation's work, but these to date have been significantly Western-centric, and the ideals of inclusion and representation implied by the principle of public participation are currently largely neglected. For example, in 2009, the WHO formed the Global Network of WHO Collaborating Centres for Bioethics to support the WHO's Global Health Ethics Unit to implement its mandated work in the field of ethics and health. By 2015, the network had only six officially designated members, and all from the global North. The number rose to thirteen by the end of 2021. However, it was only in the period 2022-2023 that the Network expanded to include 14 collaborating centres across all six WHO regions (but still dominated by Western institutions), and yet the WHO expected all WHO Member States to take the recommendations of the Network seriously even when they were not represented in it.

Moreover, since 2020 WHO's ethics unit has arguably been quiet on issues such as the restrictions imposed on many populations as public health responses to Covid-19. Prolonged school and workplace closures promoting poverty are estimated to have placed millions of girls into child marriage, increased child labour, teenage pregnancies, and have reduced educational opportunities that will have intergenerational effects on poverty and correspondingly on future health. WHO was remarkably quiet on these issues, despite their direct impacts on WHO's core priorities and their concentration in lower-income, vulnerable populations as WHO had predicted in previous reports. Response harms remain unlisted in the activities of the WHO's Covid-19 ethics working group. Concentration has rather been on managing messaging and promoting the organization's public health positions through its Infodemic narrative. Lastly, an analysis by researchers at the University of Leeds suggests that this narrative regarding infodemics and its emphasis on mis- and disinformation lacks critical self-reflection about the role of public health authorities in promoting mis-and disinformation while also actively suppressing alternative forms of credible evidence. As the analysis argues, the WHO understands infodemics as a result of external actors, and not via public health authorities, which runs counter to experience during Covid-19, and thus undermines the WHO's own ethical emphasis on the need for accurate communication and trust.

These practical responses, or lack thereof, reflect the stance WHO has taken in its approach to the relative primacy of the individual, in which it appears to prioritise collective rights over those of the individual. In Guideline 12 of its 2017 Guidelines on Ethical Issues in Public Health Surveillance, the WHO declares:

> *"Individuals have an obligation to contribute to surveillance when reliable, valid, complete data sets are required and relevant protection is in place. Under these circumstances, informed consent is not ethically required".*

This guidance is critical as it denies the agency of the individual because it does not provide him/her with the opportunity to evaluate the credibility of the parameters that it lays down. This flaw is evident when, in its explanatory note to the Guideline, the WHO states:

> *"It is the obligation of the public health authorities accountable for surveillance to assess the importance and feasibility of seeking informed consent".*

To be sure, the explanatory note later states:

> *"Whether or not consent is sought, information about the nature and purpose of surveillance and about any risk for harm should be publicly accessible".*

There are situations where high-level de-identified data are required for decision making that are a clear public good, and would not reasonably be seen as impinging in individual rights. However, the default, based on the understanding of human rights and medical and public health ethics laid out in Part II.1.1, 1.2, clearly put the onus on public health authorities. The onus is to inform, and most importantly, not to require individual contribution if the basic assumption of individual sovereignty or bodily autonomy is to be upheld. Determining circumstances where data can appropriately be used is clearly a task to be determined near the impacted population rather than centrally, to ensure context and local norms and knowledge are taken into account. The WHO's apparent default to a collectivist approach, based on a centralised structure and a network dominated by Western institutions with little LMIC representation, appears a considerable drift from the principles on which the WHO was intended to be based.

WHO, health, and human rights

The concept of the right to health, as an important responsibility of countries and society within the context of rights considered non-derogable such as bodily autonomy, was discussed in Section II.1.1. These concepts are therefore fundamental to WHO's work and to implementation of WHO recommendations within a country context. As noted previously, the ICESCR clarified the meaning of the right to health through the CESCR General Comment No.14, commencing:

> *"The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, nonconsensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".* [Full comment in Section II.1.1].

Over the past two decades WHO has introduced a new term; a "human rights-based approach to health" that complicates this understanding somewhat and raises concerns regarding interpretation. It is important to understand the difference between the right to health and a human-rights based approach to health. WHO released "The human rights-based approach to Tuberculosis" in 2001, and later in 2008 WHO and OHCHR jointly published their factsheet "A Human Rights-Based Approach to Health"., WHO's website explains that this approach "*commits countries to develop rights-compliant, effective, gender transformative, integrated, accountable health systems and implement other public health measures that improve the underlying determinants of health, like access to water and sanitation*".

The quote above is not a legal concept but a programming principle intended to be used by UN country teams and offices to guide health policies, strategies and programs toward the realisation of other human rights related to the provision of healthcare. Together with an abundance of academic papers, multiple guidelines have been published as practical and operational guidance across the UN system, including the "Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity" (OHCHR, 2012), and "Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations" (WHO, 2014), "Healthy Food: A Human Rights-Based Approach" (PAHO/IRIS, 2022).

It is essential for policy-makers to have a broad goal and be aware of the interconnections of human rights, as WHO promotes. However, WHO's approach risks misinterpreting or even neglecting the human right to health itself. A human-rights-based approach can be about everything and anything, and should be applied with careful consideration. Overall, the implementing measures must be weighed against the right to health legally speaking and the respect of human dignity, and cannot over-ride the fundamental negative rights that underlie the interactions of an individual with society more broadly, or be used to shut down debate on alternate priorities to specific aspects of healthcare implementation. The promotion of certain recent Western cultural policies disguised under human-rights based approaches are stark examples. The WHO Standards for Sexuality Education in Europe states that "sexual education is based on a (sexual and reproductive) human rights approach" (p. 27). But this cannot universally justify the recommendation that "sexual education starts at birth" (p. 27) or the understanding that "a child is understood to be a sexual being from the beginning" (p. 34), and the recommendation that information on "early childhood masturbation" be given to babies and children aged 0-4 (p. 38). The standards do not necessarily align with international norms concerning children's rights (Convention on the Rights of the Child [CRC]) and broad cultural beliefs regarding "the best interests of the child" (Article 3.1, CRC), as well as "responsibilities, duties and responsibilities of parents" regarding guidance for their children (Article 5, CRC). These would raise difficult questions on whether an approach to young children as sexual beings is respectful to their human dignity, as a fundamental right.

The WHO 2022 Abortion Care Guidelines raise a similar example of the apparent selective use of human rights verbiage in WHO recommendations. The Guidelines choose to make abstraction of the foetus or unborn baby as "pregnancy tissue", while restricting the argument regarding rights to the pregnant woman only, thereby recommending policies for abortion without counselling until delivery and offering the possibility of over-riding the right of the healthcare provider to choose not to perform an abortion based on the basis of his/her conscience, culture or religion (see The Right to Health Sovereignty Policy Report, Part V.). This might fit the policies of some countries and cultures, but may be seen as inappropriate or immoral in others. As a result, interpretation based on such local context is not considered by WHO, but specific 'human rights' considerations invoked instead, contradicting the ICESCR and the WHO/OHCHR 2008 joint factsheet.

IV.2.3. WHO internal culture

Part III outlined eight baseline conditions necessary for maintaining a positive internal culture for an IHO. These included: 1. Trust and psychological safety; 2. Professional development; 3. Countering inertia; 4. Inclusiveness and belonging; 5. Tackling professional misconduct; 6. Appropriate capacities; 7. Stability, and 8. Workplace environment. When compared against the WHO several shortcomings can be identified in the literature on WHO. Each condition will be reviewed in turn:

- **Trust and psychological safety.** A rapid scoping review produced no studies demonstrating that WHO maintained policies that actively and systematically silenced internal dissent or retaliated against opposing views within the organisation. However, there were significant results suggesting that most United Nations organisations, including the WHO, were cultures where internal dissent was not welcomed, which often resulted in self-censorship, the suppression of criticism, and a lack of institutional learning. Although there are no official studies on 'constructive dissent' within WHO, there is sufficient anecdotal evidence to suggest that an implicit culture of selfcensorship and suppression exists. Notable manifestations include the avoidance to raise critical issues or to challenge policies out of fear that it will harm job security or promotion and/or fear that challenging existing paradigms will result in social exclusion, public 'cancelling', or job insecurity. For example, consistent messaging was encouraged by WHO leadership during Covid-19 with critical voices often feeling marginalised or unable to speak freely. A memo titled 'Reactive Q&A in Case of Media Questions', which was seen as an overly top-down mechanism to suppress critical viewpoints and opinions by WHO staff, was circulated, while a critical WHO report on Italy's pandemic preparation and response was removed by the WHO Assistant Director General Ranieri Guerra, who was a former high level official in the Italian Ministry of Health. These examples raise a level of reasonable concern about WHO internal culture and its ability to promote open dialogue and constructive dissent as a method to advance accountability, transparency, representation and institutional learning.

- **Professional Development.** A persistent criticism of WHO relates to claims of favouritism, political patronage and quota fulfilment with a reduced focus on technical expertise. This has been

noted to undermine morale and performance as well as the maintenance of appropriate WHO capacities. Further criticisms relate to a tendency in WHO to cut lower-level positions instead of freezing senior level hires or capping senior salaries, an issue exposed during recent restructuring following the US withdrawal. An over reliance on temporary staff and consultants has also been noted as "crowding out" career development opportunities for permanent staff.

- **Countering inertia.** Relatedly, WHO has received criticism for allowing role stagnation of personnel, which has been noted to undermine innovation and cross-learning opportunities within WHO. Additional claims of overly top-down structures and command and control management styles have been consistently made against WHO management.

- **Inclusiveness and belonging.** WHO maintains equality and inclusion policies consistent with the policies of the United Nations. Yet there are concerns that linguistic and geographic quotas undermine meritocracy and the appropriate assignment of expertise. As noted in The Right to Health Sovereignty Policy Report (Part II), as a UN organisation the WHO must balance its need for international representation with suitable expertise, a persistent challenge across all UN institutions.

- **Tackling professional misconduct.** The WHO has been embroiled in several scandals involving senior management, staff, consultants and during WHO missions. In this regard, the WHO has not performed better or worse than other UN institutions and most public and private organisations display shortcomings in this area. In the case of WHO, however, one particular concern involves the ability of political patronage and political power to influence internal and external investigations with WHO being criticised for trying to silence or sweep misconduct 'under the rug'. For example, WHO attempted to cover-up a large scandal of sexual misconduct by some of its staff in the Democratic Republic of Congo. It was only after significant pressure that the WHO launched an Independent Commission to review sexual abuse and exploitation during the response to the 10th Ebola virus disease epidemic in DRC.

- **Appropriate capacities.** An IHO needs to have the appropriate capacities required to fulfil its mandate. There are four issues arising within the literature on WHO. First, the WHO relies on a high number of consultants. According to one source, 'the number of WHO consultants has exploded, from an estimated 3200 full-time equivalent positions to approximately 7600 in July 2024 – approaching the number of regular WHO staff'. Although the use of consultants is often necessary to bring in expertise, concerns have been raised about their lack of accountability, unclarity about their financial cost, nondisclosure of costs, and conflict of interest.460 Second, as mentioned above, the WHO has often been criticised for prioritising quotas over expertise, raising concerns that WHO is not deploying the most suitable personnel in all cases. Third, there have been concerns raised that the WHO has "overstretched" its remit into an increasing number of policy areas. A result of this "mission creep" is an increased inability to address these policy areas appropriately, thus increasing a reliance on consultants, non-experts, and/or redeployed staff, reducing capacities elsewhere. Lastly, budgetary competition between an increasing number of departments has undermined coordination and cooperation.

- **Stability.** Recent cuts in WHO funding have exposed concerns about job security for lower-level staff and the potential to overuse consultants and temporary staff to reduce core budgets. Moreover, as discussed in Part IV.6.2, WHO's overdependence on voluntary contributions undermines its ability for long-term strategic planning. A byproduct of its financing is an unstable environment where departments cannot develop long-term plans and are subject to donor whims, while staff remain unsure of their future employment. This has been linked to retention and performance issues.

- **Workplace Environment.** A survey of the literature revealed that WHO suffers from "crippling" levels of bureaucracy within a rigid management hierarchy. Moreover, the literature suggests that tensions exist between WHO regional offices and WHO Geneva, often resulting in poor communication, delays, friction, and suboptimal performance.464 Further concerns arise with what is labelled the "Geneva bubble", in which policy decisions are made in the rarified environment of Switzerland and not "from the ground up". Lastly, the WHO has been criticised for poor communication between senior executives and WHO personnel, resulting in perceptions of an overly top-down command style of management.

In summary, most organisations struggle to maintain positive internal cultures, and the WHO is no exception. As a UN institution, WHO is bound by many of the human resource and hierarchical parameters set by the UN. That said, after over 80 years of operation, five key concerns exist that are particularly germane to WHO and its effectiveness as an IHO: 1) An overly bureaucratic and top-down culture that can stifle innovation, effectiveness and performance; 2) Less than sufficient communication mechanisms between management, staff, departments, HQ, regions and country offices, which can supress constructive dissent, undermine effectiveness, and reduce institutional learning; 3) An over use of temporary staff and consultants with unclear and often non-disclosed costs, with the use of consultants now nearly equal to full-time staffing levels; 4) A culture where political patronage or quotas can sideline promotional practices based on merit, while affecting how expertise is assigned and misconduct investigated; 5) An ever expanding WHO remit and portfolio of programmes stretching capacity and organisational focus.

IV.3. LEGITIMACY AND GOVERNANCE

The WHO is widely understood as the primary epistemic and policy authority in international public health. Born in the aftermath of World War II, WHO has a mandate from its current 193 Member States to promote and safeguard the health of its Member States as well as stateless peoples. Evolving from the League of Nations Health Organization, WHO consists of six regional offices, 150 country offices, and its Headquarters in Geneva, Switzerland. WHO's mandate is to facilitate the creation of international health standards and guidance, legal regulations and implementation frameworks, as well as to respond to acute health emergencies and infectious disease outbreaks.

With the demise of the League of Nations during World War Two, countries forming the UN looked to replace the League's health agency with a new structure (see Section II.2.2) – essentially transforming the former agency under a new name, the World Health Organization (WHO), with the objective of:

> *"the attainment by all peoples of the highest possible level of health".*

Article 2 of WHO's 1946 constitution lays out functions the Organization should undertake in order to achieve this objective, ranging from technical support to standard setting and dissemination of information, to encouraging and coordinating research. It was to do this under the auspices of the emerging UN, as the world's primary health agency, but as a servant of the UN's Member States, not their director in such matters, including:

> *"(a) to act as the directing and co-ordinating authority on international health work;*
>
> *(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;*
>
> *(c) to assist Governments, upon request, in strengthening health services;..."*

WHO's remit was extensive, extending to 22 clauses in Article 2, discussed in more detail below. As a coordinating authority, it was to work with and advise other agencies as well as its Member States, recruit staff that reflect expertise as well as geographic diversity, and work through a somewhat subsidiarised structure that included (eventually) six Regional Offices and over 150 country offices, governed by mechanisms including the World Health Assembly and executive Board intended to give its Member States, on the basis of one-country one-vote, joint control of its policy and strategy.

The following sections discuss the WHO's constitution and its rules governing external relationships that shape, or should shape, its current structure and function. Source material is found in the WHO publication *Basic Documents, Forty Ninth Edition, 2020*.

IV.3.1. The WHO constitution: the role and function of WHO, as defined by founding and governing documents

The Objectives and Organization of WHO (Preamble and Articles 2-9)

The constitution of WHO was written in New York in 1946, and agreed at a convention of countries interested in forming a new international health organisation for "*the happiness, harmonious relations and security of all peoples*". The new organisation would replace or absorb existing international health agencies including the health office of the League of Nations and the Pan American Sanitary Organization (now the Pan American Health

Organization). Its remit was intended to be broad, with 'health' being defined as:

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".*

Further, the preamble spells out an ambitious goal that:

> *"The enjoyment of the highest attainable standard of health is one of the Fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".*

Whether this is achievable or not depends on whether "highest attainable" is seen in a literal sense (highest standard of care equally to all humans irrespective of context), or a practical sense (in context of competing priorities). However, relevantly, this right is to be considered:

> "*...without distinction of race, religion, political belief, economic or social condition*".

We can reasonably take the intent to be a process of making a standard of healthcare that can assure a high probability of a long life to all people, and so with a focus on those who through reasons not related to their choice currently have a reduced level of access. (See *WHO, health and human rights* section above).

Written in the context of the end of World War II, the suppression of European fascism and growing calls for de-colonisation, the WHO constitution reflects the approach of contemporary documents and agreements codifying human rights, medical and research ethics and the relationships between States (e.g. the Universal Declaration of Human Rights, the UN Charter and the Nuremberg Code – see Part II). It differs importantly from the UN Charter in that decision-making through the World Health Assembly (WHA) is based on one country – one vote, unlike the hierarchy in the United Nations Organization itself where certain States on the security council have a power of veto – see IHRP Policy Report).

The constitution recognises the importance of the "*fullest cooperation*" between States to attain health, and that a collective good is achieved by such cooperation as

> *"The achievement of any State in the promotion and protection of health is of value to all".*

This is a responsibility of States' governments (arguably intended to imply primarily their responsibility), each for their own people:

> *"Governments have a responsibility for the health of their peoples".*

And importantly must involve the public – those whose health is at stake

> *"Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people".*

Functions of the WHO are laid out in Article 2, but are somewhat ambiguous. They include the following:

> *"(a) to act as the directing and co-ordinating authority on international health work;"*

However, this is not intended to be directing in a sense of requiring, as it is

> *"(c) to assist Governments, upon request, in strengthening health services;"*

Recognising the drivers of longevity and health, WHO is to work towards:

> *"the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene"*

but also has a role in preventing and managing outbreaks or emergencies on request of countries, to

> *"furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments"* and
>
> *"to stimulate and advance work to eradicate epidemic, endemic and other disease".*

Of further relevance to the current international health climate, WHO is:

> *"to propose conventions, agreements and regulations, and make recommendations with respect to international health matters"* and

"to assist in developing an informed public opinion among all peoples on matters of health"

The wording of these statements is important, as they imply that WHO is only to assist Member States in providing information and propose regulations. However, as noted below, Article 20 of the constitution allows the WHA to develop treaties intended to bind Member States. An intent by the WHO secretariat to directly influence populations without State consent, such as through social media, could reasonably be argued to be at odds with its constitution.

The remainder of Article 2 expands examples of healthcare where assistance might be given and allows cooperation with other (non-State) agencies and promotion of cooperation.

Articles 3 to 8 deal with housekeeping organisational issues, including Article 7, added at the eighteenth WHA meeting in the 1960s (Resolution 18:46) but as of 2020 not yet come into force, would provide the WHA with the ability to suspend a Member State's voting rights if it fails to fulfil agreed financial obligations to support WHO.

In Article 9, the governance and administrative structure of WHO is laid out, comprising the World Health Assembly (WHA), the Executive Board (EB) and the secretariat, the structure and function of which is provided in subsequent Articles.

The World Health Assembly, Executive Board and State's obligations (Chapter V (Articles 10 to 29) of the WHO constitution)

Each WHO Member State is allowed up to three delegates, and various support personnel, to participate in the WHA meetings. Voting is by one vote per Member State (Article 59). These meetings are at least annually, usually in May and extending for a week, but may also be convened more frequently based on a majority vote. Originally, the intent was to choose a Region for the venue of the subsequent meeting (Article 14) but in recent years have been held solely in the European Region in Geneva, Switzerland, where the WHO headquarters is sited. This is perhaps an interesting expression of the increasing centralisation that has occurred over the decades of WHO's existence.

It is also worth recognising that although Member States are allowed up to three delegates and support personnel, in practice many lower resource countries have limited support staff and struggle to appropriately cover the multiple sessions that occur at the WHA and other forums. As noted above, the suspension of Article 55.2 during negotiations on the IHR amendments meant that low resource Members struggled to stay on top of developments, were not given appropriate time to review materials, and were pressured to act rapidly without proper analysis from their own experts. This put several Member States at a disadvantage, usurping the democratic legitimacy for the WHO. The point here is that enshrined within the WHO is a spirit of democratic participation and equality that is often not mirrored in practice.

Whilst voting rights are restricted to Member States, other entities such as private foundations may participate in sessions as non-voting participants with WHA consent (Article 18 (h). Article 18 lays out areas of responsibility of the WHA, but in paragraph 18 (m) expands this to:

"...take any other appropriate action to further the objective of the Organization".

The WHA may adopt conventions and agreements binding Members within the limits of a treaty (Article 19) by a two thirds majority vote, to come into force for each member based on their own constitutional processes of adoption of international agreements, with an 18-month window to perform this adoption or explain why it is delayed (Article 20). This 18 month window was reduced to 10 months for most States (those that agreed) at the WHA in 2022.

Article 21 then lays out the scope of regulations to be considered:

"The Health Assembly shall have authority to adopt regulations concerning:

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

(b) nomenclatures with respect to diseases, causes of death and public health practices;

(c) standards with respect to diagnostic procedures for international use;

(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;

(e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce".

Unlike conventions or treaties, these regulations shall come into force automatically after a defined period unless the State notifies the Director General (DG) of reservation or rejection (Article 22).

Thus, this unusual arrangement allows the WHA to adopt requirements involving cost, resources and compliance of Member States without the State actively agreeing (just failing to reject). These are then enforceable, within the realms of international law and the potential for, or lack of potential for, enforcement therein (Section III.2.3).

Further obligations of Member States of the WHA (Chapter XIV, Articles 61-65) include an obligation of disclosure by States of basic health indices. Member States are expected to submit annual reports on major health indices including epidemiological and statistical reports, and on action on recommendations made by WHO.

Chapter VI (Articles 24-29): The Executive Board

The Executive Board (EB) is intended as a more streamlined substitute of the WHA, with 34 members including at least three from each of the (now six) WHO Regions. These representatives are intended to be technically competent in the health field, and at least one per year from each Region rotates through a vote of the Regional Assembly. The EB submits the planned programme of work of WHO for approval by the WHA, and is intended to act as the executive arm of the WHA, having sufficient flexibility to react in emergencies, guiding WHO in ways the WHA would be too cumbersome to manage (Article 28 (l)).

Other states or territories have interactions with the WHO. Taiwan (Chinese Taipeh) has had relationships with the WHO with varying status and participated in the WHO's World Health Assembly as an observer, through invitation, during 2009-2016 (other observer entities include Palestine and the Holy See). Invitations were discontinued since 2017 despite calls for continued participation from Taiwan itself, various WHO Member States, and the World Medical Association. Notably, Taiwan has been a full member of the World Trade Organization (since 1st January 2002), the Asian Development Bank and the Asia-Pacific Economic Cooperation (APEC).

Chapter VII (Articles 30-37) – The WHO Secretariat (Workforce) and independence

The WHO workforce and the implications of its organisation are discussed further in Sections IV.3.1 and IV.6.3. Here, we deal with aspects of this defined by the constitution. As Article 30 states:

"The Secretariat shall comprise the Director-General and such technical and administrative staff as the Organization may require".

Thus, WHO was designed as a hierarchical organisation with a Director General (DG) as the chief technical and administrative officer of the organisation but subject to the Board (EB) (Article 31), able to determine the structure and staffing of the secretariat serving under them. The term and mode of selection of the DG was originally left open in the constitution, but is now established as a vote of the WHA and a five-year term, that is customarily repeated once. The DG shall prepare the WHO budget (now biennial) and submit this to the EB, who may approve and then pass it on to the WHA for approval.

Articles 44-54 describe the setting up of Regional Committees, comprising the Member States of each Region of WHO (Regions which are determined by the WHA). Regional office structure generally mirrors the office under the DG (i.e. WHO headquarters) but is ultimately subject to the DG, and thereby the EB and WHA. This allows some regional autonomy, but only within the scope that the DG and WHA allows.

The WHO secretariat and DG were intended to be independent of the direction of individual States. Article 37 states that the DG and staff shall work only in an international role and not for national interests, whilst no Member State shall seek to influence them. This independence from individual States is laid out more bluntly in The immunities and Staff Regulations of the World Health Organization. As these Regulations state, WHO staff are expected to work solely for WHO, and not take instruction or give favour to their governments or other entities:

Paragraph 1.1:

"All staff members of the Organization are international civil servants. Their responsibilities are not national but exclusively international. By accepting appointment, they pledge themselves to discharge

their functions and to regulate their conduct with the interests of the World Health Organization only in view",

and Paragraph 1.2:

"...In principle, the whole time of staff members shall be at the disposal of the DirectorGeneral", and Paragraph 1.3:

"In the performance of their duties staff members shall neither seek nor accept instructions from any government or from any other authority external to the Organization".

And are expected to exercise confidentiality regarding information held by WHO (Paragraph 1.6)

There are legitimate questions regarding whether this is upheld within WHO, or whether certain countries exert influence through their citizens or others working within the organisation. In particular, the increase in voluntary specified funding, in which a State or non-State actor provides funding to the WHO secretariat for use in specified activities raises legitimate questions as to whether Article 37 can be truly operationalised within such a funding model. (see Section IV.6.2).

Immunity

Further efforts to ensure independence of WHO staff are included in Chapter XV (Articles 6668: Legal capacities, privileges and immunities. These Articles lay out in vague terms the requirement of States to provide sufficient immunity and legal standing to the WHO secretariat (i.e. staff):

"...as may be necessary for the fulfilment of its objective and for the exercise of its functions"

Immunity was further defined in 1948, when the 1946 UN Convention on the Privileges and Immunities of the Specialized Agencies was adopted with certain later modifications. This Convention was adopted by the General Assembly of the UN on 13th February 1946, to be subsequently agreed by individual UN agencies. The WHA adopted the Convention for application to WHO staff and other specified personnel (Annex 7) in its first Assembly on 17th July 1948 with modifications at subsequent Assemblies.492 The following details sections in Annex 7 of the Convention relevant to WHO function. ('Article #' in the notes below refers to the article in the main text of the Convention):

'UN Convention on the Privileges and Immunities of the Specialized Agencies Annex 7: Immunities'.

Legal immunity for WHO employees extends to others asked to serve on WHO committees and expert panels, providing WHO with considerable authority to effectively grant immunity to individuals:

"*Experts (other than officials coming within the scope of Article VI) serving on committees of, or performing missions for, the Organization*" .

including:

"(a) Immunity from personal arrest or seizure of their personal baggage;

(b) In respect of words spoken or written or acts done by them in the performance of their official functions, immunity of legal process of every kind, such immunity to continue notwithstanding that the persons concerned are no longer serving on committees of, or employed on missions for, the Organization."

and a proviso is provided in Paragraph 2 (iii) specifying that immunity should only be for official organisational benefit, but the approach remains quite broad:

"Privileges and immunities are granted to the experts of the Organization in the interests of the Organization and not for the personal benefit of the individuals themselves. The Organization shall have the right and the duty to waive the immunity of any expert in any case where in its opinion the immunity would impede the course of justice and it can be waived without prejudice to the interests of the Organization".

Articles V & VI of the main Convention include freedom from income taxes, confidentiality of documentation, freedom to import personal effects free of duty, and other entitlements common to UN staff and mirroring common diplomatic privileges.

Most WHO staff therefore enjoy basic legal immunity from prosecution within Member States unless this is waived by WHO. This makes it difficult to hold WHO staff, or consultants of committee members in their direct work on behalf of WHO, legally liable for their

recommendations or actions. This has significant implications regarding accountability of WHO and its secretariat for actions or recommendations they make, or fail to make (see Section IV.3.3). While not intrinsically a good or bad thing, it has implications for the role WHO can perform within a basic democratically accountable framework.

Immunity can also be extended temporarily to non-WHO staff. WHO can convene expert advisory panels and committees, recruiting from organisations beyond Member States (Articles 41 & 42). Article 71 (discussed below) goes further, allowing WHO to engage with non-State organisations as it sees fit for the performance of its work, but with governing State permission. However, such dealings are further managed by a series of regulations, FENSA, described in Section IV.3.1. Whilst members are serving on WHO committees and acting in that capacity they enjoy similar immunities as WHO staff, and are required to follow similar requirements of serving only WHO interests, and not taking instruction from outside entities:

> *(Paragraph 4.6): "In the exercise of their functions, the members of expert advisory panels and committees shall act as international experts serving the Organization exclusively; in that capacity they may not request or receive instructions from any government or authority external to the Organization".*

Therefore, members of Ministries of Health or other national entities, or of philanthropic funders or other non-State entities, are in theory prevented from taking instruction from their home country or workplace/employer, in the context of WHO business. This is difficult to enforce and a clear potential area for conflict of interest, though in many contexts expertise is found most in entities that could also benefit from WHO decisions. It is an issue that WHO staff are supposed to manage, though exclusion of members of major funding organisations, or failure to include those recommended by such funders, could potentially carry consequences in availability of future support.

IV.3.2. Subsidiarity

Health Sovereignty and Subsidiarity

To reverse the decades-long advance of global health principles and personnel into a sector that lies "essentially within the domestic jurisdiction" of States (Article 2.7 of the UN Charter), international health governance must be reorganised on the basis of the principle of subsidiarity,moving ultimate decision making as close as possible to the level closest to those effected. Health policy and healthcare that use subsidiarity as the organising principle would begin with individual agency and autonomy, informed consent, and prioritisation of patients' individual health outcomes over collective public health benefits. The doctor-patient relationship in the clinic has to be sacrosanct and inviolate. If medical regulators violate that sanctity to invade the clinic, for example by prohibiting the doctor from discussing risk of collateral harms because this could increase vaccine hesitancy, they destroy patient faith in the doctor's professional integrity, increase public distrust of health experts, and promote crossvaccine hesitancy. All this has already happened and has been documented in multiple surveys in several countries.

Medical and drug regulators should prioritise patient safety over every other consideration. On this criterion, there was an unacceptable dereliction of the duty of care during Covid. To enable emergency use authorisation of vaccines, regulators hugely exaggerated health risks and threats, refused to draw accurate risk profiles by age and regions, dismissed legitimate concerns and questions about side effects and harms, condemned and mocked ('horse dewormers') efforts to identify promising possible repurposed drugs like hydroxychloroquine and ivermectin as dangerous, and short-circuited the normal multi-year stringent safety and efficacy trials. Remarkably, all this was done in the name of science.

In reality, much of it was based in very weak or contradictory evidence. Speaking at a media briefing in Geneva on 3 March 2020, WHO director general Tedros Adhanom Ghebreyesus said Covid's case fatality rate (CFR) was 3.4 percent, against the seasonal flu's CFR of under 1 percent. Addressing an internal meeting on 7 April 2025 of the body negotiating the new Pandemic Agreement, he said: "Officially 7 million people were killed [by Covid-19], but we estimate the true toll to be 20 million", seemingly conflating deaths reported as due to SARSCOV-2 with excess all-cause deaths during the entire period.

It is hard to see why the two statements, delivered five years apart as bookends to the Covid pandemic, do not constitute examples of misinformation. They can be viewed as catastrophising and fear-mongering and underpinned efforts to change recommendations to requirements in early drafts of the IHR amendments and Pandemic Agreement. For, like New Zealand's former Prime Minister Jacinda Ardern in her well-known and unfortunate statement, the WHO and its Director

(through Article 12 of the IHR) was being set up as a single source of pandemic truth for the world.

Governments, in response to predictions of catastrophic health consequences, frequently abdicated responsibility for pandemic policy to their health bureaucrats, and both to international technocrats in and around the WHO. In doing so, they acted on the basis of the very opposite of the principle of subsidiarity, from the individual and the State to the regional and the global.

The US Exit is a Wake-up Call

On 21 January 2025, President Trump signed an executive order to withdraw the US from the WHO. Since that order the US has also stopped funding to GAVI, the global vaccine alliance as well as reduced funding for the Global Fund. Other countries have followed suit, reducing funding for global development and key global health initiatives. The US withdrawal from the IHR was announced jointly by the US Secretary of Health and Human Services and the US Secretary of State on 18 July 2025. According to this announcement "The first reason is national sovereignty". The announcement goes on to state, though inaccurately, that nations that "accept the new regulations are signing over their power in health emergencies", or even when confronting nebulous "potential public health risks", to "an unelected international organisation that could order lockdowns, travel restrictions, or any other measures it sees fit".

The pandemic accords' vision, according to the US health secretary, is of "a technocratic control system that uses 'health risks' and 'pandemic preparedness' as a Trojan Horse to curtail basic democratic freedoms" by creating "global systems of health IDs, vaccine passports, and a centralised medical database". The United States is not prepared to subject itself to "a future where every person, every movement, every transaction, every human body is under surveillance at all times".

The accuracy of this statement is contestable, since the WHO constitution does not grant it this power and the final draft of the Pandemic Agreement specifically says that the WHO does not have this authority. That aside, it would be churlish to discount the concerns and perceptions of eroded national sovereignty underpinning US action. Studies in globalisation have also demonstrated that an erosion of sovereignty has occurred across most sectors, while antiglobalisation views are clearly guiding new policies. Moreover, the current US administration is not alone in their perception and there is a significant literature in global health policy, particularly from the perspective of low- and middle-income countries (LMICs), articulating concerns about global health policy as a vehicle for "neocolonialism" and "Western centrism". All of which reflect a concern for eroded national ownership.

A more salient point, regardless of WHO's lack of legal authority, is that it does hold a significant amount of epistemic authority combined with normative, convening, and agendasetting power. The WHO is often relied upon by States, particularly LMICs, for information, guidance, and assistance. As a result, policies can act as a form of soft power, which manifests both internationally and domestically. When this form of agenda-setting soft power is combined with the hard financial power of the World Bank, the International Monetary Fund (IMF), GAVI, and other global health initiatives, it becomes a structural form of power. Although processes of global health governance can have extremely positive effects on health outcomes, which should not be dismissed, there are also well known concerns within the development aid for health literature about how these forms of power can undermine the creation of nationally owned programmes, generating aid dependencies, producing vertical and misaligned policies, imposing uncontextualized "travelling models", and demanding funding conditionalities that can run counter to local needs.

In this light, the Pandemic Agreement and revised IHRs have been viewed by several LMICs and high-income countries (HICs) as a technocratic control system that uses potentially inflated claims of "existential threat" to lock in existing forms of asymmetric power, which risks the promotion of vested interests while curtailing local control.

The proposed actions of the US and its America First Global Health Strategy (AFGHS) provide potential opportunities to reevaluate and reform global health governance to reduce foreign aid dependencies and drive meaningful change towards better and more sustainable global health outcomes, an emphasis reflected more broadly by African States in the Accra Reset of 2025. The key to promoting positive change is to design assistance that strengthens local capacities to self-administer and self-finance their health systems in the medium and long term. An important goal articulated in the AFGHS is to reverse structures that undermine local control, self-reliance, sustainability, and overall population and system health. Taking the Health and Human Services Secretary's words at face value, the process for rethinking global

health must start to "strengthen national and local autonomy to hold global organisations in check and to restore a real balance of power". Again, if genuine, and not merely window dressing to obscure US business as usual, then AFGHS could be a catalyst for change.

On any understanding, creating a permanent dependency on financial and technical assistance from external actors undermines self-reliance and is a de facto threat to health sovereignty. Since 1948, huge leaps have occurred in healthcare technology and the economic growth that underpins improved health outcomes. This should, rationally, reduce the burden of disease and the lack of capacity that WHO was intended to address. Instead, as outlined in Parts I and II, the growth in mandates, authority, resources, and personnel to match an expansion of WHO's scope of work has catered to the corporate interest of the WHO as an international bureaucracy and to the career interests of a continually expanding corps of international civil servants, technocrats, philanthropic foundations, health-related think tanks, and the profit-maximising pharmaceutical and biotech industries. This shift becomes increasingly clear in the remaining sections below.

Yet, there is one final consideration in relation to the health sovereignty of low-income countries as a group and WHO's over-prioritisation of pandemic preparedness post Covid. The relative disease burden of pandemics as measured by disability adjusted life years (DALYs - being the years of life lost through early death, and additional years lost proportionate to their curtailment through disability) has had a low salience over the past century, covering the period during which the WHO has been in existence. According to Our World in Data, the only other pandemics to have occurred were the Asian and Hong Kong flu pandemics in 1957–58 and 1968–69, in each of which around two million people died (the WHO gives the death estimates as 1.1 and 1 million respectively); and the swine flu pandemic in 2009–10, in which between 0.1 and 1.9 million people died (WHO estimates the range as 123,000-203,000). The Russian flu pandemic of 1977 was even milder. The historical timeline of pandemics shows how improvements in sanitation, hygiene, potable water, antibiotics and other forms of expanding access to good healthcare have massively reduced the morbidity and mortality of pandemics since the Spanish flu (1918–20) in which fifty million people are estimated to have died.

In the 105 years since the Spanish flu, a total of 10-14 million people have died around the world in acute pandemics including Covid-19.507 To put this in perspective, in 2019 alone, 10.1 million people died from infectious, maternal, neonatal and nutritional diseases: pneumonia and other lower respiratory diseases, 2.5 million; diarrhoeal diseases, 1.3 million; tuberculosis, 1.2 million; HIV/AIDS, 910,000; malaria, 650,000; and other infectious diseases, 1.2 million. . Another 44.8 million deaths were caused by non-communicable diseases. The three leading causes of deaths in the year before Covid were cardiovascular diseases (19.1 million), cancers (10.6 million) and chronic respiratory diseases (4.1 million).

In summary, the founding mission of the WHO was to alleviate existing health disadvantages of developing countries and to assist them to build their public health capacity to the point of self-sustaining resilience. What the US withdrawal signals, for better or for worse, is that it will be impossible to return to "business as usual", thus requiring reinvigorated thinking not only about the future of the WHO, but about the entire global health architecture itself.

IV.3.3. WHO accountability

As a UN agency WHO is directly accountable to its Member States as well as indirectly accountable to promote human health regardless of citizenship and political affiliation with a Member State (to include stateless people).

In terms of accountability to Member States, WHO has several formal institutional processes in place to receive input from its members. The primary governance and accountability forum is the World Health Assembly, which meets annually to discuss and vote upon issues and policies presented to Member States 40 days prior to their vote. The WHO also maintains an Executive Board, the Independent Expert Oversight Advisory Committee (IEOAC), regional committees, and several Working Groups (such as the IHRWG or the Working Group on Sustainable Financing). These forums allow Member States to directly relate their preferences to WHO leadership and other members. Although there are criticisms concerning how these formal processes operate, they are at least formal locations from which democratic governance and accountability could be promoted.

In terms of self-evaluation, WHO has several processes to self-assess and propose reform agendas. Thematic and programme evaluations are conducted by its Evaluation Office as well as through the United Nations Joint Inspection Unit. Furthermore, WHO maintains several

oversight committees (e.g. IHR Review Committee and Expert Oversight Advisory Committee (IEOAC)) and working groups with the ability to propose reforms, which can then be elevated to the Secretariat, the Executive Board, and the WHA.

Despite these formal processes, there have been consistent critiques of WHO's general accountability. These can be divided into five categories: 1. A lack of democratic accountability within WHO decision making and legislative processes. 2. A lack of public accountability and liability for Executive Board decisions. 3. An accountability disconnect between WHO General Programmes of Work and the WHA due to budgetary control and direction setting by State and non-State donors.513 4. A general lack of independent evaluations and self-learning (see Section IV.5.2). 5. A tendency for cherry-picking internal rules in order to maintain WHO's perceived standing.

The literature on WHO reform and accountability suggests that there are two main drivers of its accountability deficit. First, that voluntary unspecified contributions allow undue legislative and executive steer within the WHO, undermining democratic participatory principles as well as to whom the WHO feels accountable. Second, there is a widely held view that the WHO lacks accountability because its processes are hugely burdensome and/or maintains processes that undermine equality of voice. In some cases, Member States are blamed for retaining too much control and over politicising the process. In this case, reforms include giving more independent authority to the WHO. In other cases, it is only a handful of States that are problematic as they exert undue influence, with suggestions to reform WHO financing to weaken rent-seeking behaviours and policy capture.

This report holds the latter view regarding the necessity of WHO financing reform, yet rejects the notion that giving WHO greater centralised authority will equate to better accountability. This is because accountability for health outcomes is best achieved by increasing control at its lowest level via subsidiarity and nationally owned programmes. As a result, the focus should not be centralising authority but the creation of legitimate political processes that allow equal access, deliberative opportunities, and collective public policy. When coupled with financial reform, the aim is to create a smaller and more tightly focused international site for multilateral political interaction that promotes the responsibility of States to improve the health of their populations.

IV.4. AUTHORITY AND EXTERNAL RELATIONSHIPS

IV.4.1. WHO´s compliance with the United Nations Charter

Article 57 of the UN Charter states that specialised agencies that are "established by international agreement and having wide international responsibilities, as defined in their basic instruments" in different sectors including health, shall be brought into relationship with the UN in accordance with Article 63. The latter confers the task of coordinating activities of specialised agencies to the UN Economic and Social Council (ECOSOC) through formal agreements, consultation with and recommendations to the agencies, and recommendations to the General Assembly and to UN Member States. In practice, the UN system coordinates with specialised agencies through the UN System Chief Executives Board for Coordination at the highest level, and a network of liaison offices.

The agreement establishing the relationship between the UN and the WHO was signed in and entered into force in 1948 following approval of respective assemblies - the UNGA and the WHA., It includes reciprocal representation without voting power, for the WHO to be present at ECOSOC and UNGA meetings (Art. II), reciprocal proposal of agenda items (Art. III), the WHO's possibility to request advisory opinions of the International Court of Justice (Art. X), alignment for staff's privileges and immunities (Art. XII), and budgetary and fiscal arrangements (Art. XV). In particular, WHO can make recommendations to, and receive recommendations from, the UN and other specialised agencies (Art. IV). Besides, the WHO also concluded specific agreements with other specialised agencies, including the International Labour Organization, the Food and Agriculture Organization, UNESCO, the International Atomic Energy Agency, and the International Fund for Agricultural Development. These cover scope of cooperation such as the establishment of joint committees and initiatives, data, statistics and documents exchanges, and consultation on matters of common interest. The UN and the WHO have used these provisions often, especially in the last few years with the Covid pandemic. In reality, the existence of coordination and cooperation agreements does not wipe out competition between agencies regarding budget, funding and public visibility – PPPR being the latest pie to be shared by the WHO and the World Bank but also various others (e.g. FAO, IFAD, UNICEF).

Thus, there is no formal requirement for a specialised agency like the WHO to comply with the UN Charter. There is probably a general and legitimate expectation from the public and States that the WHO, being affiliated with the UN system, respect the Charter, but the chief text with which the WHO must comply remains its constitution.

IV.4.2. WHO treaties and pitfalss

As the first treaty enacted by WHO beyond the regularly evolving International Health Regulations, the WHO Framework Convention on Tobacco Control (FCTC) stands as a cautionary example of the risks of restricting complex public health problems to legal dogma and anchoring its oversight in vested interests. It has major implications for the current path toward centralisation and legal obligation underlying the WHO's growing pandemic agenda, and the need to anchor public health policy within local context.

The WHO's efforts to lead an international campaign to drastically reduce smoking reflects good intentions in pursuit of a laudable goal falling victim to the law of unintended and perverse consequences. Tobacco use is acknowledged to be a major driver of non-communicable diseases like cancers and heart diseases, causing widespread death and disability. Tobacco kills more than seven million people each year and lifelong smokers lose ten years of their life on average. Tobacco cultivation depletes vital land and water resources and diverts them from sustainable food production. Tobacco-related illnesses are responsible for "catastrophic" health expenditures, particularly for the poor peoples of the world. Trillions of discarded cigarette butts pollute ecosystems. The industry's aggressive lobbying and marketing efforts undermine public health goals and efforts to combat the scourge of smoking.

Article 19 of the WHO constitution vests the World Health Assembly, the organisation's policy setting and budget approving organ, with the "authority to adopt conventions or agreements with respect to any matter within the competence of the Organization" by a two-thirds majority. The new legal instrument comes into force for each member on ratification by it in accordance with its constitutional processes. The FCTC was adopted by the Health Assembly on 21 May 2003, the first treaty to be adopted under Article 19. It came into force on 27 February 2005. It has 183 States parties. It is hosted by the WHO in its headquarters but is not a unit under WHO control. Free of any direct WHO legal authority over it, the FCTC has its own governing body in the Conference of the Parties (COP). This model looks to be repeated if and when the Pandemic Agreement is adopted.

The goals of the treaty are to reduce and end the consumption of tobacco, addiction to nicotine, and exposure to tobacco smoke. To help achieve these goals, the treaty's provisions include measures to govern the production, sale, distribution, advertisement, and taxation of tobacco. The FCTC tackles both demand and supply and sets out a framework for tobacco control measures to be implemented at the national, regional, and international levels. These include price and tax measures to reduce demand; sales, advertising, and packaging restrictions; and public health messaging on the dangers of tobacco. Dr Adriana Blanco Marquizo, head of the FCTC secretariat, said in February 2025 in remarks to mark its twentieth anniversary, the treaty "equips Parties with a comprehensive set of measures to protect populations from the industry's ever-evolving tactics – designed to profit at the cost of people's lives and the health of our planet". FCTC standards are set out as minimum requirements, and States are encouraged to adopt more stringent regulations wherever possible.

Marking the twentieth anniversary of the FCTC entry into force on 20 February 2025, WHO Director-General (DG) Tedros Adhanom Ghebreyesus described tobacco as "a plague on humanity – the leading cause of preventable death and disease globally". He claimed that the FCTC's "comprehensive package of evidence-based tobacco control measures underpinned by international law" – pictorial health warnings on cigarette packages, smoke free laws, increased taxes – "have saved millions of lives". Expert evaluation teams that studied the treaty's impact in its first decade of operation found that it had accelerated the development and implementation of tobacco control legislation, serving as the catalyst for new policies and strategies in some countries and strengthening existing weak laws in others. Health measures under the stimulus of the FCTC, such as smoke-free laws, health warnings, and youth access laws, were claimed to have achieved measurable progress on tobacco consumption. The FCTC was described as "a powerful legal instrument" and evidence showed that "FCTC-compliant measures are effective". By one estimate, nearly 22 million future premature smoking-attributable deaths had been averted between 2007 and 2014.

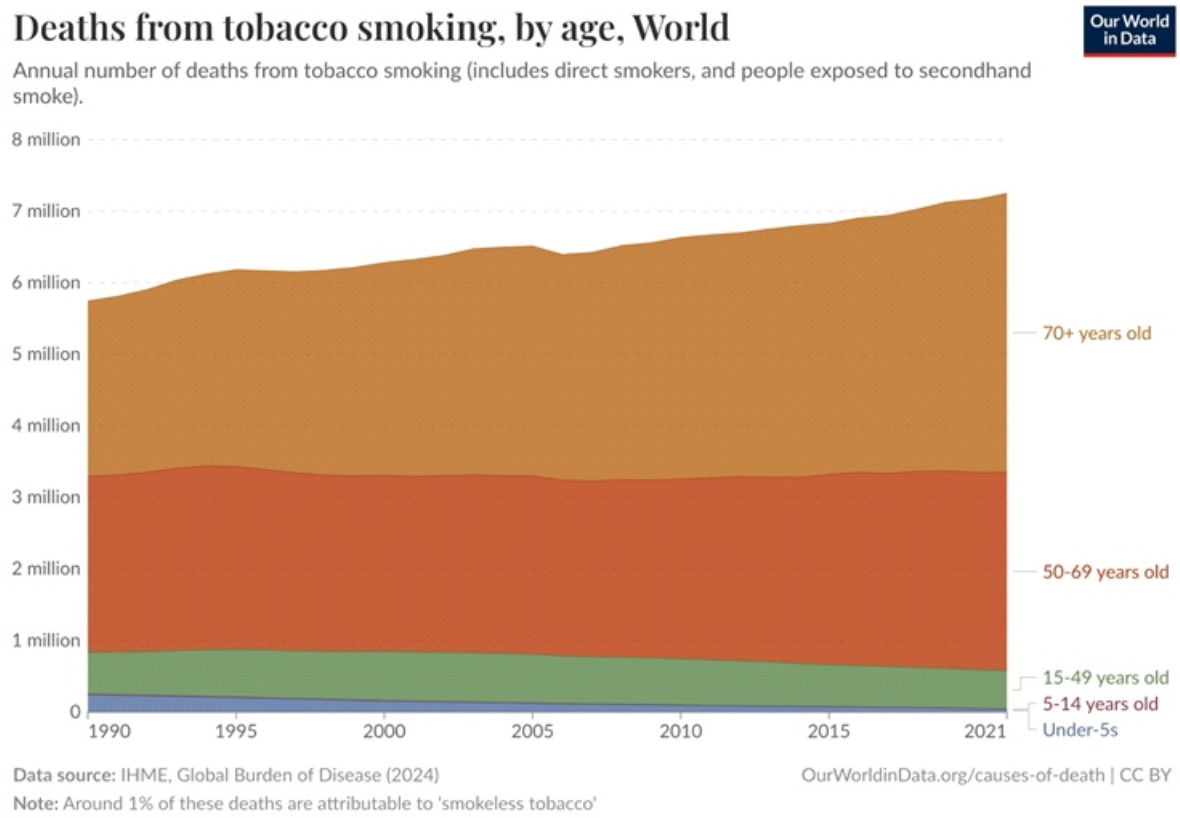

Figure IV.3 – Graph showing global deaths from tobacco smoking, by age Source: Our World in Data, www.ourworldindata.org/causes-of-death

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Not everyone is convinced. To be sure, tobacco use had fallen globally by a third from 29.3 percent in 2005 to 20.9 percent in 2022, albeit with a recent slowing in the rate of decline. However, how much of this can be explained by the impact of the FCTC? Figure IV.3 shows no real discernible impact of the FCTC in 2005 on age-segregated deaths from smoking between 1990 and 2021. The total number of deaths went up from 5.75 million in 1990 to 6.51 million in 2005 (+760,000) and 7.25 million in 2021 (+740,000). The only age group in which the deaths increased, from 583,627 in 1990 to 678,809 in 2005, before falling to 536,486 in 2021, were the 15-49 year olds. There was a steady fall in deaths in the under-15s over the entire period and a steady rise in deaths among those aged 50 and over, with no evidence that the FCTC marked an inflection point in 2005 for either age group. Moreover, against a fall in smokers from 34.3 to 21.7 percent between 2000 and 2022, global tobacco yield has maintained an upward trajectory since 1961 while tobacco production and land used for tobacco cultivation increased from 1961 to peak levels in 1997 before beginning a decline.

There is a fundamental ambiguity at the heart of the FCTC. Is it a production, consumption, addiction, and harm-reduction treaty, or a prohibition treaty? Some scholarly works suggest that political activists appropriate the language of "public health", cloaking health regulation as consumer protection, to promote the interests of bureaucracies and bureaucrats, industries, and their own careers. Does funding from health-centric philanthropic foundations to promote more stringent regulations therefore constitute a declarable conflict of interest similarly to industry funding? Independent efforts to evaluate FCTC effectiveness and implementation show State compliance with the framework is low. Steven Hoffman and Zain Rizvi of McMaster University in Canada found that one-third of country responses had been misreported in the WHO database, one-quarter of submitted reports were missing, some had been misinterpreted by WHO staff, and some were clear errors, for example "yes" being recorded as "no".

As with many public policies driven by good intentions, tobacco regulations are also subject to the law of unintended and perverse consequences. Experts have described Australia's tobacco regulations, for example, as the world's "worst example of bad policy". Steeply rising

taxes on cigarettes that amount to more than half the total sale price have driven sales into the black market controlled by organised crime. The projected tax take of A$7 billion in 2025 is down from A$16.3 billion in 2020. The Australian Association of Convenience Stores blames government policies for the $2 billion collapse in sales, with the tobacco market handed over to criminals. Tax revenues have halved as tax rates have doubled and a health issue has been corrupted into a crime issue with shops firebombed as gangs fight for control of territory. As economists Dmitri Burshtein and Peter Swan put it in the Spectator Australia magazine (6 September 2025): "Government thought it was squeezing smokers; in truth, it squeezed the legal market out of existence. The result was a windfall for organised crime, which now pockets the margin, while Treasury bleeds and the deficit balloons".

Designed around tobacco control, the FCTC has also struggled to adapt to innovations involving low-risk nicotine-containing alternatives such as vapes. Its institutions, guidance, and politic sare path-dependent on a "quit or die" paradigm rather than comparative-risk regulation. The COP decisions incentivising blanket restrictions (taxation parity with cigarettes, flavour bans, retail prohibitions, advertising blackouts) ignore large differences in harm between combustibles and non-combustibles. With its advisory and negotiating processes excluding independent harm-reduction scientists and manufacturers who hold safety and usage data, a moral-political coalition has replaced public health science under the treaty process, treating all nicotine as if it were tobacco smoke. The treaty architecture tends to apply the precautionary principle asymmetrically – demanding proof of zero risk for alternatives rather than prioritising reduction of the accepted harms of combustible tobacco use. Scientific review and surveillance are weakly integrated into COP deliberations. The legal framework of the treaty, formed at a time when few alternatives existed, are now driving a dogmatic rather than science-based public health agenda and arguably impeding a reduction in use.

The FCTC illustrates the risks of turning a public health issue into a treaty. A response driven by evidence and science becomes a response driven by a rigid legal framework. While management would normally evolve with changing evidence, the fixed aims of the treaty and the bureaucracy that grows to support it become an end unto themselves, over time reducing impact and potentially doing harm. The same issues appear likely to arise from the Pandemic Agreement adopted by the World Health Assembly (WHA) in 2025 but with ongoing negotiation, and is seen with other policies. Decision-making is removed from local priorities and context, and ultimately can pass to judicial mechanisms with no public health background.

IV.4.3. WHO´s relationship with private entities

FENSA, conflict of interest, and relations with other organizations

The 1946 WHO constitution recognises the reality that WHO would need to work with nonState actors. Within national jurisdictions, this is limited in that it requires consent of the governing State concerned, as stated in Article 71:

> *"The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental".*

The term international organisation usually refers to an intergovernmental organisation designated by treaty or similar mechanism, such as the various agencies of the UN, multilateral development banks and certain international conservation or sporting organizations. The wording does not specify inclusion of for-profit corporate entities or non-governmental organisations (NGOs) registered in States, except with the permission of the governing State (see Section IV.3.1). Formal agreements with intergovernmental organisations require a two thirds majority vote of the WHA (Constitution of the WHO, Article 70).

These rules impact WHO relationships with other international organisations such as the PublicPrivate Partnerships (PPPs) that have arisen more recently (see Section II.3.4), arguably giving such permission but requiring WHA approval for a formal agreement. However, these PPPs have private sector representatives (i.e. subject to national jurisdiction) on their governing boards and may differ considerably in governance and representativeness. Cooperation with these entities by WHO is not well addressed in Articles 69-72 or elsewhere.

To address these uncertainties arising from WHO's need

to interact with a rapidly growing international global health industry, the WHA adopted a set of rules; the Framework of Engagement with Non-State Actors (FENSA). FENSA was adopted at the 69th WHA in 2016 (WHA resolution 69.10),541 intended to define the way in which WHO should work with nonState actors, including private sources providing funding to WHO:

> *"Principles. Paragraph 6 (d): the additional resources non-State actors can contribute to WHO's Work".*

FENSA introduces a process by which WHO will assess non-State actors for potential conflict of interest:

> *"Paragraph 21: WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor."*

Such potential conflicts are to be managed within WHO, overseen by the Executive Board (Paragraphs 67 & 68).

The definition of a conflict of interest (Paragraph 22) includes:

> *"A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO's work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO's work)".*

This raises a major question for WHO regarding specified funding from private sources who could derive any potential benefit from public health policy, including the development of markets for commodities such as vaccines, medicines or diagnostics from which they may derive profit or hold intellectual property interests. As of the end of 2025, WHO's largest funder was a private donor, The Gates Foundation.

WHO further maintains a list of non-State actors in 'Official relations with WHO'. Paragraph 50:

> *"'Official relations' is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement".*

This status, which includes significant funders of WHO, offers an opportunity for private entities to have direct inside knowledge of, if potentially an influence on, WHO governing bodies (Paragraph 55):

> *"Entities in official relations are invited to participate in sessions of WHO's governing bodies. This privilege shall include:*
>
> *(a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO's governing bodies or in meetings of the committees and conferences convened under its authority,*
>
> *(b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed,*
>
> *(c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website".*

Funding from non-State actors is managed under the FENSA section 'WHO Policy and Procedures on Operational Engagement with Non-governmental Organisations. Paragraph 6 states:

> *"WHO can accept financial and in-kind contributions from nongovernmental organizations as long as such contributions fall within WHO's General Programme of work, do not create conflicts of interest, are managed in accordance with the framework".*

Paragraph 8 states:

> *"The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:*
>
> *(a) the acceptance of a contribution does not constitute an endorsement by WHO of the nongovernmental organization,*
>
> *(b) the acceptance of a contribution does not confer on the contributor any privilege or advantage,*

(c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities,

(d) WHO keeps its discretionary right to decline a contribution, without any further explanation".

Conferring of advantage (8b) is clearly a potential with funding from pharmaceutical manufacturers and private foundations where leadership is also invested in commodities (such as The Gates Foundation). WHO staff are commonly aware of the source of funding for their own salaries and those of their colleagues, and clearly the job security of many is dependent on continued private sector funding, as this comprises approximately 25% of WHO's current budget. Added to non-State funders such as the World Bank and European Union, and major countries giving for a purpose through specified funding, and most salaries at WHO are arguably dependent on ensuring that the aims of specific funders are achieved.

This situation appears incongruent with Paragraph 13 (b) governing private sector contributions:

"Financial contributions may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 36 below)".

An exception is included for the formerly established Pandemic Influenza Preparedness (PIP) framework, which involves pharmaceutical manufacturers contributing to a fund that has implications for vaccine sales:

"The provisions set out in paragraph 13(b) shall be without prejudice to specific mechanisms, such as the Pandemic Influenza Preparedness Framework ("PIP Framework"), set up by the Health Assembly that involve the receipt and pooling of resources".

While the potential for PIP conflict of interest seems to be accepted, the excision does not address private foundations such as the Gates Foundation with direct investments in pharmaceutical manufacturers, or indirect interest through its own funding source and founders.

Philanthropic foundations, the main source of private funding to WHO's budget (The Gates Foundation is at the end of 2025 WHO's largest single funder), are addressed in a separate section of FENSA; WHO policy and Operation Procedures on Engagement with Philanthropic Foundations. Paragraph 7 states that:

"WHO can accept financial and in-kind contributions from philanthropic foundations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO".

While Paragraph 8 states:

"As for all contributors, philanthropic foundations shall align their contributions to the priorities set by the Health Assembly in the approved Programme budget".

When a philanthropic foundation's contribution is small, it can be imagined that such a contribution could well fit within a pre-determined program of work. When the contribution is among the largest that WHO receives, with the Gates Foundation contributing over 13% of WHO's recent budget directly and further funds indirectly through Gavi's contribution (second largest funder), the availability of this specified funding must by definition have a significant impact on WHO's program of work, as it must be expended as agreed with the funding source.

If the funding source is found to be non-compliant, then funding would have to be returned.

(Paragraph 71 of FENSA main text): *"Any financial contribution received by WHO that is subsequently discovered to be non-compliant with the terms of this framework shall be returned to the contributor".*

On a practical level, if Gates Foundation funding were found to be non-compliant with FENSA and needed to be returned, this would currently (late 2025) require closure of programs and/or considerable staff retrenchment on top of a 25% downsizing currently underway.

Thus, the FENSA mechanism facilitates private funding and involvement of such entities in WHO governing bodies and programs, with the WHO secretariat who benefits from this, and are increasingly dependent on it, managing the vetting and oversight process. The potential

for conflicts of interest of these private entities, some on the list of entities in official relations with WHO, are clear. They fund commodity-based programs and have direct or indirect financial interests in sales of pharmaceutical and biotech commodities that may be affected by such programs. Currently, therefore, there are clear conflicts of interest both among staff and among funders, both with interests to avoid rigorous implementation of FENSA rules regarding private sector funding.

IV.5. GOALS AND STRATEGY

WHO's evolution is shaped by various factors, btu can be traced through its General Programmes of Work (GPWs) which lay out strategy for future years. These reflect external and internal pressures, and also ability to learn. Here we assess WHO through this lens.

IV.5.1. WHO evolving through its General Programmes of Work

Trends in WHO General Programmes of Work (1996-2025)

The General Programme of Work (GPW) is a WHO high level document that outlines the WHO's strategic direction, resource allocations, agenda, and decision-making in global health for a specified period. The GPW is approved by the WHA and is developed in consultation with Member States, experts and stakeholders in global health. Although approval is via the WHA, it should be noted that there have been concerns raised about how the GPW is created prior to the WHA and the level to which the WHO Secretariat sets the agenda in a way that may not reflect the interests of Member States over the interests of the WHO.

That aside, as a strategic document, the GPW acts as the basis for the WHO's biennial Programme Budget to meet its strategy, justifies the resources required, and details the mechanisms to be used to measure progress toward GPW targets as well as how those results will be recorded and communicated. As part of its monitoring and evaluation processes, the WHO has established the WHO Results Framework,549 WHO Results Reports, and the WHO Programme Budget Portal.

Analysis of GPW documents from 1996 identifies three trends in GPW development: 1) An increased biomedical securitisation of health; 2) A continued overreliance on voluntary contributions with disproportionate policy influence, and: 3) A shift toward the greater use of results-based metrics, which relies on underdeveloped monitoring and evaluation techniques (see Section II.3.6).

The securitisation of GPWs

Analysis of GPW documents from 1996 reveals a significant increase in the emphasis on health security. This focus has grown, especially in response to major global health crises like the Covid-19 pandemic and the West Africa Ebola epidemic, moving health security from a general concern in global public health to a central, measurable priority.

An abridged genealogy of health security in key GPWs illustrates this trend:

- **GPW9 – 1996-2001:** In the late 1990s the term "security" was initially used as a frame to reassert the WHO's value in a globalising post-cold war world, with an early focus on HIV/AIDS and its potential impact on national and regional stability. The SARS outbreak and the threat of an avian influenza pandemic further highlighted the need for better international cooperation and health emergency preparedness. As a result, a visible shift occurs from the late 1990s to the early 2000s, where earlier goals associated with 'Health for All by 2000' were slowly replaced and fused with elevated narratives focusing on health security approaches and disease specific vertical interventions.

- **GPW11 – 2006-2015:** A significant acceleration of an emerging health security paradigm was the adoption of amendments to the International Health Regulations (IHRs) in 2005, which provided a legal framework for global alert and response to public health emergencies of international concern. The IHR require countries to build core capacities for preventing, detecting, assessing, reporting, and responding to public health risks, thus cementing "health security" in international law and national programmes. A result of the IHRs was a further prioritisation of health security approaches within GPW11 coupled with an increased use of benchmarks to help direct and track IHR compliance and progress.

- **GPW12 - 2014-2019:** Health security and communicable diseases were explicitly identified in GPW12 as one of the five key technical areas and strategic directions, reflecting WHO's further commitment to health security paradigms. The launch of the Global Health Security Agenda (GHSA) by the Group of Seven (G7) in 2014, with WHO as a key

partner, further intensified WHO efforts to benchmark and improve preparedness for biothreats. The GHSA placed additional pressure on WHO to shift strategic alignment from broader global public health issues such as Universal Health Coverage (UHC), since the GHSA represented a new "global priority" and competitor for financial resources and epistemic authority. Narratives around the creation of GHSA clearly had an impact on the strategic thinking of the WHO Secretariat and GPW12, since GHSA was explicitly adopted at the 2014 G7 Leaders' Summit as a response to perceived WHO failures during the West African Ebola outbreak.553

- **GPW13 (2019–2023):** Health security became one of the three core strategic priorities, explicitly defined by the "triple billion" targets. One of these targets was dedicated to having one billion more people better protected from health emergencies. It is important to note that GPW13 was written prior to the Covid-19 pandemic, which can explain a lesser focus on pandemic preparedness. That said, given renewed concerns for pandemic risk within key Western countries and the establishment of the GHSA, the WHO understood GPW13 to represent a step-change in policy, offering a more proactive and results-oriented approach with specific metrics and indices for outbreak preparedness and response.

- **GPW14 (2025–2028):** The current GPW14 builds upon GPW13, further solidifying the focus on health security. However, unlike GPW13, it places a much greater emphasis on pandemic prevention, preparedness and response. Like GPW13, GPW14 extends its strategy to help building resilient health systems capable of preventing, preparing for, and responding to all public health and humanitarian emergencies, while explicitly linking health security efforts with broader health systems strengthening and universal health coverage goals. In theory this suggests some attempts to rebalance "health security" toward more holistic approaches to resiliency,554 although given post-Covid preparedness and response policies, this looks to be more normative and symbolic than driving resource allocation and policy implementation.555 Moreover, securitised language of emergency preparedness within GPW13 is extended in GPW14, such as a greater emphasis on climate related risk and emergencies, strengthening results-based evaluations for IHR compliance to mitigate threats, and making "the WHO more capable of serving as both a first responder and a provider of last resort of essential health services in humanitarian emergencies".

As noted above, since GPW13 (2019-2023) was approved in May 2018 it did not put the same emphasis on pandemic preparedness as GPW14. Moreover, unlike GPW14, which focuses more on "health security" and "results based" strategies, GPW13 aligns closer to the WHO's wider definition of health, outlining its strategic vision to "promote health, keep the world safe, and serve the vulnerable". GPW13 highlights its overriding values and commitment to "human rights, universality and equity, based on principles set out in WHO's Constitution", language that is less prevalent in GPW14. Whereas GPW14 has six strategic priorities (see Figure IV.5), GPW13 is structured around three interconnected strategic priorities:

- achieving universal health coverage
- addressing health emergencies
- and promoting healthier populations.

As illustrated in Figure IV.4, GPW13 seeks to promote these strategic priorities through three activities: "stepping up leadership; driving public health impact in every country; and focusing global public goods on impact". These themes are continued and extended in GPW14, with a greater emphasis on impact and a more detailed result-based approach outlined. This suggests a further shift to performance-based monitoring and evaluation.

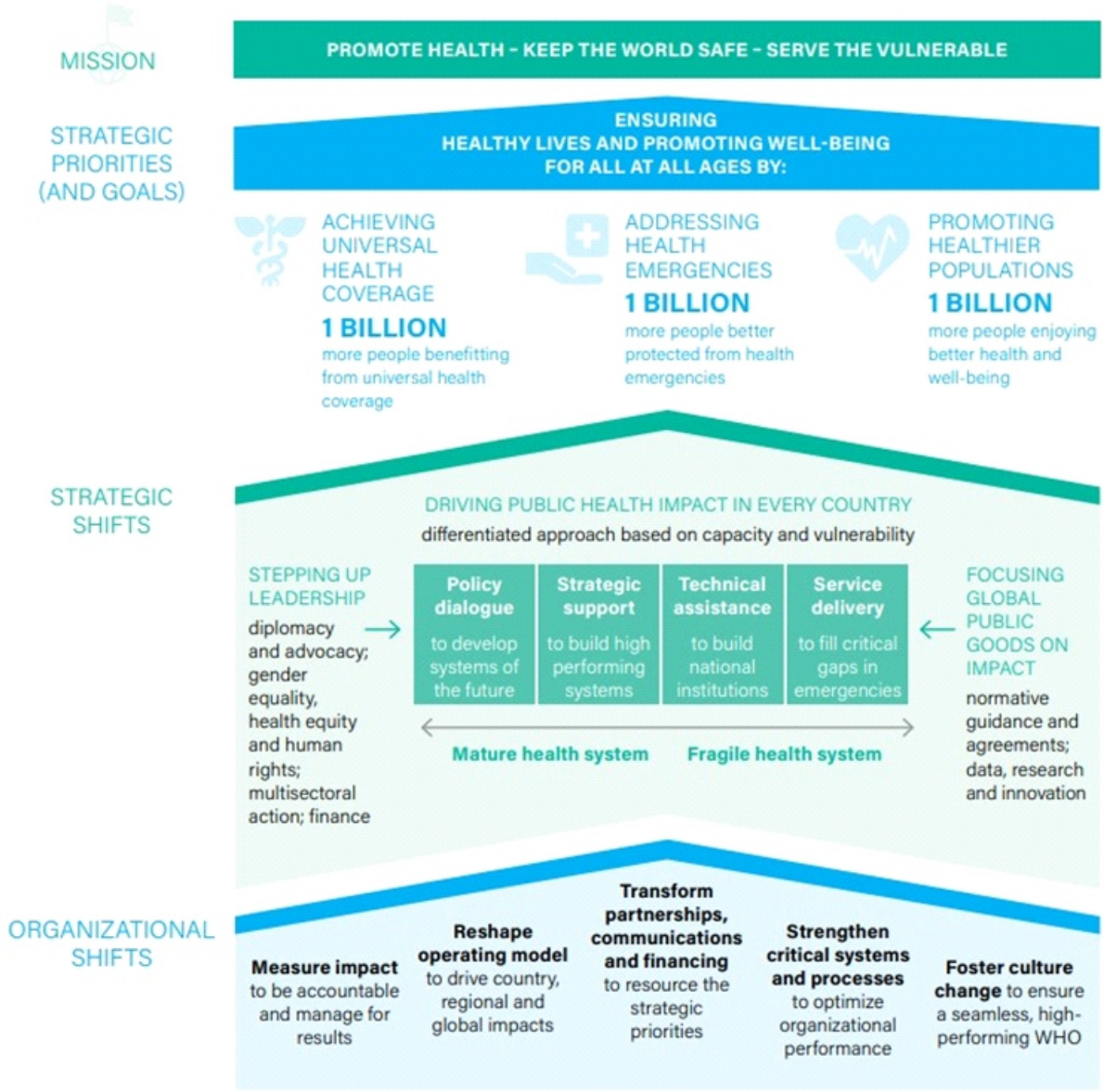


Figure IV.4 – Overview of WHO Thirteenth General Programme of Work (GPW13).
Source, WHO, https://www.who.int/about/general-programme-of-work/thirteenth

Figure IV.5 – Overview of Fourteenth General Programme of Work (GPW14).
Source: WHO, https://www.who.int/about/general-programme-of-work/fourteenth

The most obvious shift from GPW13 to GPW14 is on pandemic preparedness as a measurable priority. In GPW13 the WHO adopts a clear "all hazards" approach using the wider language of "health emergencies" rather than an emphasis on outbreaks and pandemics. Although outbreaks are featured, GPW13 has a better balance between the various types of health emergencies addressed. Given that the GPW13 was written prior to the SARs-CoV-2 outbreak, and given the high personal, social and economic costs of Covid-19, GPW14's focus on pandemics is understandable. Nevertheless, it does signal that GPW14 places high priority on pandemic policy, which will undoubtably create resource shifts, opportunity costs, and potential misalignment away from endemic diseases and other health risks.

Although present in both programmes, GPW13 places greater emphasis on the link between UHC and health security. This signals that GPW14 has potentially downplayed or sidelined this relationship, an interpretation supported by the amount of space dedicated to "strengthening" core capacities in surveillance, diagnostics and access to countermeasures. Thus, GPW14 focuses strategy on detection and response, while "preparedness" measures are undervalued in comparison to GPW13, where basic health and health system strengthening was deemed as a cornerstone of resiliency.

Well-being is also a featured element in GPW13 in comparison to GPW14, although both documents dedicate space to well-being strategies. Interestingly, in GPW13, the focus on communicable disease control is applied to high impact endemic diseases, with a more proportionate account of preparedness for emerging infectious diseases (EIDs) and zoonotic spillover risk. However, GPW14 reflects the current trend to overemphasise the disease burden threat of EIDs in comparison to endemic diseases of much higher burden.

Comparative Budget Breakdown

GPW13 WHO budget for 2024–2025

The total approved Programme Budget for the 2024–2025 biennium was (as of late 2025) **$6.83 billion**. This includes a base budget of $4.968 billion. The funding was allocated across the following budgetary lines:

- **Universal Health Coverage:** $1.96 billion
- **Health Emergencies:** $1.21 billion
- **Healthier Populations:** $0.43 billion
- **More effective and efficient WHO:** $1.35 billion
- **Emergency Operations and Appeals:** $1 billion (Covid-19 related increase)
- **Polio Eradication:** $694 million
- **Special Programmes:** $172 million

GPW14 WHO budget for 2026–2027

In May 2025, the World Health Assembly approved a new budget for the 2026–2027 biennium. The total approved budget under all sources of funds is **$6.21 billion**. This includes **a base budget of $4.27 billion**, which is a 14% decrease from the 2024–2025 base budget.

The 2026–2027 base budget of $4.27 billion is allocated according to GPW 14, which runs from 2025 to 2028. Key thematic budgetary lines include:

- **Promote health:** $399.9 million
- **Provide health:** $1.787 billion
- **Protect health:** $918.5 million
- **Power the global health agenda:** $577.2 million
- **Optimise WHO's performance:** $583.7 million
- **Other areas:**
  - **Polio eradication:** $770.9 million
  - **Special programmes:** $168.7 million

At first brush the final biennium budget of GPW13 looks to have a much higher budgetary allowance for health emergencies and health security related programmes. However, there are three important confounders. First, the final GPW13 budget was agreed in May 2023 during Covid-19 while higher than normal resources were being mobilised for health security measures. Second, an entire budget line associated with GPW13 is directed largely to Covid19 specific and post-Covid related activities, again

suggesting a state of exception. Third, the overall budget for WHO was increased significantly during Covid-19 with a surge of voluntary contributions across most of WHO's base budget and programmes.

Furthermore, when examining the budget allocations across the six strategic priorities of GPW14 it is possible to find health security programmes embedded in all six priorities. This represents a further securitisation of the GPW14 in general, an acceleration of a trend present in GPW12 and GPW13. As two examples, programmes related to zoonosis prevention and One Health integrated surveillance are incorporated into Strategic Objective 1 and 2 dealing with climate change adaptation and determinants of health respectively. In addition, programmes associated with preparedness via improved access to outbreak countermeasures and related system capacities are linked to Strategic Objective 3 and 4 to improve system strengthening and service coverage. Although this does reflect a more integrated and systems approach, which is to be commended, the prioritisation of programmes for health security threaten to undermine a more holistic approach to health policy.

Consequently, in relative terms, it is possible to assess that the health security component of GPW14 represents a larger percentage than what was allocated for GPW13, once the exception of Covid-19 is factored. This signals a continued trend within the GPWs of a creeping biomedical securitisation of health. This is not without associated challenges (see Sections II.1.3 and II.3.2).

Security from what and security for whom?

A closer analysis of GPW14 reveals an increasing tension within the strategic vision of the WHO. On one hand, like GPW13, GPW14 uses the explicit language of strengthened health systems as being the key foundation for health security from all hazards and placing emphasis on the positive spillover effects health system strengthening can have on routine service delivery and everyday health. Moreover, GPW14 clearly reasserts a preventative logic based on a primary health care approach. Namely, that healthier people will promote long-term population and system resilience able to both withstand and "bounce back" from any acute health emergency (this approach is also supported in new secondary policies such as Health Systems for Health Security). This in theory pivots GPW14 away from traditional health security policies, which have historically focused on preparedness via improved surveillance, diagnostics, and the discovery, production and rollout of medical countermeasures.

However, the language of GPW14 does not match the current reorganisation and policy prioritisation taking place at the WHO nor is it reflected in many of its post-Covid emergency policies. This is because recent reorganisation of the WHO has placed increased emphasis on health emergencies and security, reducing the WHO into four operational "pillars" (Business operations and compliance; Health promotion, disease prevention and control; Health systems, and; Health emergency preparedness and response). Within this new structure, GPW14 budget commitments now favour health emergencies, communicable disease control, climate harm risk mitigation and preparedness, and disease prevention through vertical inoculation programmes (see budgets above).

GPW financing restraints and overreliance on public-private partnerships

Much of the disconnect between the WHO's normative vision and practice is again arguably a result of voluntary specified contributions (see Section IV.6.2), which have historically favoured health security related interventions, particularly vertical programmes for communicable disease. For example, a recent BMJ study of where the Gates Foundation targets its voluptuary specified contributions found that 82.6% of its money between 2010 and 2023 focused on infectious diseases, whereas "relatively little BMGF funding went to noncommunicable diseases, strengthening health systems, and broader social determinants of health, despite their importance to WHO strategy and to global health more generally". The ability of specified financing to steer GPWs is not limited to non-State actors and was used to establish the new WHO Hub for Pandemic and Epidemic Intelligence in Berlin as a key pandemic prevention preparedness and response initiative. Although it is officially a WHO "partnership", the WHO Hub was largely underwritten by German voluntary specified funding, technical expertise, and in partnership with European pharmaceutical collaborators.

GPW Results-based performance and public-private partnerships

Further analysis of GPW14 can identify several new WHO directives aimed to improve the performance of its policies yet reveal lingering concerns about the centralisation of epistemic authority, policy overreach, and inadequate transparency.

First, although GPW14 articulates its objective to increase positive impact at country level, its method for doing so looks immediately outdated and subject to traditional shortcomings associated with many results-based monitoring and evaluation mechanisms. For example, the WHO seeks to implement "output scorecards" and "impact methodologies for measurable results", yet it remains unclear how these indicators will align with country level needs versus simply measuring whether a country has adopted a specific WHO policy within its national strategic health plans (NSHPs). As noted in GPW14, WHO's organisational transformation is to:

> *"ensure that the Organization's leadership, technical products and country support plans are fully aligned with national needs and WHO's strategic priorities. Performance management processes now link the day-to-day work of the entire workforce directly to WHO's mission and strategy".*

In some respects, this reads like the furtherance of unidirectional and top-down strategies, operating under the assumption that WHO priorities are also those of every Member State. A more generous reading could be that "*fully aligned with national needs*" means the redesign of WHO policies so that they are aimed to address general global public health needs, while allowing bespoke policy adaptations and context driven interventions, which would better reflect commitments to increasing national ownership made under the Paris Declaration on Aid Effectiveness, the Lusaka Agenda and the Accra Reset. Regardless of GPW14's intent, in practice there remain key questions about how the WHO will better align their strategic priorities with the national needs of Member States, especially given concerns of underrepresentation of LMICs within WHO governance processes such as the WHA committees and decision-making (see Section IV.3.2).

Second, GPW14 posits a strategic priority to "*enable the full potential of WHO's workforce to provide authoritative advice and leadership*". This includes the establishment of the Chief Scientist and the Science Division, with an increased role for the use of collaboration centres. By doing so, GPW14 suggests that WHO should be able to augment "*the Secretariat's capacity to shape global health research priorities, to ensure that its normative work is of the highest ethical and quality standards, and to help countries strengthen their health research capabilities*". In many regards a greater emphasis on research collaboration, evidence production, and evidence-informed policy making is to be welcomed. However, the reliability of the WHO as an epistemic authority to shape global health priorities requires that its research processes are science led and not captured by vested interests, specified funded pet-projects, or by dominant paradigms that lock-out meaningful scientific enquiry (see Section IV.5.3).

Third, GPW14 outlines its strategic priority to "*create better links with key actors*" to increase 'partnerships' and to further "*WHO's engagement for health in multilateral forums*", which "*has been elevated and professionalized through the Office of the Envoy for Multilateral Affairs and a strengthened WHO office at the UN*". Additional initiatives like the '*WHO Civil Society Commission*' and the '*WHO Youth Council*' are outlined in GPW14 as key mechanisms to draw upon the "*expertise of the key constituencies of civil society and young people*." Lastly, GPW14 seeks to build on the "*provisions of the Framework of Engagement with Non-State Actors.*

(FENSA)", by strengthening "WHO engagement with parliamentarians, international business associations, philanthropic foundations and other constituencies".

The use of "*constituencies*" is noteworthy, since it elevates non-State actors, particularly businesses and foundations, to political shareholders of a represented public. In addition, it signals GPW14's strategic vision to increase private-public partnerships in the determination of policy and to professionalise these links. The concern is that the word "*constituencies*" in common usage denotes a special relational condition of political obligation, in which a political organization is assumed to be representative of its constituents. In the case of WHO, its formal constituents are its Member States and the citizens of those countries through their representatives. In terms of FENSA, and conflicts of interest, it is general practice to refer to these other organizations as "stakeholders", which appropriately recognises that they have a meaningful stake in global health policy that should be reasonably reflected and consulted. Yet, responsiveness to the needs of stakeholders should not be conflated with assumptions of official representation of non-State actors (see Section IV.3.1 on FENSA).

Fourth, GPW14 rightly acknowledges the need for WHO to have predictable financing through increased assessed contributions. Yet, GPW14 again relies heavily on further "investment rounds" to broaden its financial base through voluntary contributions as well as financial input from a new and potentially problematic WHO Foundation (WHOF). In the case of the latter, a BMJ study found the

level of transparency with WHOF to be "low" (receiving a 'D' rating in which less than 50% of donations by value are disclosed), "exposing the WHOF and by extension the WHO to risks of perceived reputational damage or undue influence". The reliance on voluntary contributions and organizations like the WHOF will further distort and direct WHO policies and thus undermine its ability to function as an appropriate international health organization.

GPW14 concludes with the following centralised and health security focused statement. It is worth reproducing in full:

> *"Together, these changes are making WHO more efficient, relevant and responsive to the needs of its Member States; better equipped to support its partners; more fit to play its essential roles in enabling and coordinating at all levels; and, in health emergencies, more capable of serving as both a first responder and a provider of last resort of essential health services in humanitarian emergencies. Since the pandemic, WHO's unique position spanning the health, sustainable development and security agendas has become more prominent, with an expectation that the Organization will play an even greater role in aligning priorities and facilitating action to improve health and well-being at country, regional and global levels, across sectors and in related forums".*

The GPW14 continues:

> *"While meaningful change takes time, many of the changes introduced through WHO's Transformation Agenda were already instrumental in enabling WHO's enhanced response to the pandemic. The pandemic was also an important test for this changing WHO paradigm, providing important lessons that are guiding the further improvement and evolution of the Organization for a post-pandemic world of even greater complexity and uncertainty".*

IV.5.2. Does the WHO have the right mission?

According to the 14th GPW (page 19):

> *"The overarching goal for the GPW 14 is to promote, provide and protect health and well being for all people, everywhere. Inherent in this goal are the principles of equity in health service coverage and health systems resilience, both of which are fundamental to accelerating and sustaining progress on the health-related Sustainable Development Goals and to future-proof health and care systems. It emphasizes the need for a paradigm shift that emphasizes prevention and to operate across the continuum of services and interventions, from prevention and health promotion through protection and the provision of essential public health services to treatment, rehabilitation and palliative care across the life course. […]".*

This mission is relatively well-aligned with the definition of health according to WHO's Constitution preamble, as well as with the needs identified in Part II and Part III of this report. However, the 14th GPW also specifies six strategies along its three goals of "promoting, providing and protecting health" (page 19 – bold are in the original text, italics are ours):

> *"**To promote health**:*
> *a. respond to **climate change**, an escalating health threat in the 21st century; and*
> *b. address **health determinants and the root causes of ill health** in key policies across sectors.*
>
> ***To provide health**:*
> *a. advance the **primary health care approach and essential health system capacities** for universal health coverage; and*
> *b. improve **health service coverage and financial protection** to address inequity and gender inequalities.*
>
> *To **protect** health:*
> *a. **prevent, mitigate and prepare** for risks to health from all hazards; and*
> *b. rapidly **detect and sustain an effective response** to all health emergencies".*

While the strategic objectives relating to addressing "health determinants and the root causes of ill health", advancing "the primary health care approach and essential health system capacities for universal health coverage" and improving "health service coverage and financial protection" are clearly within the scope of an IHO, the others are more controversial. The two strategic objectives related to protecting health – that is, pandemic prevention, preparedness, and response (PPPR) – have taken excessive place in the two most recent GPWs (see

section above on trends in GPWs since the 1990s). More worryingly, responding to climate change should definitely not be the role of a health organisation – except for supporting Member States to adapt to, mitigate and reduce the environmental impacts of healthcare systems.

IV.5.3. Is the WHO appropriately reflective and innovative?

Section III.5.2 outlined aspects associated with a self-learning and innovative organisation. Although it did not provide an exhaustive list, it featured eleven elements widely understood as crucial: 1) Stakeholder-centric design; 2) Agile and adaptive culture; 3) Radical Transparency; 4) Constructive dissent and the acknowledgement of failure; 5) Deconstructing siloes; 6) Decentralised decision making and subsidiarity; 7) Risk-awareness versus risk-aversion; 8) Evidence driven decision-making; 9) Intolerance for incompetence; 10) Multi-perspective hiring, and; 11) Leadership by example. This section compares the WHO against these elements to identify strengths and weaknesses necessary to consider when assessing the WHO as an appropriate IHO.

A need to regain its stakeholder-centric design. The WHO is one of the largest specialised agencies within the United Nations system. It operates worldwide advocating for universal healthcare, monitoring public health risks, preparing for emergencies by identifying, mitigating, and managing risks, and coordinating responses to health emergencies.575 The WHO sets international health standards and guidelines and provides technical assistance to countries. To deliver on this broad mandate, it employs over 9,000 staff dispersed across 150 countries and five regional offices in addition to the headquarters in Geneva.576 As a result, the WHO is widely understood as the primary epistemic and policy authority in international public health with a mandate from countries to promote and safeguard the health of its Member States as well as stateless peoples. The WHO mandate is therefore in essence a mandate from its Member States and their populations for which the WHO ultimately exists to represent in its policies and actions.

As noted in The Right to Health Sovereignty Policy Report, there are concerns regarding WHO's drift from its political mandate, particularly in regards to outside political and corporate influence via how it is financed (Section IV.6.2), ongoing mission creep infringing on traditional concerns of national governments and their sovereignty (Policy Report Part V), and self-promotion of the organisation at the cost of wider accountability to Member States and their peoples (Section IV.3.3).577 Moreover, recent events within the South-East Asia Regional Office (SEARO) and controversies with its leadership selection process suggest governance design and accountability flaws both within regional processes and between regional offices and WHO Headquarters. Consequently, whether WHO is sufficiently built around equitable representation of stakeholder needs is increasing being questioned, resulting in an organisation that struggles to innovate and meet expectations amidst accelerating levels of distrust and policy fragmentation.

- **An unagile and slow to adapt culture.** WHO is well known for its high levels of bureaucracy and rigid hierarchical structures. This has historically led to portrayals of WHO as lacking adaptive capacities, as being bureaucratically "fossilized", as well as difficult to reform through internal processes. A short list of shortcomings include: An overly politicised culture; Slow response times; Operational inefficiencies; Internal departmental competition, and WHO remit overreach.

- **A need for radical transparency.** There have been consistent concerns about the lack of transparency, both within internal WHO processes and with external relationships. This has been particularly notable in relation to specified voluntary contributions, contracts with external non-governmental partners (e.g. COVAX), the use and cost of external consultants, and obscured internal decision-making processes. A lack of transparency can stifle information flows and thus limit institutional learning, problem solving, policy legitimation, and the vetting out of poor constructs.

- **A lack of constructive dissent and the acknowledgement of failure** (see also Sections IV.5.3, IV.5.4). Although there are no official studies on an internal culture of "constructive dissent" within WHO, there is sufficient anecdotal evidence to suggest a notable culture of self-censorship and suppression exists. Manifestations include avoidance of raising critical issues or challenging policies out of fear that it will harm job security or promotion, and/or fear that challenging existing paradigms will result in social exclusion, public "cancelling", or job insecurity. Moreover, WHO has been accused of sidestepping the acknowledgement of failure, attempting to sweep issues under the rug, and/or to redirecting blame to retain political capital at the cost of learning lessons for population-wide Covid-19 vaccinations there.

- **Rigid siloes.** Although there have been recent attempts to reorganise and streamline the WHO with an aim to increase interdepartmental collaboration, efficiencies, and opportunities for innovation, questions remain about WHO's "fossilized" bureaucracy, stagnant internal culture and its ability to effectively reform. Furthermore, budgetary competition between departments has historically fuelled the establishment of fiefdoms with negative knock-on effects, a condition exacerbated by recent funding cuts. Moreover, expanding remits and policy foci has resulted in the growth of niche departments and committees, which places additional resource and coordination strains on WHO. Lastly, despite the introduction of a new mobility scheme, Geneva Headquarters has the highest percentage of tenured staff (15 years +) with the lowest rate of mobility, at less than 1%, suggesting extremely low movement between departments. This results in entrenched staff with corresponding potential for performance stagnation. These factors undermine WHO's ability to be a self-learning, adaptive and innovative organization, and thus are key areas for reform.

- **Overly centralised decision making and the need for subsidiarity.** Recent reform strategies at the WHO have pinpointed the need to increase the roles of country offices and regional offices, moving decision making downward from Geneva. Nevertheless, these reforms have struggled to take effect in practice, with the WHO's recent Global Programme of Work (GPW14) looking to expand its mandate rather than distribute it downward. Moreover, a common critique of WHO management is that it is overly "top-heavy" and highly centralised, reducing agility, but also undermining WHO's internal culture (See section on Internal Culture). In addition, an expanding mandate works against the principle of subsidiarity, which stipulates that decisions are made at the lowest level capable of acting effectively, whilst facilitating global cooperation on joint priorities. National governments coordinate health policy and finance, working through their network of facilities and practitioners. Transborder concerns are first addressed at regional levels, where regional bodies act as intermediaries between national and global priorities and manage cross-border cooperation. Although regional cooperation is often acknowledged within the global health literature as a crucial level for economies of scale and collective action (which also allows for better policy contextualisation), the utilisation of regional coordination remains underdeveloped. Lastly, the role of WHO is to play a crucial supportive and advisory role, providing technical assistance, knowledge on capacity building, data sharing, and normative guidance. Ultimately, the aim of WHO should be to support localised, self-reliant, and sustainable health systems, not to consolidate additional authority in Geneva.

- **Skewed risk-awareness versus risk-aversion.** The literature on WHO's riskawareness and risk-aversion is extremely mixed.

In terms of responding to epidemiological and wider health risks, the WHO has often been accused of being overly cautious in its response, most notably in its slow response to the 2014 Ebola outbreak. Other popular narratives suggest that WHO was also too slow to advocate for stricter measures during the first days of the SARs-CoV-2 outbreak, and that it only offered more authoritative guidance once it perceived that it had lost its epistemic authority to more aggressive policies in East Asia and Southern Europe. According to this literature, WHO rapidly "flip-flopped", quickly abandoning its own managing epidemics recommendations to signal its support for stricter PHSM measures used in China and elsewhere. This latter example highlights the fact that WHO operates with a heightened sense of institutional risk-aversion and image protection, resulting in potentially counterproductive or harmful policy shifts. Furthermore, this heightened sense of institutional risk is a result of learned experience, since WHO is fully aware of the criticisms it received for its prior "failure" to respond effectively to outbreaks (e.g. Ebola). These further support literature arguing that WHO often finds itself in a defensive position, where demands for speedy action can be in tension with its more precautionary policies. These performance problems partly rest with Member States who place divergent interests and political pressures on WHO, and which through voluntary specified funding, often include additional financial risks. Yet, responsibility also resides with WHO, which must remain committed to the best available evidence and not pivot toward vested interests or to accommodate a few powerful Member States.

In terms of risk-awareness, there has been an increasing securitisation of WHO health policy since the 1990s, a condition exacerbated by Covid-19. As discussed in Part II and in the above Section on Global Programmes of Work, securitisation narratives tend to inflate risk and produce hyper-awareness, driving

disproportionate policy response and resource mobilisation. As noted in the Section on Financing, the estimated budget associated with the General Programme of Work Fourteen (GPW14) for 2025–2028 is predominantly focused on health security and health risks, which allocates scarce resources to a specified list of global public health priorities. Moreover, since the emergence of SARs-CoV-2, WHO has adopted a highly securitised language of "existential threat" regarding climate change and pandemics, resulting in a current restructuring of WHO that disproportionately favours health emergencies, particularly focussed on response to emerging infectious diseases (EIDs).

In the case of the pandemic preparedness, WHO begins most of their recent statements and policy recommendations with the assertion that pandemics are increasing in frequency and severity. This securitised language has dominated discussions around the Pandemic Agreement and amendments to the International Health Regulations with the intent to mobilise political and resource support for these WHO initiatives. Most global health actors have followed suit, seeking to securitise the current global health landscape to capitalise on "the post Covid moment", which has resulted in an accelerated political process and rushed policy making. The narrative of high-risk continues even though many risk claims are based on underwhelming evidence, including cases where the cited evidence fails to support WHO claims.

- **The need for better evidence driven decision-making.** Structurally, the WHO is meant to incorporate evidence into policymaking through its Evidence-Informed Decision-Making (EIDM) structure, which aims to identify, appraise, and apply the best available research to guide public health policies. The approach was developed by the Evidence-Informed Policy Network (EVIPNet) within the WHO Secretariat to ensure that decisions are not based solely on expert opinion but on rigorous, systematic, and contextualised data. Moreover, the WHO operates a Grading of Recommendations Assessment, Development and Evaluation (GRADE) framework to assess the quality of evidence and determine the strength of recommendations. Further institutional structures for evidence-based policy include a Guideline Review Committee (GRC), a Health Evidence Network, and the creation of a new Science Division to reinforce the WHO's mandate to lead with science and evidence. (see Section on GPWs above).

Although the WHO has implemented important structures for evidence production, synthesis, and its translation into policy, there have been critiques regarding the quality of these processes, the WHO's commitment to these processes, and their ultimate use in the final delivery of policy or WHO recommendations. A brief list of critical points include: 1. WHO has historically issued "strong recommendations" based on low quality and / or poor levels of evidence; 2. Evidence is at times employed ex-post to justify decisions already made for political reasons versus decisions originally based on best available evidence; 3. A tendency in WHO to prioritise quantitative studies and Randomised Controlled Trials (RCTs) over qualitative or other observational studies, and; 4. A tendency to prefer Westernised biomedical evidence over locally based evidence.

The establishment of the Science Division suggests that WHO is aware of the actual and perceived shortcomings with its use of evidence, a condition which it is seeking to correct. Presumably this is a result of a backlash resulting from poor Covid-19 performance, since there is a growing body of literature suggesting that WHO made counterproductive and harmful recommendations and/or provided policy support to questionable policies during the pandemic, as discussed above regarding failure to

emphasise expected harms of lockdown-related measures and diversion of funds to population-wide vaccination programs of mostly-immune people.

- **A tolerance for incompetence.** Like any large organisation, the WHO is subject to poor performing and incompetent staff. Moreover, like any UN organisation, it is subject to UN human resource policies, which are famous for being highly bureaucratic, making it difficult to remove incompetent or inert staff. Yet, WHO's capacity for self-reflection and acceptance of failure, as an important part of institutional learning (see Sections on Internal Culture and Workforce), was concerning during Covid-19 and its aftermath.

- **A need for strategic multi-perspective staffing.** A key element of innovative cultures is collaboration between multiple perspectives and approaches within an open and communicative environment. There are three potential areas of weakness in how WHO allocates human resources (also see the Section

on Workforce). First, the number of WHO consultants is approximately 7600 as of July 2024 which is on par with the number of regular WHO staff'. Although the use of consultants is often necessary to bring in expertise and new ideas or to sidestep complex Human Resource regulations, it can also lock-in paradigms while raising concerns of conflict of interest. Second, the WHO is criticised for prioritising quotas over expertise, which has translated into concerns that WHO is not deploying the most suitable personnel in all cases. Although this might promote the introduction of new perspectives into WHO departments, it may also embed incompetence. Third, there are concerns that the WHO has "overstretched" its remit into an increasing number of policy areas. A result of this "mission creep" is an increased inability to address these policy areas appropriately, thus increasing a reliance on consultants, non-experts, and/or redeployed staff. Although this might increase different perspectives, it does so non-strategically with a high potential to be counterproductive.

- Leadership by who's example? WHO leadership has faced several recent criticisms, with a polarisation of views.

On one hand, criticisms have focused on structural conditions that undermine WHO's ability to lead, particularly during health emergencies, and especially during Covid-19. These include arguments that the WHO has weak enforcement power and thus requires increased authority; that the WHO delays declaring public health emergencies of international concern (PHEIC) due to fear of upsetting Member States; that the WHO fails to assure vaccine equity due to a lack of authority and finances, and; that it fails to be politically neutral due to an overreliance on voluntary contributions from both powerful Member States and non-State funders. In the reform literature on WHO, criticisms conclude with recommendations for increased authority, more financing, and enforcement powers to address these shortcomings. This report argues the opposite, suggesting that there is a need for a global public health focused IHO that aims to place control and decision making at the lowest levels possible within regional bodies and Member States, that this IHO does not inflate pandemic risk as a means to swell its organisation and centralisation, and that the IHO has appropriate financing so that it can operate independently of the external influence of donors (yet within normal accountability mechanisms).

Other criticisms of WHO leadership have focused on it being overly 'China-centric' and deferential to China, particularly during Covid-19. Further critiques have focused on its poor transparency, confused communications and position switching during Covid-19, as well as inherent conflicts of interest and undue influence on WHO policies because of its overreliance on voluntary specified contributions.

In summary, adaptive and effective organisations require an ability to learn, innovate and alter internal processes and policy. Although there have been historical concerns about WHO's capacities in this regard, these concerns gained prominence post-Covid-19. Key issues include a need for better evidence-based policy making; a need for greater transparency, open communication and constructive dissent; increased subsidiarity; the removal of siloes and increased mobility; proportional risk awareness; and leadership focused on WHO's core mission and global health priorities.

IV.5.4. Does WHO have insufficient development of the evaluation function?

The evaluation practice is still poorly developed at WHO, especially compared to other large international organisations. It is only recently that WHO has started to develop its evaluation function and to utilise evaluation outcomes to support decision-making – but so far, WHO's Evaluation Office606 has not played a sufficient role in monitoring WHO programmes and in feeding policy and normative work based on evaluation lessons.

As part of WHO's reform process, the Executive Board approved the first WHO evaluation policy in May 2012. WHO then issued an Evaluation Practice Handbook in 2013, aimed at providing practical guidance on how to prepare and conduct evaluations in WHO, and on the utilisation and follow-up of evaluation results. In August 2014, the evaluation function was moved from the Office of Internal Oversight Services to become a separate unit to support independent evaluation within the Office of the Director-General. In 2015, WHO started to develop its evaluation capacity, with a Framework for Strengthening Evaluation and Organizational Learning in WHO. In 2017, the Office of the Director-General launched an independent review of the evaluation function at WHO, which provided critical recommendations, one of which was the need to revise the 2012 evaluation policy.Thus, in 2018, WHO issued its revised Evaluation Policy which

supports the organizational shift initiated by the 13th GPW 2019-2023 and aimed at strengthening accountability and management for results, requiring a meaningful account of WHO's contribution on each goal and by each level of the Organization. The purpose of the revised Evaluation Policy is:

> *"to define the overall framework for evaluation at WHO, to foster the culture and use of evaluation across the Organization, and to facilitate conformity of evaluation at WHO with best practices and with the norms and standards for evaluation of the United Nations Evaluation Group".*

It allows for three types of evaluations to be commissioned by the WHO Secretariat: (a) *thematic evaluations* focused on selected topics; (b) *programmatic evaluations* focused on a specific programme and addressing achievements in relation to WHO's results chain; and (c) *office-specific evaluations* focused on WHO's work in a country, region or at headquarters in respect of WHO's objectives and commitments. Further evaluation guidance developed by WHO include the 2022 Framework for evaluations of WHO's contribution at country level and the 2023 Practical Guide on Evaluation for Programme Managers and Evaluation Staff aimed at supporting managers and staff who are not professional evaluators to plan and commission evaluations, as well as "*to share a common approach to evaluation [...] that reflects standards applied broadly by the professional evaluation community*". However, it only focuses on evaluation process management, not on evaluation approaches and methods. Finally, the Executive Board approved a revised WHO Evaluation Policy in 2025 which reinforces evaluation as the cornerstone of results-based management and reflects key evolutions in the professional practice of evaluation and the structure and operations of evaluation functions across the UN. It emphasises norms for impartiality, credibility and stakeholder engagement, and promotes the use of evaluation findings in policymaking and learning. It also aligns with the 14th General Programme of Work (2025–2028), ensuring evaluations support WHO's strategic priorities. As a result, although WHO has acknowledged weakness in this area, and has made strides to fill needed gaps in its evaluative functions, it has struggled to implement its own strategies, and thus there remains a critical area in need of reform.

IV.6. STRUCTURE AND PERFORMANCE

IV.6.1. Organization

The institutional structure of WHO/HQ is characterised by duplications in roles and responsibilities between departments and teams. As a result of this inherent institutional complexity, in its normative work, WHO has developed a vast array of guidelines and standard operating procedures.614 While itself constituting something of an 'infodemic' with which countries must deal,615 they risk duplication leading to confusion for implementing partners and countries.616 The physical structure, comprising WHO/HQ and six Regional Offices, is discussed in Section IV.3.1 and elsewhere in Part IV, including the increasing centring of WHO roles in its HQ. Here we discuss the drivers and results of its current structure.

WHO's securitization agenda

As detailed in Part II and in the above section tracking the evolution of GPWs since the 1990s, there has been increasing focus on health security resulting in what is often termed the 'securitisation of health'. The securitisation of health is a concept used to examine global health policy when an issue is elevated to an "existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure".617 The securitisation of health can be both ideational and performative, influenced by dominant discourses and the positional power of securitising actors, which includes intentional tactics and strategies to elevate issues to the level of a security threat, so as to change the way those issues are perceived, thus motivating action.

There are several relational concepts involved in WHO's increasing securitisation of health. In connection with an increased 'biomedical reductionism' discussed below, the WHO has increasingly engaged in processes of "*medicalising security*", "*pharmaceuticalizing security*", "*healthifying security*", and the "*riskification of health*", whereby security issues are increasingly framed in biomedical terms and where uncertainty is ever more constructed as risk. Importantly, within these processes health experts and public health authorities gain importance in the security field, with pharmaceutical interventions becoming important instruments for security policy.

As noted in Part II, WHO has become a key reproducer of the securitisation of health, a condition that has accelerated after SARs-CoV-2. As discussed above, the estimated budget associated with GPW14 for 2025–2028 is predominantly focused on health security and health risks, which allocates scarce resources to a specified list of global public health priorities.

Moreover, since the emergence of SARs-CoV-2, WHO has adopted a highly securitised language of the "existential threat" from pandemics, resulting in the current restructuring of WHO that disproportionately favours health emergencies, particularly responding to those frequently labelled as emerging infectious diseases (EIDs). As one example of this elevated language, the 2024 World Economic Forum (WEF) in Davos co-sponsored an event with the WHO on preparing for Disease-X. In the build-up to its pandemics panel, the WEF website posed the following question: "with fresh warnings from the World Health Organization (WHO) that an unknown 'Disease X' could result in 20 times more fatalities than the coronavirus pandemic, what novel efforts are needed to prepare healthcare systems for the multiple challenges ahead?" The problem with this statement is that the number was entirely madeup, historically unprecedented, and representative of the type of fearmongering used to heighten interest and resources for the pandemic preparedness agenda.

As discussed earlier, WHO's assertions of rapidly increasing outbreak and pandemic risk, intended to mobilise political and resource support for WHO initiatives such as the IHR amendments and Pandemic Agreement, are based on underwhelming evidence, including cases where the cited evidence actually undermines WHO's claims. Most global health actors have followed suit, seeking to securitise the current global health landscape to capitalise on "the postCovid moment"

WHO's biomedical reductionism

It follows from our presentation of general concepts in public health (Part I and Part II) that medicine cannot be limited to applying protocols. Therefore, WHO's guidance needs to be used with caution and critical assessment. In recent years, and particularly during the Covid-19 pandemic, WHO has taken an increasingly interferent role in national public health policies and even medical practice. Even if, early in the pandemic, some insider WHO voices launched a call for more inclusive and transparent decision-making in the governance of the Covid-19 response, the WHO tendency to standardise procedures and to rely on inappropriate study designs to approach complex issues (e.g. in the case of early treatments for Covid-19) has led to a global response that took insufficient account of local contexts, community-developed strategies and heterogeneity in patients' needs.

Moreover, as outlined in Part II, and as presented in the academic global health literature writ large, WHO has adopted an increasingly biomedical approach to global public health. Biomedical reductionism is a concept used for understanding the increasing dominance of medical and technoscientific solutions within our understanding of ill-health and the promotion of good health. As a concept, biomedical reductionism has been closely aligned, and sometimes conflated with, notions of medicalisation and pharmaceuticalisation (see Part II), in which the promotion of health has increasingly relied on medical and pharmaceutical products.

The results of the biomedicalization of global health include:

- The growing dominance of technological or scientific solutions to health, particularly biology, biochemistry, genetics, and the use of pharmaceuticals for both treating illhealth and the promotion of good health.

- The growing dominance of biomedical solutions as a preferred method of addressing issues of health across an increasing range of social and personal experiences. For example, it is often suggested that the focused use of pharmaceuticals for pandemic preparedness versus focusing on the promotion of basic health to improve immune response is a form of biomedical reductionism.

- A trend toward greater surveillance, diagnostics and biomedical assessment in the reduction of ill-health as well as the promotion of good health.

- A trend towards biomedical solutions for the human body, which treat the body as a machine-like entity that needs 'fixing' and/or as a 'biopolitical' space that requires reengineering towards a predetermined upgrading of health.

Similar to the increased promotion of health security narratives, the WHO has moved solidly in the direction of

biomedicalised solutions which runs counter to its traditional public health role (See history of WHO and its public health foundations in Part II). This obviously raises key concerns as outlined throughout this report. Yet, as will be argued below, a key explanation for this shift can be found in the way WHO is financed, including the ability of key donors to direct biomedical and commodity based approaches via specified voluntary contributions.

WHO's never ending plans, toolkits, frameworks, and review exercises

In the framework of its technical support role in countries, WHO – just like other technical and financial agencies – tends to put a lot of emphasis on evaluation exercises, health policy design, and programme planning, but to leave away support for implementation, monitoring and evaluation. This results in an exponential rise in action reviews, evaluation exercises, planning seminars, new tool kits, and resulting plans which are often overwhelming in number, overly generalised, time consuming and expensive, and often neither funded nor implemented.

IV.6.2. WHO financing

The past 25 years have seen a large shift in WHO funding, as is discussed in detail later in this report. Fundamentally, this shift has involved a reduction in the proportion of WHO's total budget derived from assessed funding, and an increase of specified funding, including funding from the private or non-State sector. This means, practically, that WHO's activities are more open to direct influence of individual State funders (by specifying the use of voluntary funds), and more open to the influence of non-State actors through the same specified funding mechanism. This change has occurred in the context of an increase in WHO's overall budget, and an increase in the number of major supra-national agencies operating in the international public health arena, particularly private foundations, multilateral funding mechanisms and public private partnerships.

On 23 July 2025, BMJ Global Health published an article that looked at funding for the WHO from the WHO Foundation. The Foundation was set up in 2020 with the goal of broadening the WHO donor pool. According to the analysis by Nason Maani, Emily Adrion, and Jeff Colin, by the end of 2023 it had received donations totalling $82,783,930. Of this amount, $51,554,203 (62.3 percent) was from anonymous funders and $39,757,326 (48 percent) were described as anonymous donations of over $100,000 each. The proportion of anonymous donations had increased each year from 9.6 at the end of 2021 to 62.9 and 79.8. percent in the following two years, downgrading the Foundation's transparency rating by Open Democracy from B (at least 85 percent of donors above the $100,000 threshold are named with the exact amounts received from them) in 2021 to D (below 50 percent) in 2024. It is a reasonable inference that these donations, characterised as "dark money" in the mainstream media, are based on donor rather than WHO priorities that expose the organisation to conflicts of interest, undue influence, and reputational risks. Funding from Meta to the WHO department of communications and digital health, for example, is questionable at a time when the role of social media in facilitating health misinformation and contributing to child and adolescent mental health problems has come under heightened scrutiny.

The context of international health funding within which WHO works

WHO, while pivotal in international public health policy, absorbs only a minority of international development assistance. It works within a network of UN agencies, PPPs, NGOs, private foundations and other national and international entities (e.g. the Global Fund, World Bank and other multilateral development banks [MDBs]). A significant portion of international health and development financing is also channelled through bilateral relationships between countries. The United States, recently WHO's largest donor, has shifted to a model based more heavily on bilateral assistance. Understanding the ecosystem of development assistance is critical to appreciating the context within which WHO, or any IHO, must work.

Official Development Assistance (ODA) is defined by the Development Aid Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) as the:

> *"financial support from official providers to aid recipients (low- and middle-income countries) in areas such as health, sanitation, education, and infrastructure. It mainly consists of either grants or 'soft' loans, and it makes up over two thirds of external finance for least-developed countries".*

The OECD-DAC is the international organisation in charge

of collecting data on ODA from donors through a Creditor Reporting System (CRS). The definition – and calculation – of ODA has evolved over time, notably to take account of "grant equivalent" of some loans provided by State donors to LMICs. Nevertheless, ODA meets three critical characteristics: (1) it is provided by official agencies, including State and local governments, or by their executive agencies; (2) it is administered with the promotion of the economic development and welfare of low-resource countries as its main objective; and (3) it is concessional in character.638 Beyond ODA, there are multiple types of other financial flows going from higher income to lower income countries, for example involving the private sector (as the source of funds, such as private foundations or individuals through remittances, or as a recipient, for instance foreign direct investment), concessional (more generous terms) and nonconcessional loans, or flows not targeted at development or welfare (e.g., military aid).

Development assistance for health (DAH) comprises the share of ODA targeted to the health sector, but also private and NGO funding sources not qualifying as ODA but aimed at improving health in recipient countries. The IHME also provides a public database enabling us to visualise DAH flows from donors, through channels of assistance, to LMICs, by health focus (Section II.3.5).

A key challenge with WHO performance and reform involves how WHO is financed. As outlined below, WHO is heavily reliant on earmarked Specified Voluntary Contributions from Member States and private entities. In recent history, these Specified Voluntary Contributions account for the vast majority of WHO's Programme Budget, raising several issues regarding how an over reliance on these contributions affects global health policy.

Current and projected WHO budgets

The WHO ended its Thirteenth Programme of Work (GPW 13) for 2024-2025 with the WHA endorsing WHO's 2026–2027 budget in May 2025 (see Section on GPWs above for a more historical account of their evolution).

The Programme Budget for 2024–2025, as of late 2025, amounted to US$6,834 million containing four "segments" (Figure IV.6), with 30% of the total going to HQ in Geneva (Figure IV.7):

Base Programmes: US$4,968 million;

Polio Eradication: US$694 million;

Special Programmes: US$172 million; and

Emergency operations and appeals: US$1,000 million.

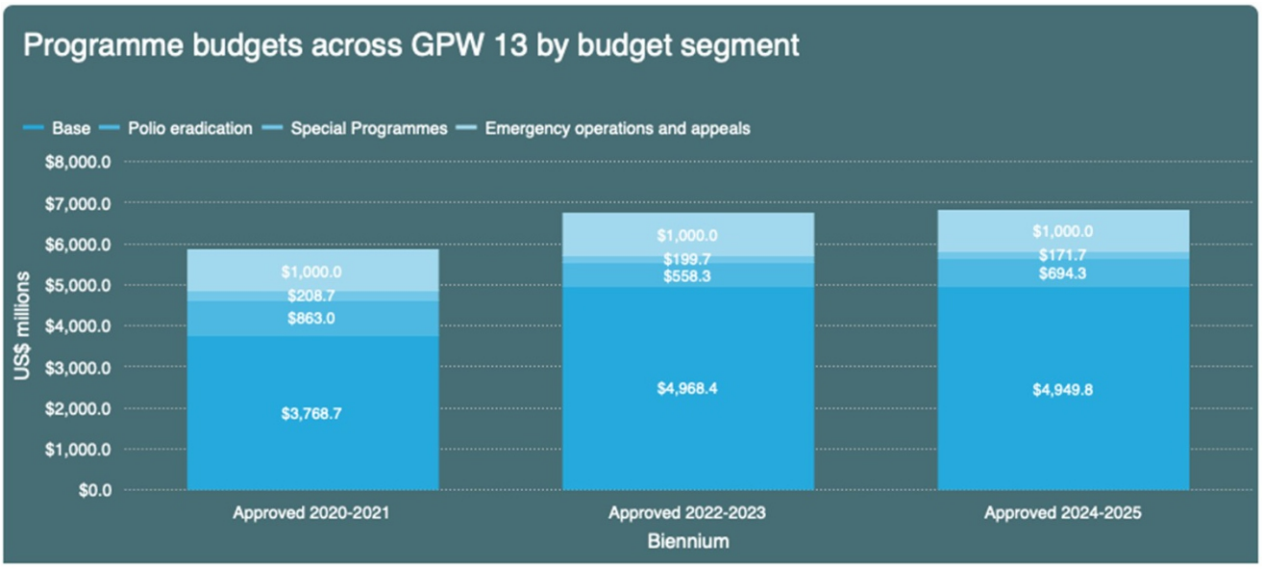


Figure IV.6 – WHO budget. Programme budgets across GPW 13 by budget segment.
Source: WHO, https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_27-en.pdf

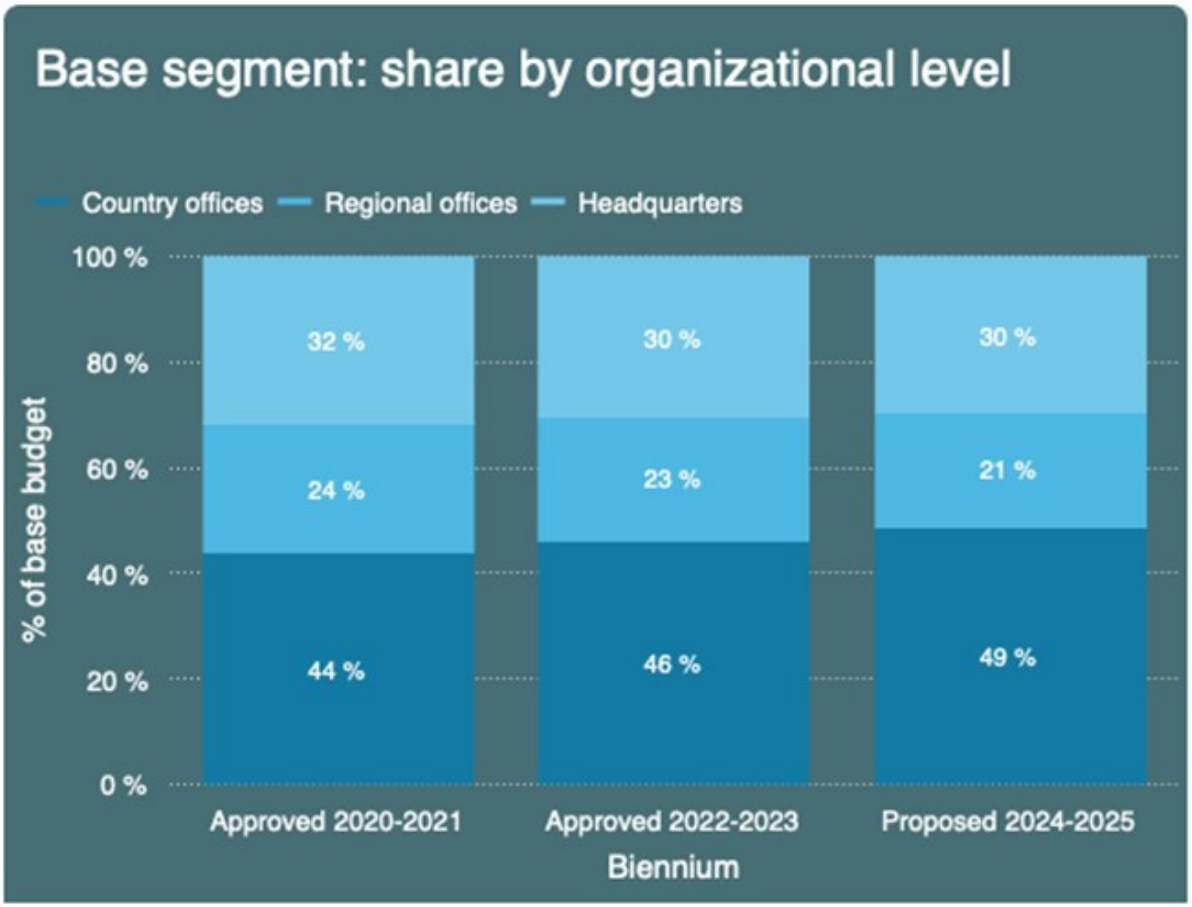
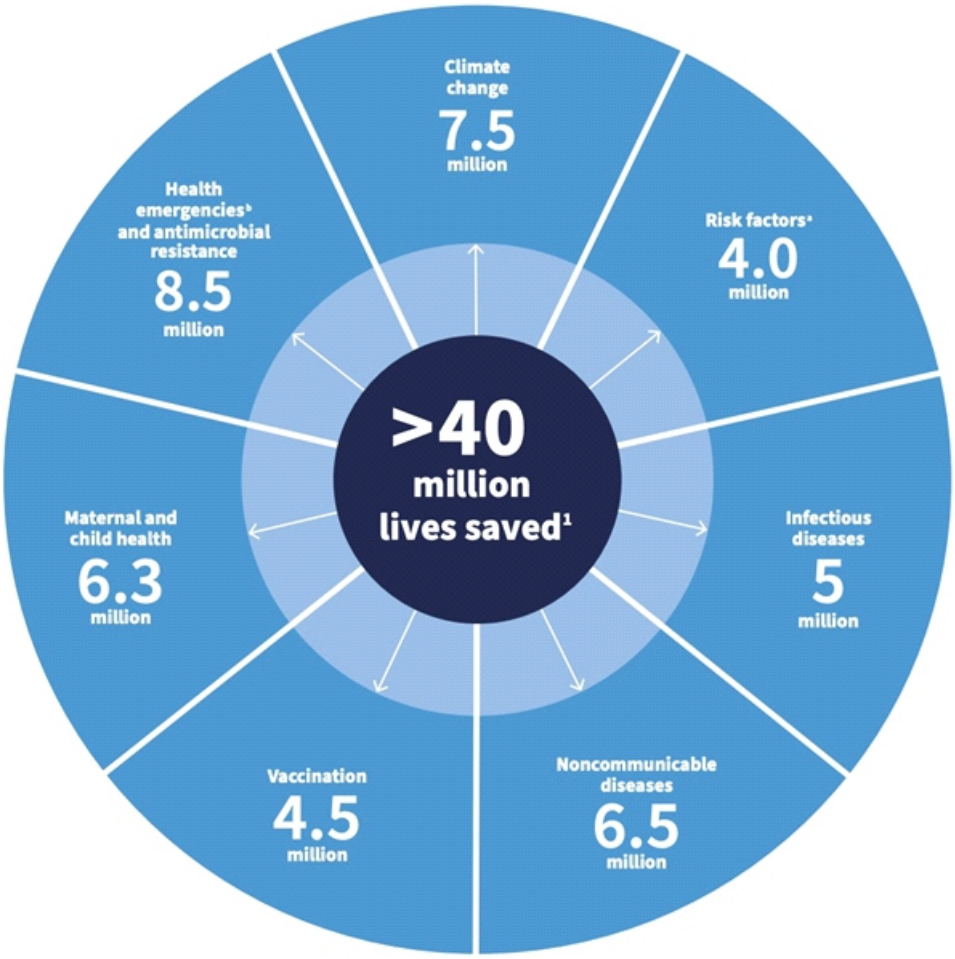


Figure IV.7 – WHO budgets: Base Segment: share by organisational level
Source: WHO, https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_27-en.pdf

In May 2025 the WHA approved a base programme budget of US$ 4.2 billion for 2026–2027 in line with WHO's Fourteenth General Programme of Work 2025–2028 (GPW 14), which details its global health strategy for the next four years. Moreover, Member States in May 2025 pledged to increase their Assessed Contributions by 20% of current baseline, which seeks to help reverse WHO's dependency on voluntary contributions (see discussion below). The GPW14 will focus on a set of core activities (Figure IV.8).

As discussed above in the section on the evolution of GPWs since the mid-1990s, a notable feature of the GPW14 investment case is that it is skewed heavily toward health emergencies, outbreaks, infectious diseases and health risks (with an additional risk area for climate change – Figure IV.8). Furthermore, the vaccination component of the GPW14 again targets mainly infectious disease control, outbreak mitigation and associated health risks, thus representing an area of close overlap with other health security activity areas. This arguably undermines a more holistic approach to global public health and undervalues WHO's own definition of health, which claims that "*health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*".



[a] Includes tobacco, alcohol, physical inactivity, unhealthy diet
[b] Includes preparedness and prevention of high-threat outbreaks, including for example measles, yellow fever, meningitis and the risk of a pandemic event

Figure IV.8 – Core activities and budget allocations for GPW14.
Source: WHO, https://www.who.int/publications/i/item/9789240095403

There are several explanations for why WHO continues to pursue this more biomedical securitisation approach to global public health. First, the failures of Covid-19 response have engrained a sense of inflated pandemic risk in most publics. Second, donor preferences for results-based activities with simple metrics largely favour simplified vertical, modular and biomedical interventions like inoculations, product delivery, and measurable service delivery. Third, donor countries and non-governmental contributors have historically overemphasised external health security risks such as infectious disease and outbreaks. Fourth, there has been a steady entrenchment of biomedical paradigms that seek technical solutions to complex and often socially determined health problems. Fifth, there has been a notable lexiconic increase in the use of "existential threat" language within policy discourses, especially in relation to climate change and pandemics. This increase continues to be used instrumentally to mobilise resources, capitalise on Covid-19 anxieties (the 'post-Covid moment'), advance political cooperation, and promote institutional vested interests. In the case of the latter, the influence of vested interests on WHO policy is best explained by understanding how WHO is financed.

The problematic shift from assessed to voluntary contributions

There has been a significant shift in how the WHO is funded since 1945. When WHO was created, its budget was funded primarily from assessed member contributions (Member State dues) with voluntary contributions representing only a small portion of its overall Programme Budget. Assessed contributions can be understood as:

"The amount each of the 196 Members and Associate Members must pay to WHO on an annual basis. The assessment scale is calculated by the United Nations based mainly on the country's GDP and is adjusted for WHO's membership. It is approved every two years by the World Health Assembly".

However, in the1980s the WHA voted to freeze assessed member contributions and in 1993 the WHA further adopted a position to eliminate adjustments for inflation and currency fluctuations. The WHO budget, however, continued to increase (Figure IV.9), with the result if a steadily increasing reliance on voluntary rather than assessed contributions. This trend away from assessed contributions was propelled in the late 1990s and early 2000s by a growing distrust from major donors toward UN institutions (also resulting in the establishment of institutions outside the UN system such as GFATM, GAVI and CEPI), increased donor preference for specific health interventions and areas of focus, an increased demand for direct donor accountability and value for money, an increased perception of health security risks, and a growing assessment of WHO's inability to address acute health emergencies as well as persistent global disease burdens. A result of this freeze has been an increased reliance on voluntary contributions, with assessed contributions accounting for only around 18% to 25% of the WHO Programme Budget in recent years.

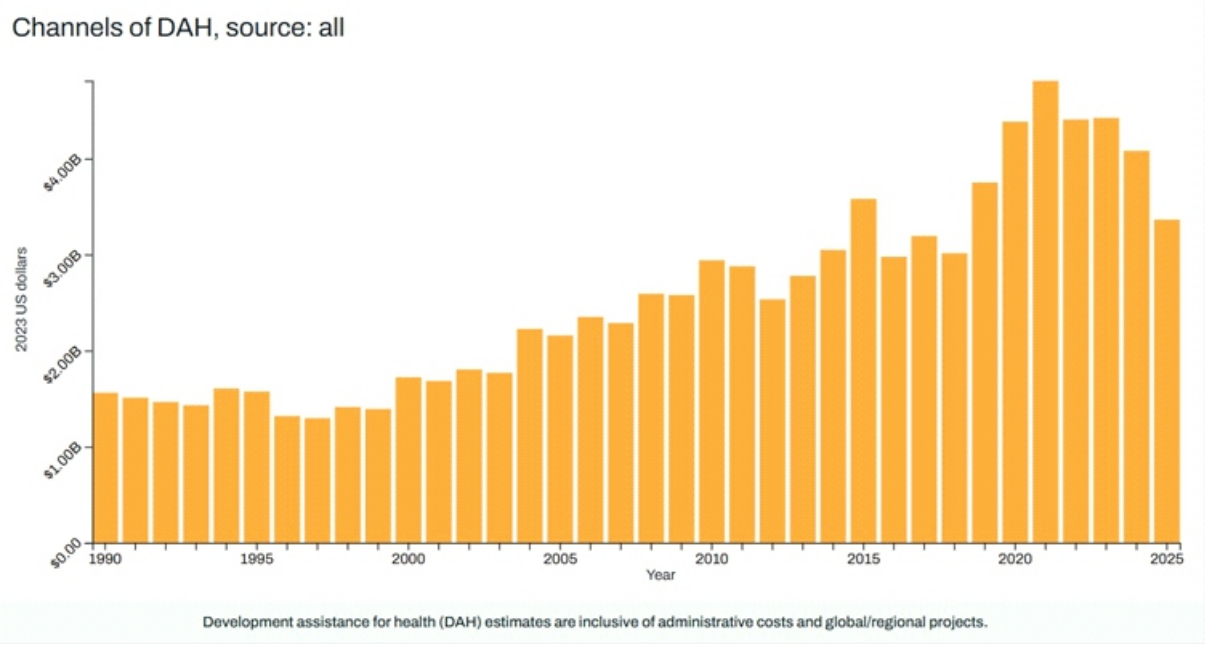


Figure IV.9 – Evolution of WHO spending per year
Source: IHME's Financing Global Health Viz tool, VizHub - Financing Global Health, https://vizhub.healthdata.org/fgh/

Whereas assessed contributions generally allow WHO to flexibly allocate funds based on its strategic priorities, voluntary contributions tend to be ringfenced and/or earmarked for specific programmes and regions. Voluntary contributions are provided by Member States (in addition to their assessed contribution) as well as from other partners, including industry, foundations, and private individuals. Voluntary contributions are categorised by the level of decision-making flexibility available to the WHO in how those funds are used. There are three levels of voluntary contribution:

Core Voluntary Contributions – Fully flexible (unconditional) where WHO has full discretion on the use of funds for its programme of work. According to WHO, Core Voluntary Contributions accounted for 6.6% of all voluntary contributions in 2022–2023.

Thematic and Strategic Engagement Funds – These funds are partially flexible and "aim to meet contributors' requirements for reporting and accountability while providing a certain degree of flexibility in their allocation". According to WHO, these thematic funds accounted for only 6% of all voluntary contributions in 2022–2023.

Specified Voluntary Contributions - These funds are "tightly earmarked" for specific programme areas and tend to be restricted to a particular timeline. According to WHO, these contributions accounted for 76% of all voluntary contributions in 2022–2023.

The shift from assessed to voluntary contributions has created a complex funding landscape in which WHO has less control over the makeup of its direct budget, creating a condition where donors are able to increase their influence on WHO health priorities (Figures IV.10, 11).

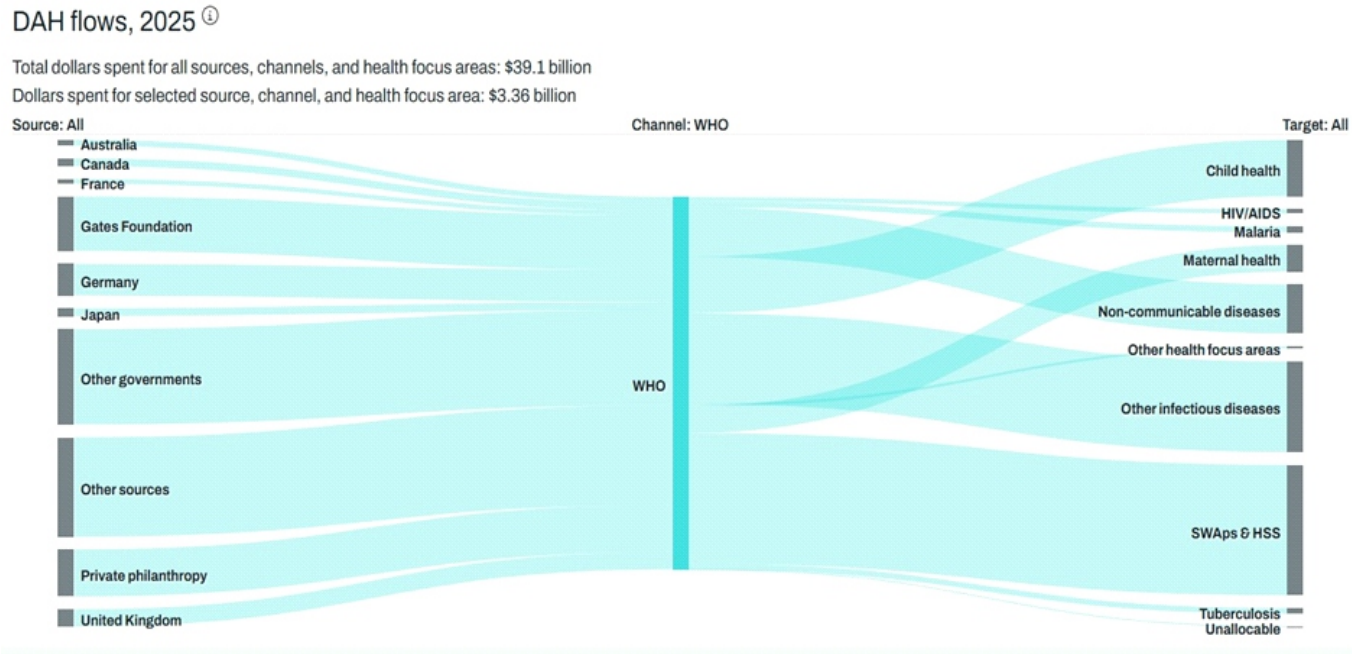


Figure IV.10 – Evolution of WHO spending per source and per health program
Source: IHME's Financing Global Health Viz tool, VizHub - Financing Global Health
https://vizhub.healthdata.org/fgh/

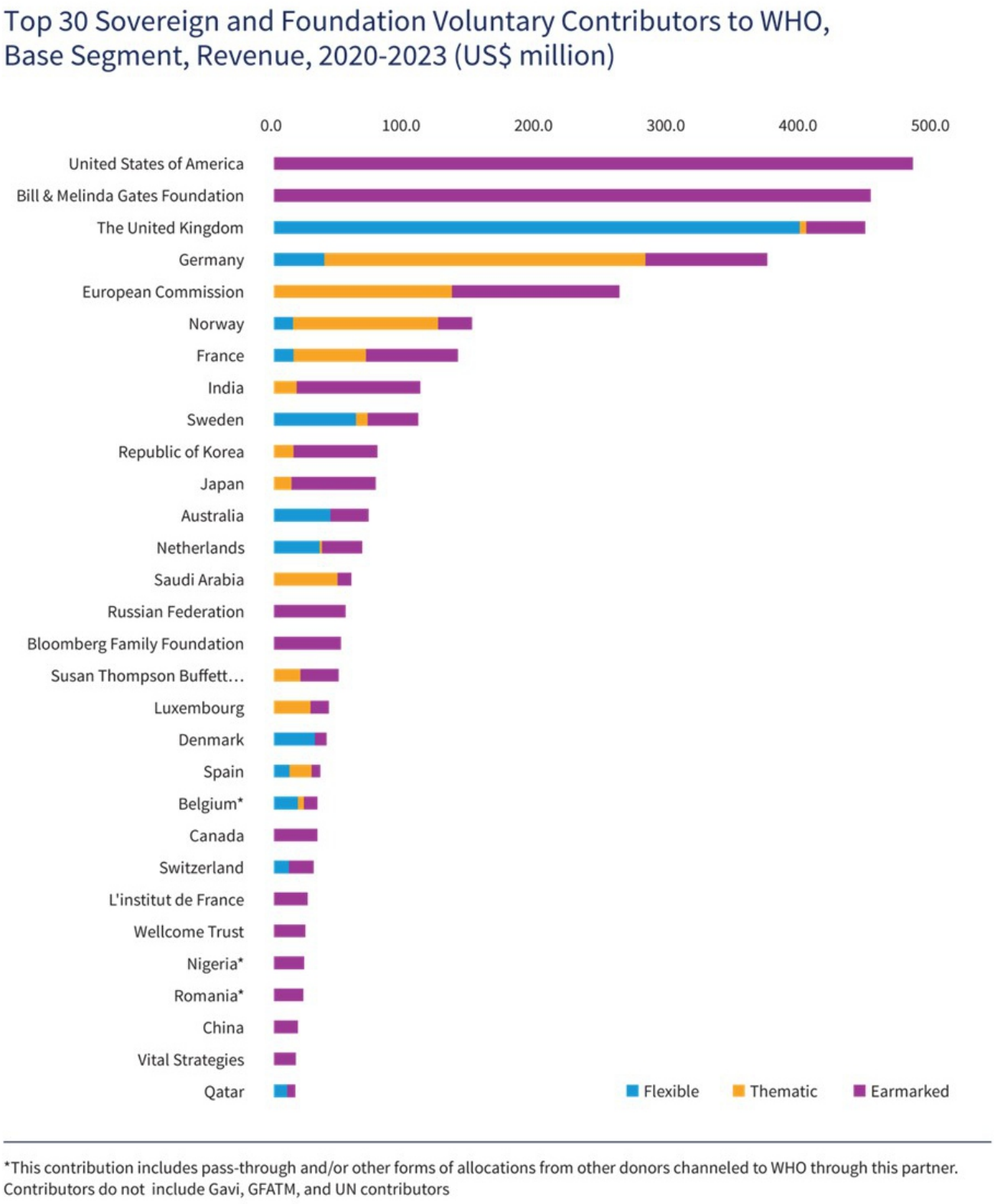


Figure IV.11 – Figure IV. 11 – Top 30 Sovereign and Foundation Voluntary Contributors to WHO
Source: WHO, https://www.who.int/publications/i/item/9789240095403

This financing condition results in several negative and positive outcomes.

Negative outcomes of financing conditions:

Although voluntary contributions allow for greater control and accountability of funds from donors, the condition does create an imbalance of funding across programme areas. This imbalance undermines a more holistic approach to global public health with a trend towards more vertical and modular approaches.

Since many donor States prioritise the containment of infectious disease at origin, there has been an increased focus on health security and emergency preparedness in the hope of keeping pathogens isolated. This approach has historically targeted a limited number of infectious diseases and/or outbreaks. In response, WHO maintains a watch list of ten diseases with Disease X acting as a placemark for a "known unknown" pathogen that has yet to emerge. Yet, when examined considering disease burden, these diseases have burdens magnitudes smaller than endemic diseases such as malaria, HIV/AIDs, and tuberculosis. This raises concerns about proportionate budgets and response policy.

The unpredictability of voluntary contributions undermines long-term WHO strategic thinking and financial sustainability, with knock on effects for WHO policy. Unreliable and unsustainable financing results in short-term strategies and disease targeting, again drawing policy focus away from traditional public health measures (nutrition, primary care, system strengthening, UHC) while largely ignoring social determinants of health.

Positive outcomes of financing conditions:

Although the evidence remains indeterminate, thematic and specified contributions are often argued by donors to have increased WHO accountability to donors (through results-based models) while incentivising programmatic efficiency measures to promote value for money. Historically, WHO has been accused of inefficiency and maintaining "bloated" overheads, which non-assessed contributions are meant to counter.

It is argued that the allowance for varied contributions has increased both the number of new funders (particularly foundations) as well as the amount those funders are willing to give, since private entities will have tailored remits, built-in incentives, and areas of interest. In other words, by allowing entities to choose what programme areas to fund, they are more likely to donate funds.

Again, although the evidence remains indeterminate, it is often argued that the Thematic and Specified focus on performance results incentivises evidence-based policy and use of more reliable return-on-investment cases to justify upfront investment. The underpinning logic is that non-assessed contributions require WHO to make a justified "business case", which further requires evidence and analytics. In addition, Thematic and Specified funding allows States to support health initiatives aligned to their own national and commercial interests, thus incentivising further contributions and improving their perceptions on value-for-money, but at the potential cost of skewing recipient State priorities away from greater national priorities.

Although there has been a historical trend since the 1980s toward an overall percentage reduction in assessed contributions, WHO and Member States have recently recognised the need to address the imbalance between assessed and voluntary contributions with several steps having been taken to increase the proportion of assessed contributions. For example, in 2022, Member States agreed to gradually increase their assessed contributions to represent 50% of the WHO's core budget by the 2030-2031 cycle. Moreover, the WHA in May 2025 agreed to increase their current assessed contributions by 20%, in an effort to meet its 2030-2031 target.

In addition, in May 2024 the WHO launched its first Investment Round, which it claims is: "a new approach to mobilizing predictable and flexible resources from a broader base of donors for WHO's core work for the next 4 years (2025–2028)". This diversification of funding now also includes a new portal to attract individual donations as well as external activities such as the independent WHO Foundation (see analysis of WHOF in prior sections of this report).

Implications and remaining challenges

There are several overlapping and reinforcing implications arising from how WHO is currently financed:

Conflicts of interest – A potential criticism of WHO's reliance on Specified Voluntary Contributions is that it increases the potential for conflicts of interest. For example, WHO receives funds from industries that also seek authorisation from WHO.

Unpredictability undermining WHO strategic planning – As noted above, an overreliance on Specified Voluntary Contributions diminishes the capacity for WHO to develop long-term strategic plans. These contributions are determined by the whims of the contributors, can be uneven one year to the next, and can force WHO to tailor policy to meet the demands of funders, as well as to focus on short-term, demonstrable results rather than health system strengthening and support for reforms. This is a particular challenge when certain funders account for a significant portion of WHO's budget, such as the Gates Foundation.

Pet-projects and ad hoc policies – An overreliance on Specified Voluntary Contributions creates a condition where WHO is compelled or incentivised to adopt and promote the specific "pet-projects" of its donors. These projects may or may not logically align with WHO strategies or reflect global health priorities. This condition can distort a coherent approach to global health, increasing fragmentation, vertical programming, misalignment, and duplication. In other words, WHO funds can be heavily influenced by donor priorities, potentially diverting resources away from areas where they are most needed or where the WHO has a comparative advantage.

Influence over coherence – An increasing literature suggests that Specified Voluntary Contributions optimises influence over policy coherency. As detailed in Table IV.1, the Gates Foundation is the largest donor to WHO in terms of voluntary (specified and thematic) funding. With the United States withdrawn and significant support from Gates Foundation to Gavi, the second largest current funder, this makes this Foundation the largest donor overall, while the top four current funders are non-State entities. This condition allows a single entity and individual to determine a substantial portion of WHO activities, a level of influence that will increase with the withdrawal of the United States from WHO. This overreliance drives a perception and practice where the WHO is considered "beholden" to donors, potentially undermining its independence and ability to act as a neutral convener.

Modular / vertical approach – The Gates Foundation is now the largest funder of WHO and is recognised as having an oversized role in global health policy. One criticism involves what has been termed "the Gates Approach" to global health policy, which directs funds towards specific diseases or activities, which can leave other critical public health needs unaddressed. While this certainly preceded the Gates Foundation, it characterises their disease-centric approach.

Overreliance on select donors, and unsustainability – WHO financing is clearly over reliant on a select number of donors, a condition that undermines financial sustainability. For example, recent concern has been raised about the sudden withdrawal of the US from the WHO and additional ODA cuts from USAID, as well as reductions in development assistance for health (DAH) from a host of other donor countries (see Section on DAH below). This development has exposed how reliant global health policy has become on a single actor while shedding additional light on the primary funding position of a handful of donors, particularly non-State actors. After the (now exited) United States, the highest Member State in terms of funding for 2024-25 was Germany (6th highest funder overall) and United Kingdom (9th), as well as private entities such as the Gates Foundation (now the largest donor) and non-State entities such as the World Bank and Gavi (both above Germany).

Assessed vs. voluntary funding

Financial Regulations of the World Health Organization

The Financial Regulations of the World Health Organization, in addition to those within its constitution, have been through various iterations and amendments since adoption at the fourth WHA. As noted earlier, funding type is predominantly divided into assessed and voluntary funds. Further funding is potentially sourced from interest on investment and other sources including the WHO Foundation, but is relatively small. Assessed funds are for use based on the discretion of WHO, through the biennial budget presented to the Executive Board (EB) and WHA by the Director General (DG).

Assessed contributions are the dues countries pay in order, as defined in the Constitution, to be a member of the Organization. The amount each Member State must pay is determined by the WHA according to a formula that the WHA can adjust, calculated relative to the country's wealth and population. Assessed contributions have declined as an overall percentage of the Programme Budget and have, for several years, accounted for less than one quarter of the Organization's financing.

As regulation V, Paragraph 5.2.1 of the Financial Regulations notes, the intent of the biennial budget process is to define a budget commensurate with WHO's work, then fund this, with the total Assessed contributions

having the potential to be adjusted based on the gap after voluntary contributions:

> *"The amount to be financed by assessed contributions from Members shall be calculated after adjusting the total amount approved by the Health Assembly to reflect that proportion of the budget to be financed by the other sources noted in 5.1 above [i.e. voluntary contributions, by projected interest earned, prior period collection of arrears and any other income attributable]".*

In addition to EB and WHA oversight, an external auditor, at the level of Auditor-General of a Member State, is to be appointed by the WHA to audit WHO's finances (Article XIV).

The reliance on voluntary contributions, discussed earlier, opens significant risk of conflict of interest impacting on the WHO program budget. While the budget is intended to be prepared based on priorities independent of influence beyond the WHA and secretariat, the predominance of voluntary contributions raises a high risk that the overall budget is skewed towards areas that private and large State donors have particular interest in, such as commodity-heavy approaches.

An increasing portion of WHO funding comes from earmarked contributions, and from organisations WHO is supposed to help hold accountable in its Member States. By the end of 2025, its largest two funding sources were the private Gates Foundation, and the PPP Gavi (Table IV.1). This obviously leads to conflicts of interest. For instance, WHO is often a recipient or an implementing partner of Gavi's and GFATM's grants in LMICs, while at the same time being in charge of guaranteeing the proper allocation and control of these resources.

Funding source	Percent of total
Gates Foundation	13.28
GAVI Alliance	11.48
United States of America	8.75
European Commission	8.26
World Bank	4.41
Germany	4.16
Rotary International	3.13
European Investment Bank	2.96
United Kingdom	2.77
Canada	2.2
India	1.89
United Nations Central Emergency Response Fund (CERF)	1.81

Table IV.1 – Top 12 donors of voluntary contributions (specified and thematic) to WHO, based on fully dispersed contributions for 2024-2025 biennium.
Source: adapted from WHO, https://open.who.int/2024-25/contributors/contributor

Moreover, as a result of its financial and governance conflicts of interest, WHO has failed to exempt itself from commercial interests. Examples include undeclared conflicts of interest during the H1N1 pandemic, regarding approved medicines, relative to Covid-19 strategies, and a lack of transparency regarding the funding of the WHO Foundation. Given the current geopolitical and funding landscape, it is difficult to imagine that things will improve now that the Gates Foundation is the top donor of WHO.

WHO and DAH

DAH channelled through WHO

We used the IHME's VizHub - Financing Global Health tool to extract data on DAH channelled through WHO (hereafter WHO-DAH) since the beginning of this century (Figures IV.13, 14).

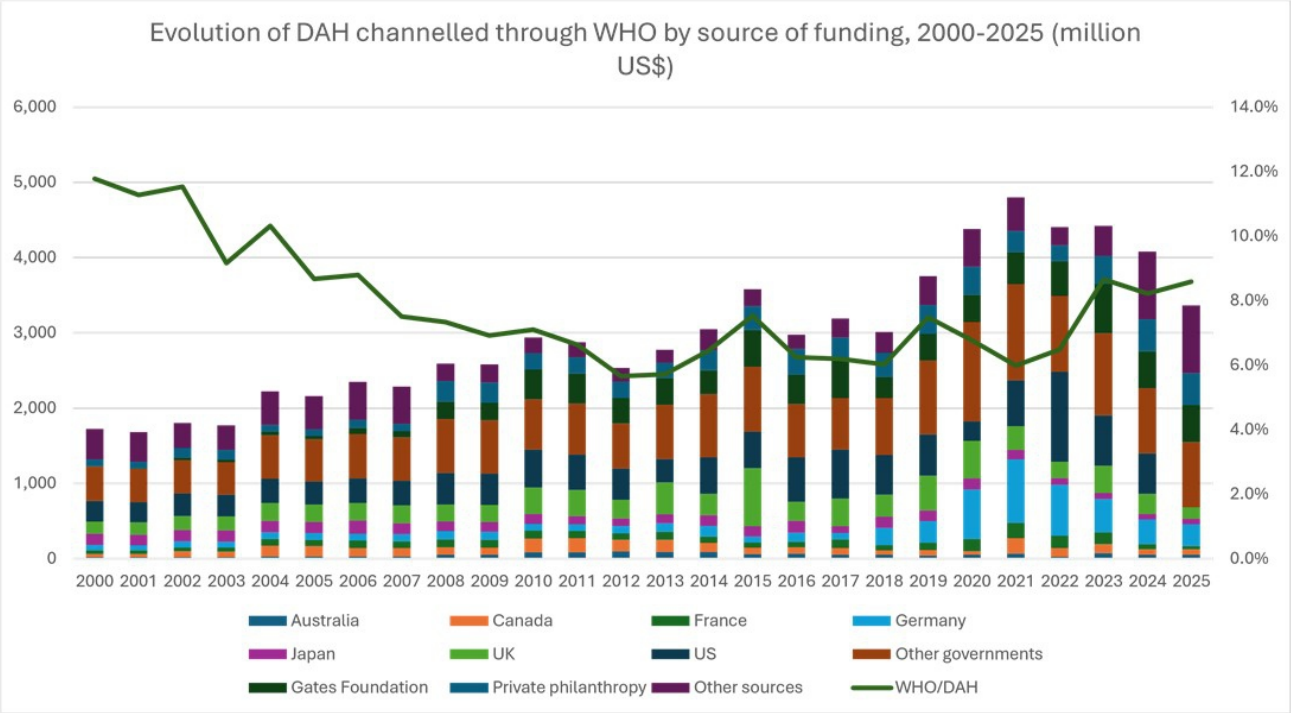


Figure IV.12 – Evolution of DAH channelled through WHO by source of funding, 2000-2025.
Source: IHRP, adapted from IHME, Note that 2025 data was later adjusted by WHO as shown in Table IV.1,VizHub - Financing Global Health data, https://vizhub.healthdata.org/fgh/

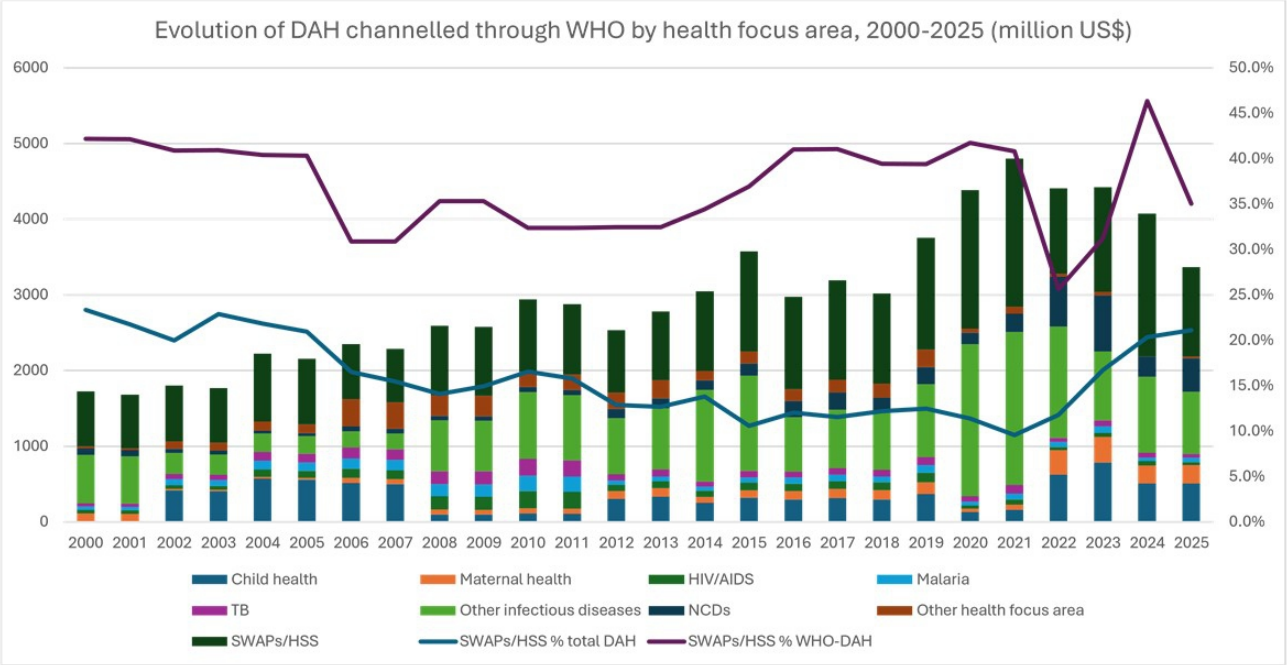


Figure IV.13 – Evolution of WHO channelled through WHO by health focus area
Source: IHRP, adapted from IHME, VizHub - Financing Global Health data, https://vizhub.healthdata.org/fgh/

Some interesting trends emerge from these two figures. Regarding the evolution of WHO-DAH by source of funding, one can observe that:

- The former seven largest bilateral donors channelling DAH through WHO – Australia, Canada, France, Germany, Japan, UK and US – have consistently accounted for about 40-50% of total WHO DAH until 2021. In 2022, their share rose to 56%, but it dropped in 2024 (34%) and further in 2025 (20%), particularly due to the interruption of US funding.

- Private philanthropy and the Gates Foundation, which accounted for a low 5.5% of WHO-DAH funding in the early 2000s, started to increase their share in 2008 (19.5%). Their share rose to 25% in 2016 and 2017 and culminates at 27% in 2025, which is much more than the remaining six largest bilateral donors.

- While the amount of DAH channelled through WHO has regularly increased over the period 2000-2021 in nominal terms, the share of DAH channelled through WHO has decreased by a factor of two between 2000 and 2012, from about 12% to about 6%.

Regarding the evolution of WHO-DAH by health focus area, one can observe that:

- Sector-Wide Approach(es) (SWAPs)/HSS has consistently represented between 30% and 40% of DAH channelled through WHO over the 2000-2025 period, except in 2022 when it dropped to 26% and in 2024 when it rose to 46%. This is a significantly higher share (about double) than the share of SWAPs/HSS in total DAH, showing the added value of WHO in supporting health systems, compared to most other global health agencies privileging targeted (vertical) approaches.

- Infectious diseases – HIV/AIDS, Malaria, TB and "other infectious diseases" – also comprise an important, and often major, target of WHO-DAH, with important yearly variations (from 26% in 2004 and 2005 to 52% in 2010 and 2011) driven by high variability in 'other infectious diseases'.

- Maternal health and NCDs receive a minor share of WHO-DAH.

IV.6.3. Workforce

An IHO's effectiveness will be dependent heavily on the skills, background and culture of its staff, as discussed in Section III.2.6). This in turn will be shaped by recruitment, location and employment conditions. There is an inevitable tension in international agencies such as WHO between ensuring a high level of technical expertise that can be offered as a service to countries, and a high level of cultural and contextual understanding that allows such expertise to be effectively shared, and allows local knowledge and context to shape central policymaking. The closer staff are located to the health systems they seek to support, the more effective and efficient they are (generally) likely to be. The more attractive the work environment, the higher staff retention will be; Good for retaining knowledge and bad for ensuring new ideas and up to date expertise. WHO's effectiveness is shaped by such issues – their importance depends significantly on what role WHO is intended to play.

As of 31st December 2024, WHO had a workforce of 9463, having increased steadily over previous decades. The largest number of staff was at WHO HQ in Geneva, Switzerland (Figure IV.14) The African Region has the largest number of staff of the six WHO Regions, spread between the Regional Office for Africa (AFRO) in Brazzaville (Republic of Congo) and the various country offices, and a little less than HQ. Overall, most WHO staff are in central offices – either headquarters or the Regional Offices, with a little under 45% being in over 150 country offices (Figure IV.15).

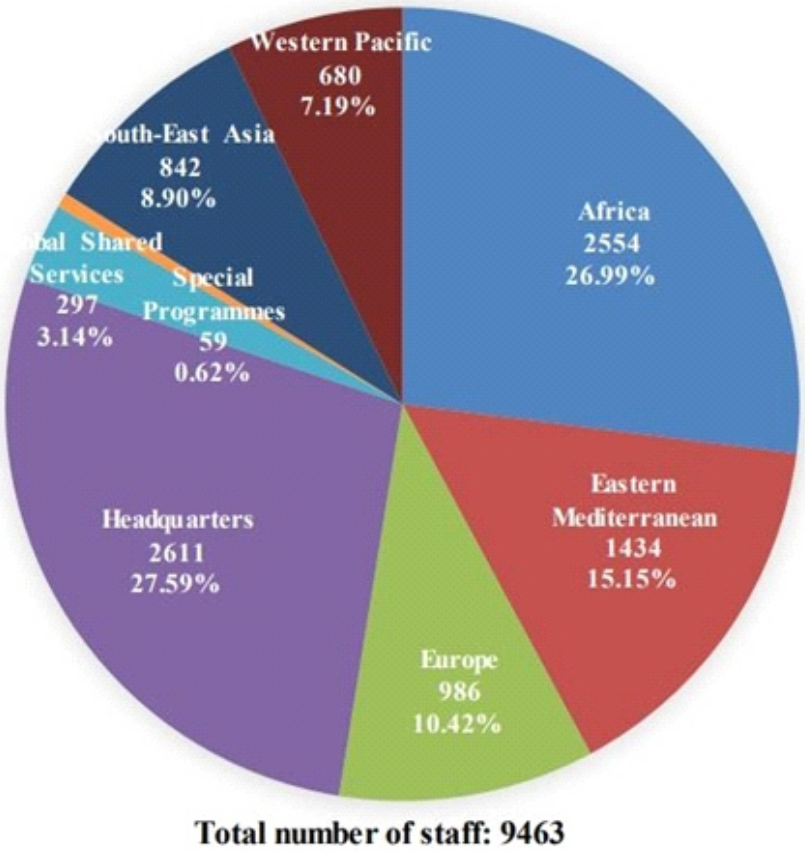


Figure IV.14 – Distribution of WHO Staff as of 31 December 2024, by major office.
Source: WHO, https://cdn.who.int/media/docs/default-source/human-resources/wha78-hr-updatetables-january-to-december-2024.pdf?sfvrsn=c8720ce7_5 c8720ce7_5

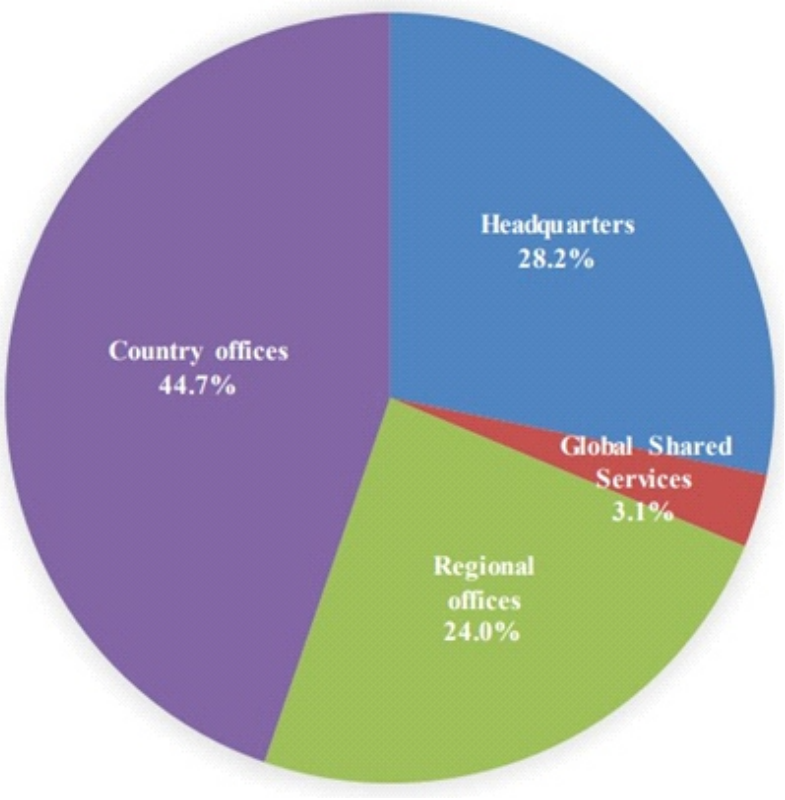


Figure IV.15 – Distribution of WHO staff between headquarters, Regional offices and country offices, as of 31 December 2024.
Source: WHO, https://cdn.who.int/media/docs/default-source/human-resources/wha78-hr-updatetables-january-to-december-2024.pdf?sfvrsn=c8720ce7_5

A reduction in staff of approximately 25% (2371 staff) is planned for 2025-26 in response to the contraction in funding resulting from the exit of the US, formerly WHO's largest funder, and reducing ODA budgets in other countries. These reductions are planned to maintain the current geographical distribution of staff between HQ, Regional and country offices, with 46% expected from attrition including early retirement and the remainder from abolition of posts,672 leaving a workforce of a little over 7000 projected by late 2026. An increase of 20% in assessed funding agreed at the WHA in 2025 will have limited impact, as assessed funding is currently only about 20% of total WHO budget.

Staff at WHO are recruited and managed under rules common to UN agencies, with general (e.g. administrative) staff or 'G' staff remunerated at various levels (G1-6) and professional (P) staff at levels (1-6) with D (Director) levels above this. Staff are permanent and temporary (fixed-term – often 11-month renewable contracts) staff, supplemented by short-term consultants. All are answerable to the Director-General through the internal hierarchy (Section IV.3.1),674 and required to sign contracts including certain ethical requirements agreeing not to take direction from countries rather than WHO (Section IV.3.1). The HQ internal structure is highly hierarchical, with a clear line of superiority and responsibility through G or P and director levels to assistant Director-Generals (DGs), with the DG having ultimate internal authority. The DG is answerable in turn to the Executive Board and ultimately the WHA, as described in Article 31 of the WHO constitution outlined in Section IV.3.1). The hierarchy within Regional Offices is similar to the Regional Director level, with country offices, directed by a WHO Country Representative (WR) or Country Liaison Officer (CLO) ultimately answerable to a Regional Director, and thereby the DG.

Remuneration is based on the UN salary scales for G, P and D staff levels, with additional payment for hardship and cost of living allowances based on geographical location, and subsidies to support child education up to and including advanced university level, family healthcare insurance and periodic travel to place of origin. Thus, once young children enter school, incentives are very strong to remain in employment and have WHO (i.e. global tax-payers) support their education and health care through to adulthood. As can be seen from Figure IV.16, these outweigh the base salary itself. Salaries are income tax-free – with a specific arrangement for US staff who must pay national taxes but gain an additional allowance to cover this), while senior professional staff (e.g. above P4) gain additional tax-free diplomatic privileges.

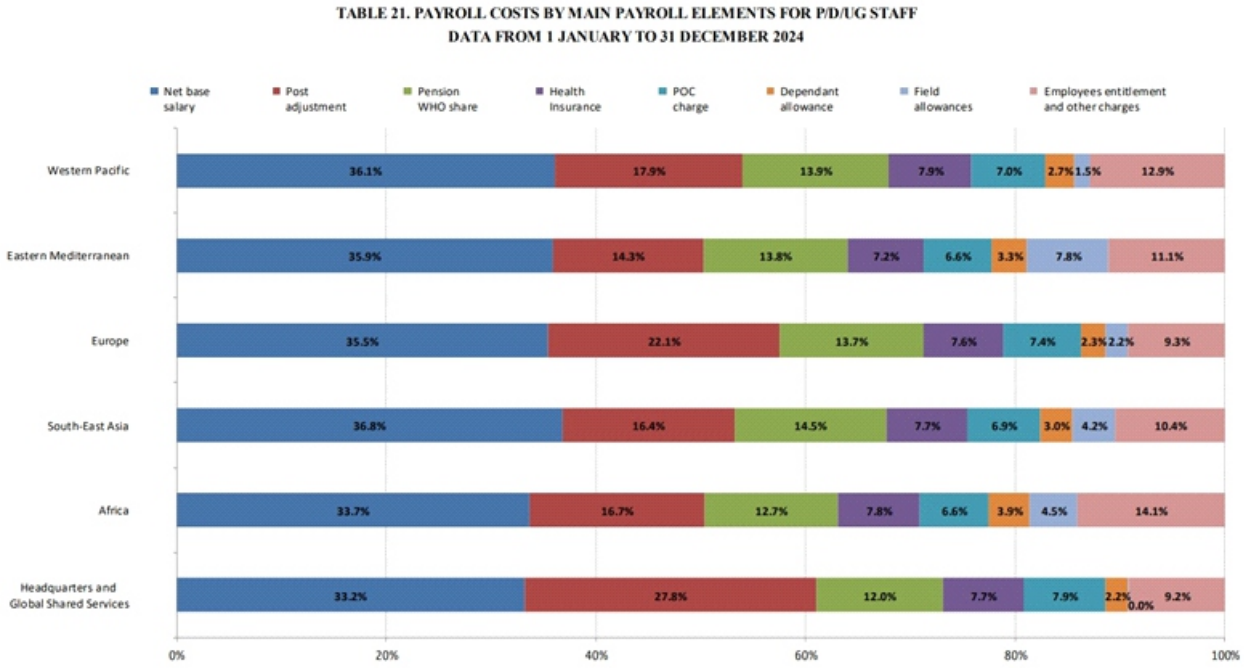


Figure IV.16 – WHO salaries and remuneration by Region.
Source: WHO, https://cdn.who.int/media/docs/default-source/human-resources/wha78-hr-updatetables-january-to-december-2024.pdf?sfvrsn=c8720ce7_5

Quotas – Pros and Cons

Staff are selected through a system of (usually) open calls of interest, followed by an interview process. Selection is based, in theory, on technical competence and influenced in pre-selection by country quotas. Quotas are based on a combination of population size and financial contribution to WHO and the number of citizens of that State already employed.

Paragraph 4.2 of the Staff Regulations of the World health Organization, addressing recruitment and transfer, stresses the highest standards of efficiency, competence and integrity as the primary criteria for recruitment, but with an intent to achieve a wide geographical representation. By the 1980s, a formal approach to ensuring geographical distribution was put in place by the WHA. This has evolved into a country allocation mechanism that prioritises staff from relatively underrepresented countries, though States' technical ability will be prioritised (Staff Regulations for the World Health Organization, Section IV, 4.2):

> *"The paramount consideration in the appointment, transfer, reassignment or promotion of staff members shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting staff members on as wide a geographical basis as possible",*

However, in practice, special permission is required for recruitment from countries above their quota.

The reason for the quota system is clear. WHO is an international organisation and must reflect the diversity of the countries that oversee it, and that it seeks to serve. The absence of such a system would inevitably lead to recruitment of a preponderance of like-minded people (similar culture and background) to those doing the recruitment, limiting the organisation's overall competency. The downside is that it can (and does) sometimes prevent recruitment of the most technically competent people for a particular role. Countries with smaller populations and less resources provided to WHO are also likely to have a relatively smaller skilled workforce in public health science, reducing the value of WHO's policy development and health system capacity building.

Any recruitment model will be imperfect, and open to abuse and degrees of nepotism as WHO's undoubtedly is. However, the intent to balance technical needs with diversity is sensible, and experience and background gained by upbringing in low-income net-recipient countries will also provide perspectives and knowledge that will have escaped a technically more qualified person from a more wealthy and distant place. The model is perhaps the most appropriate for an IHO that does not and cannot dictate policy but plays a coordinating and supportive role. Almost by definition, capacity building requires people with higher skills in certain areas than the recipient country concerned, and would probably be best addressed by use of short-term experts with specific skill sets. However, incentives on long-term employment over staff turnover work against this.

Pensions, rotation and staff turnover

The structure of the WHO pension scheme, part of the wider UN scheme, is important to understanding certain limitations and incentives that may influence WHO efficiency and purpose. While all salaried staff contribute to the UN pension scheme ostensibly by matched to an employer contribution, they must remain employed for over 5 years in order to ultimately receive the employer contribution within their pension (for a shorter period, only the employee contribution is considered). The proportion of the employer contribution that may be received on retirement then increases incrementally, with all being available after 15 or more years of employment. This is an unusual arrangement as normally an employer contribution accrues to an employees pension fund once allocated, regardless of time of termination. Thus, this scheme works against a culture of short-term employment of specialised expertise for specific tasks, incentivising staff to remain in posts longterm, working in ways that maximise their chances of remaining employed. As discussed elsewhere (see Sections IV2.3 and IV.6.1), this likely encourages bureaucratic malaise and loyalty to the institution rather than its purpose.

To encourage (or attempt to force) wider experience and relevance of staff in support of WHO's purpose, rotation schemes have repeatedly been proposed by DGs. By ensuring that staff rotate through geographical locations, they may better understand the context of the populations where their work impacts and be less likely to "vegetate" in comfortable locations such as Geneva far-removed from exposure to the hardships and cultures of countries where disease burdens are highest. However, these schemes have repeatedly failed due to staff resistance – those in comfortable positions in wealthier-income locations with matching income adjustments, education and health subsidies are understandably reluctant to dislocate families to locations with lower living standards and generally harsher living conditions.

Loyalties of staff

Under I. Duties, Obligations and Privileges of the Staff Regulations of the World Health Organization, all staff are required, in Article 1.1, to:

> *"...pledge themselves to discharge their functions and to regulate their conduct with the interest s of the World Health Organization only in view",*

and Article 1.10:

> *"All staff members shall subscribe to the following oath or declaration: I solemnly swear (undertake, affirm, promise) to exercise in all loyalty, discretion, and conscience the functions entrusted to me as an international civil servant of the World Health Organization..."*

One intent of these requirements is to separate staff from partisan loyalty to the interests of specific States or other external actors. To achieve its mission, there must be a structure that allows efficient internal management and joint effort towards clearly defined goals, independent of undue influence of individual States (versus a collective thereof) or external entities. This is necessary for the organisation to be trusted by all, and work in a way that is a common good.

However, as discussed in Section III.6.2, an IHO cannot be an end unto itself, and so loyalty of staff must ultimately be to its mission. If the above pledge and oath are taken to imply such a loyalty to a mission as expressed in the name of the Organization, then it fits well with the requirements of an IHO that is solely an organ of a collective of States. If taken as the organisational entity itself, then this risks furthering the problem of a bureaucracy working for its own enhancement rather than its original purpose. With almost 80 years of existence, this interpretation would be expected to drive the WHO considerably far from its original goals.

Summary

As an organisation primarily tasked with managing international coordination and supporting development of capacity and expertise in a rapidly changing field of science and technology, the WHO seems poorly structured. Staff policies encourage life-time employment in centralised locations rather than recruitment of new skills and expertise to address specific needs. A structure promoting turnover of up-to-date technical expertise and rotating through a diverse workforce, which itself would help build national capacity as they return to in-country employment, would seem most appropriate for purpose. Long tenure also risks a culture of bureaucratic ossification and expansion that encourages prioritisation of the institution over its purpose, common to any large bureaucracy (Sections I.3.1, III.6.1). Lack of clarity on loyalty requirements risk enhancing this problem (above). It is likely that the development of distance between staff culture and understanding and the reality of global health burdens has contributed to the misalignment of WHO claims and policy in areas such as pandemic preparedness compared to the health priorities and disease burdens of Member States.

Similar misalignments discussed earlier have occurred in examples such as mitigation of harms from tobacco (the FCTC – see Section IV.4.2) and the complex interactions of health and climate. Associated bureaucratic inertia also makes the task of reform all the more difficult.

A staffing model designed for purpose would include the mix of prioritisation of technical expertise and geographic diversity found in the WHO model, but encourage turn-over, new blood and reward for doing a set task and then moving. A re-allocation of staff away from HQ (the largest office and one of the furthest removed culturally and geographically from the major health burdens WHO is to address) to Regional and sub-Regional offices and direct country support would increase the relevance of WHO work and increase the influence of target populations in shaping this work. In this age of digital communications and access to information, there is no logical justification for the world's major IHO to concentrate its staff in one of the most expensive cities on earth, in a country with one of the longest life expectancies. The downsizing forced by recent funding restrictions is reducing both peripheral and central staffing, and so will exacerbate the lack of contact and interaction at a country or near-country level. It appears an opportunity to address over-centralisation is being lost, but a very different culture and structure is required to address this.

IV.7. SUMMARY OF THE WHO´S PROS AND CONS

No organisation is monolithic or both purely altruistic and omniscient. On the contrary, organisations are composed of individuals who have distinct interests, sometimes non congruent with the organisation's official mandate and objectives. Consequently, the outcomes from an organisation result from power (political) struggles, and they are not necessarily coherent. In fact, in large organisations, governance models are often a mix of bureaucracy and market-like measures, and policy incoherence is rather the rule than the exception.

In this section, we point out successes and failures of WHO. Assessing them as successes or failures is somewhat subjective, depending on our values, but there has been an attempt to be as evidencebased as possible, and to respect the principles and values pointed out in previous parts of this report. Some issues are considered both as successes and failures, but this follows from inherent multiplicity of public health visions.

IV.7.1. Pros

Analysing the functioning of WHO along various analytical dimensions, it is possible to demonstrate that WHO has achieved impressive results with respect to several of its core functions. These include:

Policy dialogue at the global level

As already stated, like any public policy, health policies cannot be fully consensual. This is because they apply to heterogeneous populations having different interests, pursue various and sometimes antagonist objectives (e.g.

efficiency vs. equity, short-term results vs. long-term impact), and their costs and benefits are not distributed according to need and ability to pay. Therefore, trade-offs are necessarily, which as far as possible should be based on clear (and consensual) criteria, supported by evidence, and through a transparent process illustrating why the choices have been made with mitigation measures to compensate the stakeholders negatively affected by the policy.

Given that health policy will require trade-offs, it is important to promote dialogue as part of the policy and decision-making processes. Policy dialogue is understood as an evidence-informed, deliberative dialogue process among multiple stakeholders for policy and practice decision-making, which can take various forms, from very formal (e.g. general assembly of the health sector, deliberative workshops during health technology assessment exercises) to informal consultations.

If policy dialogue is necessary at national and even local level, as pointed out above, there are several health issues that are transnational by nature (e.g. global public goods) and which require policy dialogue at the global level. WHO has played a major role as a global health policy forum, to ensure that all Member States are involved, and all (legitimate) interests represented, in debates over transnational health issues and policies. WHO, through its General Assembly, but also through dedicated programs and hosting of several international Partnerships, has played a crucial role and has achieved important results, notably in terms of agenda-setting (see below).

Agenda-setting and advocacy

As an outcome of this global health policy dialogue, several "global public goods" have been put at the forefront of the policy agenda thanks to WHO involvement and efforts, be it through international declarations, World Health Reports (WHRs) and/or the setting up of global alliances on these matters. In particular:

Primary healthcare

Primary healthcare (PHC) is widely accepted as the most efficient and equitable way of organising health services, and it has been supported by WHO for decades despite several "market forces" driving health systems away from PHC values.

WHO, together with UNICEF, was involved in the initiative resulting in the Declaration of Alma-Ata on Primary Health Care in 1978. Following this, WHO has continued support for the conceptualisation and implementation of PHC, particularly through the World Health Report of 2008, the creation of the Primary Health Care Performance Initiative (PHCPI) (2015-2022) and the Special Programme on Primary Health Care (SP-PHC) in 2020.

Social determinants of health and health promotion

WHO initiated the first International Conference on Health Promotion and resulting Ottawa Charter in 1986, which was the first to highlight the need to prioritise social determinants of health in a multi-sectorial way.

In 2004, WHO set up its Commission on the Social Determinants of Health which produced its final report in 2009, entitled "Closing the gap in a generation: health equity through action on the social determinants of health".

Universal health coverage (UHC)

In 2005, the World Health Assembly (WHA) passed resolution WHA58.33 on "Sustainable health financing, universal coverage and social health insurance". It was the first time the WHA explicitly endorsed UHC. This resolution urged Member States to develop sustainable health financing systems based on prepayment and risk pooling to reduce reliance on out-ofpocket payments. The resolution also emphasised the need for equitable distribution of healthcare resources and quality services. It also requested the WHO Director-General to:

"provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly prepayment schemes, including social health insurance, with a view to achieving the goal of universal coverage…".

Following this resolution, two World Health Reports were dedicated to UHC:

- The World Health Report 2008: even if named after PHC, this report actually structures the PHC reforms it advocates for in four groups: universal coverage reforms, service delivery reforms,

public policy reforms, and leadership reforms. The first two correspond to the two main dimensions of UHC, while the two last refer to its governance. Moreover, it also introduces in the public domain a figure on the "*three ways of moving towards universal coverage*", which is commonly referred to as 'the WHO cube', which served as a foundation for WHR 2010.

- The World Health Report 2010: entitled *'Health Systems Financing: the Path to Universal Coverage'*, it focuses on the financial aspects of UHC. It notably addresses three fundamental questions: (i) how to finance health systems; (ii) how to protect people from the financial consequences of ill-health and paying for health services; (iii) how to encourage the optimum use of available resources.

Then, UHC's place on top of the world public health agenda gained even more traction through various political declarations by the UN General Assembly (GA). In 2012, the UNGA adopted a Resolution A/RES/67/81 on Global Health and Foreign Policy which reaffirmed commitment to UHC and health financing. It notably

"[u]rges Governments, civil society organizations and international organizations to promote the inclusion of universal health coverage as an important element on the international development agenda and in the implementation of the internationally agreed development goals…".

As a result, UHC was integrated as a core objective within the Sustainable Development Goals. In 2019, on the occasion of UN High-level Meetings on Universal Health Coverage, the UNGA adopted a political declaration of the high-level meeting on universal health coverage through resolution A/RES/74/2. In 2023 again, through resolution A/RES/78/4, the UNGA adopted another political declaration of the high-level meeting on universal health coverage entitled *'Universal health coverage: expanding our ambition for health and well-being in a post-COVID world'*. WHO also does a lot of advocacy to support the UHC agenda worldwide.

Health policies & systems research (HPSR)

While health products and clinical interventions are supposed to be initially assessed through rigorous study designs and methodologies, aimed at controlling potential bias, their effectiveness and indirect effects in real-life situations may be very different, notably due to the influence of implementation modalities and operating contexts (including heterogeneity in population). This is even more the case for complex interventions and multi-pronged policies.

Consequently, health policy and systems research (HPSR) emerged as a:

"field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is inter-disciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape – and be shaped by – health systems and the broader determinants of health".

Following the publication, in 1996, of the report of the Ad Hoc Committee on Health Research Relating to Future Intervention Options, WHO and other global health leaders set up the Alliance for Health Policy and Systems Research (AHPSR) in 1999.706 Its "core mission is to support the generation and use of health policy and systems research through building capacity to do so and through supporting approaches to maximize its impact". Its secretariat is hosted and managed by WHO HQ in Geneva. Currently, its thematic areas of focus are embedded research, evidence synthesis, gender and intersectionality, health financing, PHC, and systems thinking.

In 2012, WHO issued the WHO Strategy on Health Policy and Systems Research707 and, in partnership with AHPSR, a Methodology Reader on Health Policy and Systems Research.708 In 2018, WHO and AHPSR published the World Report on Health Policy and Systems Research. The current strategy of the AHPSR, called 'Aiming for impact', covers the period 2024-2028.

Health financing

WHO has been at the forefront of research,

conceptualization and advocacy regarding health financing. It has conceptualized the health financing "building block" as comprising three functions: resource mobilization, pooling, and purchasing. It has initiated the Montreux Collaborative aimed at gathering a global network of experts working on the relationship between fiscal space, public financial management and health financing towards the goal of UHC. More recently, it has reinforced its work on health taxes – both as a way of raising resources for health and preventing non-communicable diseases (NCDs).

Non-communicable diseases (NCDs)

WHO has been a leader in the fight against NCDs. It is in charge of supporting Member States in implementing the United Nations Political Declaration on the Prevention and Control of NCDs (resolution A/RES/66/2), notably through various resolutions, global strategies, numerous operational guidelines, and advocacy.

Conceptualisation of health systems and health systems strengthening

WHO has been at the forefront of the conceptualisation of health systems, a necessary step before assessing their performance and how to strengthen them. The first large-scale attempt at defining health systems performance and comparing the performance of health systems worldwide is to be found in The World Health Report 2000, published by the Health Systems Governance and Financing Team of WHO. The report identified three (or five) health index of overall goal attainment, and health expenditure per capita, used as a way of computing the 'performance' (or, rather, efficiency) of national health systems.

In 2007, the Emergency Preparedness Team of WHO published a report entitled: 'Everybody's business -- strengthening health systems to improve health outcomes'. The report revisits the health system conceptualisation of WHR 2000 by using a framework with six building blocks – service delivery, health workforce, information, medical products/vaccines/& technologies, financing, and leadership/governance - rather than function, and adding a fourth goal (improved efficiency). For each building block, the report identifies common challenges and strengthening strategies.

In 2009, in partnership with the Alliance for Health Policy and Systems Research, WHO published a report entitled "Systems Thinking for Health Systems Strengthening", which in turn revisits the 2007 health systems framework by organising the six building blocks in a dynamic and interconnected model, and adding a seventh element: people, at the centre of health systems.

In 2022, under the European Observatory on Health Systems and Policies, WHO published Health system performance assessment: a framework for policy analysis which, based on a critical review of existing health systems frameworks and tools, develops a Health System Performance Assessment (HSPA) framework relying on (again) four functions (governance, financing, resource generation, and service provision), seven intermediate objectives (effectiveness, safety, user experience, access, quality, efficiency and equity of service provision) and five final goals (people-centeredness, health improvement, financial protection, efficiency and equity of health system). Contrary to most other frameworks, HSPA also integrates the context and social determinants of health.

Beyond the general conceptualisation of health systems presented above, WHO has also done a lot of research on specific aspects of health systems, enabling harmonisation of concepts, indicators and measurement practice among countries. For instance, following the Declaration on strengthening district health systems based on primary health care (Declaration of Harare in 1987), it has supported the development of the district approach.723 In the context of the International Health Partnership and related Initiatives (IHP+), it developed a common framework or "country-led platform for information and accountability" for the monitoring, evaluation and review of national health strategies in 2011. Together with UNICEF, it developed the Primary health care measurement framework and indicators in 2022.725 WHO has also developed various methodologies, conceptual frameworks and measurement approaches about specific health system building blocks, for instance the system of Health accounts enabling the measurement of health expenditure per source and per destination;726 the handbook "Health financing country diagnostic: a foundation for national strategy development"; the National health workforce accounts; the WHO Model Lists of Essential Medicines; the Harmonized Health Facility

Assessment (HHFA) methodology; a number of reference classifications;731 a Global reference list of 100 core health indicators; and it collaborated with the Health Metrics Network (now integrated within WHO) to develop a framework and standards for country health information systems.

Data and knowledge repository

In the wake of the conceptualisation work developed above, WHO – including through the Alliances and Partnerships it hosts – is now an invaluable source of information on health systems and health data across the globe. One can cite, among other things, the following repositories of health data, which are freely available and very useful for policymakers, scholars, students and other stakeholders (these are global public goods):

- The World Health Statistics which compiles a wide range of health statistics, enabling cross-country comparison and tracking of evolutions over time, and the Global Health Observatory which brings together a whole range of indicators, publications, country profiles and analyses on global health.

- The Global Health Expenditure Database which compiles all relevant health financing statistics, and Health Financing Dashboard which presents a dashboard of health financing data by country o The NHWA Web portal which gathers data on healthcare personnel worldwide.

- The SCORE data collection tool enabling the analysis, comparison and improvement of the performance of countries' national information systems.

- The World Health Survey Plus which is: "the World Health Organization's flagship household survey programme, focused on generating data needed to align with shifting data needs in health programming, policy and analysis, while also working to strengthen household survey systems in member countries". o The Health Inequality Monitor enabling tracking of global health inequalities. o The NCD portal enabling tracking of the evolution of NCDs. o Together with the World Bank, it is in charge of Monitoring universal health coverage.

Beyond global databases, WHO supports a number of regional health observatories that gather data and analyse specific health issues relevant to their region, such as the WHO AFRO Region Health Observatory, the European Observatory on Health Systems and Policies, the portal Regional Health Data in the Americas and the Pan American Health Organization's Observatory on Health and Aging for the Americas.

Supporting health systems strengthening and providing technical advice in countries

It must be noted that:

"guidance will only produce positive health outcomes if critical national structures, policies, decision-makers and resources are available to implement and monitor progress. To be impactful, WHO normative products should be locally contextualized and relevant to countries. Such contextualization cannot be achieved without understanding the lived experience of the people implementing the normative products, the contexts in which they work, and the supports and challenges they encounter in the process of change".

This requires subsidiarity – favouring adaptation to local contexts – and strengthening national capacities in evidence-based decision making for the uptake and impact of norms and standards. It must be noted that not only LMICs' capacities need to be strengthened, but HICs' as well. WHO – or an ideal IHO – is particularly suited to foster exchange of experiences between countries, even more so in the current context of increasing need to "*reverse innovation*".

Therefore, beyond conceptual and methodological tools, as well as harmonised indicators, WHO has developed numerous strategies, tools and guidelines for supporting national health systems strengthening, often with other partners. Examples include:

- World Health Organization (2017) Developing a national health financing strategy: A Reference Guide. Geneva: WHO.

- World Health Organization (2020) The Health Financing Progress Matrix – Country Assessment Guide. Geneva: WHO.

- World Health Organization (2020) Global strategy on human resources for health: Workforce 2030. Geneva: WHO.

- World Health Organization (2021) Global strategy on digital health 2020-2025. Geneva: WHO.

- World Health Organization (2024) Implementing the primary health care approach: a primer. Geneva: WHO.

Moreover, it offers a large network of technical assistance that can be mobilised to support HSS in countries, whatever their level of development. This is done through country-based WHO experts (in WHO country offices in LMICs); through on-demand support provided by headquarters (e.g. in the field of health laws), regional offices and sub-regional technical centres; and through networks with other partners or dedicated partnerships.

Supporting policy dialogue and national policymaking

In addition to supporting health system strengthening, WHO has also developed guidance to support countries in leading policy dialogue with health sector stakeholders, including through intersectoral governance (a necessary condition to address social determinants of health), and in developing, implementing and monitoring & evaluating their national health development plans. It is also supporting health sector policy dialogue in LMICs, be it through the role of privileged counsellor of the Minister of Health of its Resident Representative, technical officers, and often, through coordinating health sector donors in countries. In particular, since global health partnerships usually do not have country offices, WHO often takes the lead in the Global Fund's Country Coordinating Mechanisms and in Gavi's operations762 in countries (together with UNICEF and/or UNDP) – which is however controversial in some countries, as it may divert local capacities away from national institutions and reduce domestic leadership over the management of those funds.

International Health Regulation – in principle

The International Health Regulations (IHR) (2005) is one of the only legal binding instruments of WHO. They "provide an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders". They are accompanied by joint management tools such as the IHR monitoring and evaluation framework and the Joint External Evaluations. Despite some controversies around their latest amendments, aspects of the IHR have undoubtedly been useful since its initiation in 1951 to foster collaboration between countries and:

"to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade" (Article 2 Purpose and Scope of the IHR).

Normative guidance in specific health management domains

WHO has produced a vast array of handbooks, technical guidelines and other standard operating procedures in nearly every possible health domain and, to mention a few, consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations; Global action plan on physical activity 2018–2030: more active people for a healthier world; Family planning: a global handbook for providers, 4th ed.; Recommendations on the delivery of health services for the prevention and care of sexually transmitted infections; WHO guidelines for malaria.

IV.7.2. Cons

Movement away from public health to medicine

Part II argued that public health cannot be limited to applying protocols – thus WHO's guidance needs to be used with caution and critical assessment. More importantly, an IHO can reasonably not deliver medical services – yet the WHO's 14th GPW's overarching goal is to "promote, provide and protect health and well-being for all people, everywhere". In recent years, exemplified during the Covid-19 pandemic, WHO adopted more direct recommendation regarding national public health policies and clinical practice. Despite insider voices advocating for a more inclusive and transparent approach, the WHO tendency to standardise procedures and rely on overly-simplified study designs to investigate complex issues (e.g. early treatments for Covid-19) led to a global response with insufficient regard for local contexts,

community-developed strategies and heterogeneity in patients' need (see e.g. Reclaiming Comprehensive Public Health: A Call to Action).

A lack of representativeness or recognition of diversity in recommendations

In addition to duplication and over-publishing, recent WHO guidelines and recommendations have lacked both adequate evidence bases and recognition of cultural diversity. Examples discussed elsewhere in this report include the Pandemic Agreement and recent IHR amendments for which the risk and return on investment cases supporting the pandemic agenda have been grossly exaggerated (Section II.3.7), the FCTC on tobacco control (Section IV.4.2) in which legalism is inhibiting evidence-based responses, and the 2022 Abortion Care Guidelines (Section IV.2.2) reflecting a relatively narrow cultural and belief system, which is poorly coherent with that of many global populations.

A 'club' or 'clique' tendency, blurring accountability

While WHO is supposed to serve its Member States' interests, its governance structure is blurred by the intrusion of external interests, be it through financing or direct governance roles. For instance, the European Commission has more and more influence in WHO governance through its Delegation of the European Union to the UN and other international organisations in Geneva – EEAS. WHO is a member of Gavi's Board and an ex officio member of the GFATM's Board. WHO is the technical lead of the Pandemic Fund hosted by the World Bank. Since these organisations provide a large amount of funding to WHO (see below), it blurs accountability mechanisms and encourages a tendency to work as a "club" or "clique".

Too much focus on implementation of donor-funded projects, leading to conflicts of interest

As outlined in the analysis of WHO financing, an increasing portion of WHO funding comes from earmarked (specified) contributions, and organisations WHO is supposed to hold accountable. This obviously leads to a risk of conflicts of interest. For instance, WHO is often a recipient and implementing partner of Gavi's and GFATM's grants in LMICs, while being at the same time in charge of guaranteeing the proper allocation and control of these resources.

Exponential growth in guidelines and duplication of work between departments

In its normative work, WHO has developed countless strategic documents, operational guidelines and standard operating procedures – see e.g. WHO Guidelines and Compendium of WHO and other UN guidance in health and environment. Not only does this translate into an 'infodemic' (Infodemic is one of the new favourite topics of WHO, but seemingly not applied to WHO output), but some of them duplicate each other, leading to confusion for implementing partners and countries (e.g. the Guidance to facilitate monitoring and evaluation for antimicrobial resistance national action plans which focuses on one specific action plan, while the handbook Strategizing national health in the 21st century: a handbook deals with M&E of national strategies in general; the Health systems for health security framework which has been developed in parallel to the more general Health system performance assessment and uses alternative health systems building blocks and indicators).

Insufficient institutionalisation of WHO's evaluation function

Despite the existence of a WHO Evaluation Office and a number of guidelines in terms of evaluation (e.g. WHO Evaluation Practice Handbook, The Practical Guide on Evaluation, Evaluation of WHO normative function at country level: 2023 report), the evaluation practice is still poorly developed at WHO, notably compared to other large international organisations (Comparative study of WHO evaluation function with selected UN entities; IEG Evaluation Products – Independent Evaluation Group). A revised WHO Evaluation Policy was approved by the Executive Board in August 2025. In the absence of an institutionalised evaluation function, and transparency and independence of evaluation of its programs and functioning, WHO can be neither accountable, nor a learning organization.

Failure to protect against commercial interests

As a result of its financial and governance conflicts of interest, WHO has failed to exempt itself from commercial interests. Examples include undeclared CoI during the H1N1 pandemic, regarding approved medicines, relative to Covid-19 strategies, and a lack of transparency regarding the funding of the WHO Foundation. It is foreseeable that this will not improve now that the Gates Foundation is the top donor of WHO.

WHO is prone to the same trappings of any large organisation and must navigate between multifarious competing interests and power dynamics. As demonstrated in Part II and above, within this challenging political landscape the WHO has been able to provide many global public goods for health, and it continues to provide the key forum for health policy dialogue. However, as noted throughout this report, WHO suffers from considerable shortcomings and mission drift that are in need of deep reform. Whether these are best served through institutional reform or through creating a new IHO is an active debate with its own set of trade-offs (See Policy Report). That said, it has been possible to identify key areas that would need to be addressed by any IHO or reformed WHO, which allows for several recommendations to be offered as a guide. It is in the final part of this report that these are now outlined.

PART V:

FINDINGS, RECOMMENDATION AND CONCLUSION

PART V
Findings, Recommendations and Conclusion

Findings and recommendations

Public health is intended to extend the actions that maintain and restore a person's health, through the promotion of well-being and practice of medicine, to populations. This entails "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals". Fundamentally it is therefore subject to the same requirements regarding ethics and human rights that arise from the assumption of individual sovereignty and the equality of all people. Correspondingly, it is subject to the principles that govern medicine itself:

- **Beneficence** – the duty to act for the good of the patient and community.
- **Non-maleficence** – "First, do no harm"; the obligation to avoid preventable injury or suffering.
- **Patient confidentiality** – respect for privacy as the foundation of trust in medical relationships.
- **Voluntary informed consent** – recognition of individual autonomy and voluntary decisionmaking.

The requirements of public health based around the right to health as a consequent responsibility of communities and governments must therefore be founded in these four principles. Individual sovereignty and the requirement for voluntary informed consent implies that public health must ultimately reflect the will of individuals through the collective mechanisms that enable them to express that will, reflecting the requirements set out internationally in instruments such as the Geneva Declarations and the Universal Declaration of Human Rights, and international human rights law and treaties discussed in this report.

The moral principle of supporting those who are disadvantaged, as well as the reality of cross-border threats to health, which will frequently require international cooperation for effective management, supports the well-established need for an International Health Organisation (IHO) to facilitate such collaboration.

The principle of individual sovereignty requires that such an organisation adhere to certain principles, including that it be managed and directed by the structures through which individual sovereignty is most effectively expressed at an international level, through their individual States.

This report outlined a set of principles upon which an IHO must operate if it is to fulfil these fundamental requirements and so have legitimacy from a human rights and public health perspective. These principles represent the negative rights of the person – freedom from coercion, manipulation, or experimentation – that must be protected in all public-health systems, and the structural requirements to prevent such principles from being abrogated through conflict of interest, perverse incentives, and the risks associated with large and often privileged bureaucracies. An IHO must therefore be based around the preservation of international health: sovereignty, accountability, transparency, and the subordination of global administration to individual and State agency.

IHO role and functions

Historically, improved health and longevity are most strongly associated with improved nutrition, sanitation and living conditions. More recently these core determinants have offered further health improvements with the advent of antibiotics. Mass vaccination has played a role in parallel for specific diseases. These main determinants of health, and access to health commodities through competent and accessible health systems, are strongly associated with economic well-being, whilst freedom from debilitating disease has in turn a positive impact on economies. Public health and economics are therefore closely connected, and ultimately the aim of most current international cooperation in public health should be to address these main drivers of well-being and support the building of resilient and sustainable national health systems. This in turn will reduce the need for future intercountry support. Alongside a continuing role of improving efficiency of healthcare globally through the setting of norms and standards, surveillance and data sharing. An IHO should therefore also concentrate on supporting nations and communities to address these fundamental determinants, with the goal of reducing its own role.

The panel consequently outlines the roles and limits of a reformed WHO or a successor IHO consistent with these principles:

- **Policy dialogue:** Facilitate open and fair consultation and coordination among countries.

- **Normative guidance and harmonization:** Develop and maintain international health standards, including the International Health Regulations, without coercive enforcement.

- **Knowledge and data sharing:** Serve as a repository of trusted information as a global public good, free from commercial or private influence.

- **Capacity building:** Support national strategies and primary health systems, emphasising technical assistance and training.

- **Focus on root determinants:** Prioritise the main drivers of improved health and resilience – sanitation, nutrition, education, and chronic-disease prevention – over bureaucratic emergency management.

- **Disease prioritization:** Concentrate resources on high-burden and preventable illnesses – both infectious and non-communicable – based on context and local need.

- **Balanced emergency response:** Integrate outbreak response within overall health resilience as a piece of a wider systems approach, not as a separate global command function.

- **Monitoring and evaluation:** Maintain transparent, centralised, and standardised data systems to track progress.

- **National and regional response:** Support operationalisation of response primarily at community, country, and regional level.

- **Sustainability:** Promote time-bound interventions that build capacity and eventually render IHO and wider multilateral assistance unnecessary, reducing dependency and encouraging national self-reliance and ownership.

The WHO's drift

This report chronicles the WHO's transformation from a technical agency intended to support international public health in an era of decolonization and reaffirmation of human rights (to a large degree consistent with the IHO model recommended here) into a politicised bureaucracy directed increasingly by non-State and vested interests.

- Early decades delivered triumphs with improvements in health systems access and support, also strengthening of disease-specific programmes such as for malaria and tuberculosis, and notably the eradication of smallpox.

- Later decades demonstrated mission creep, associated with dependence on earmarked funding (approximately 80 percent of WHO's current budget), and alignment with corporate and ideological agendas. A focus on vertical, commodity-based programmes has resulted in a narrowing of focus, neglecting the broad definition of health – physical, mental and social – that WHO's constitution requires it to address.

- The Covid-19 response – marked by contradictory messaging, censorship, and neglect of established pandemic science – and subsequent disproportionate emphasis on relatively lowburden acute outbreaks over core determinants of health reveals how far the WHO has strayed from its founding principles. It also suggests an acceleration in an overly biomedicalized and securitised approach to health.

This report highlights some underlying reasons for the loss of the WHO's original focus. As of early 2026, the largest single donor to WHO is a private entity and roughly 80% of its funding, including nearly all private funds, are earmarked. WHO must follow the requirements of external parties, often with clear vested interests in certain public health approaches, rather than recommend policy decisions based on remediable disease burden and equity. Unfortunately, a potential byproduct is that financial profit or commercial gain becomes potentially as important in eventual outcomes as population health. A steadily growing, highly centralised workforce supported by this funding has inevitable interest in pleasing funders and facilitating their desired outcomes, in order to maintain income and job security.

A corollary of these changes is a drift away from an orthodox human rights-based approach emphasising the primacy of individual sovereignty in health decision-making, and the related essential emphasis on community inclusion and control in public health implementation. A growing emphasis on vertical programmes and uniform responses to complex challenges has made WHO policy and recommendations

increasingly discordant with the post-World War Two understandings of human dignity, and with increasing calls for de-colonisation and national ownership of health policies.

The pandemic accords of 2024-25 (the Pandemic Agreement and amended International Health Regulations,) risk institutionalising this drift by centralising authority and legitimising censorship under the pretext of combating "misinformation" and managing "infodemics", consolidating priorities of specific funders whilst misrepresenting relative health risks and expected returns on further investment to Member States. The Pandemic Agreement is also a raw deal for many low- and middle-income countries, which make up most of the world's population. It entrenches unfair practices by burdening lower-resource States with unrealistic demands, for example aspects of the One Health agenda and other requirements for resource diversion, whilst benefitting those influencing policy through specified funding.

The legalism inherent in the pandemic accords and further demonstrated in the Framework Convention on Tobacco Control and adherence to climate-related requirements demonstrate a concerning drift into a dogma-driven approach rather than a reliance on evidence and public health science. This threatens to confine WHO to the requirements of narrow agendas, replacing good public health policy with an adherence to inflexible rules often disconnected from local context, changing epidemiology and established understanding of the key drivers of well-being.

The structure of WHO, with a strong central office and a human resource approach designed to maximise the benefits of longevity within the organisation, makes the organisation intrinsically susceptible to the risks of bureaucratic growth, self-preservation and expansion. This makes it susceptible to influence by wealthy non-State actors. This in turn reduces the organisation's ability to reflect the will and needs of the populations it is supposed to serve. These structural problems make the organisation intrinsically difficult to reform in a way that would enhance responsiveness to populations and Member States, and restricts its ability to reduce the influence of vested financial interests on policy making. Put bluntly, the WHO has major structural issues that prevent it from performing as an effective and appropriate IHO.

Rebuilding international health cooperation

The world is in a period marked by rapid changes in international relations, including reductions in international aid and calls for *"decolonization of global health"*. Reform of multilateral cooperation in health is timely and much needed.

Reform of an IHO as a central multilateral operator in international health (i.e. the WHO) must be based around some underlying requirements:

- An IHO should not interfere with individual health and thus should limit itself to acting in the field of public health. Evidence synthesis, knowledge transfer tools, norms and guidelines shall recall the fact that patients' characteristics and preferences must be assessed in a one-to-one manner by the healthcare practitioner and the patient and ideally, carers and family, in accordance with the principles of people-centred care.

- An IHO should continue supporting health system performance assessment and strengthening, and also support Member States to move away from aid dependency. It could for instance advocate for the defragmentation of global health and the transformation of foreign aid to investment in global public goods.

The core functions of an IHO need to be (re-)focussed on global public goods (including global policy dialogue, conceptual work on health systems, knowledge management and dissemination) and technical support, at a systems level, addressing determinants of health and with a focus on high burden diseases. To this extent, the IHRP broadly agrees with some conclusions from the Wellcome Trust's recent commissioned regional proposals to 'reimagine global health in this new era':

> *"First…that the current global health system has reached its limits, and incremental reforms will not suffice. Second, decentralisation emerges as inevitable… Third, new financing models were perceived essential, recognising the volatility of voluntary and charity-based aid. …A consensus that reform…[must include]…primary health care, health systems strengthening, and equity".*

> *"From a governance perspective, future reforms are urged to shift power and favour health governance and leadership at the country and regional levels".*

There is a need to strengthen subsidiarity through regionalisation, but without leading to duplication – and possible incoherence – for tasks relating to truly global public goods. Thus, tasks such as technical assistance; support for policy dialogue, policy implementation, monitoring and evaluation; and practical guidelines should translate global public goods to the needs of regions and countries. This would enable better adaptation of support and implementation to address cultural specificities, and development of capacities corresponding to the specific needs of countries.

Individual sovereignty must be expressed at a national and international level through various forms of representative government. Since 1945, global interdependence has deepened, but so too has resistance to technocratic and centralised global governance, which is often detached from democratic legitimacy. This has been reflected through the reassertion of independence by former colonies and the affirmation of fundamental human rights within international law. Over recent years, a populist or people-centred reassertion of sovereignty can be understood as a challenge to supranational overreach. This report considers this to be an opportunity to engage in healthy dialogue to address present shortcomings and undue mission creep. Cooperation remains essential – but cooperation that is voluntary, accountable, legitimate, and anchored in the sovereign equality of States.

The 2025 notification of the withdrawal of the United States from the WHO illustrates further demands consistent with concerns in this report: international coordination s needed that is scientific, transparent, and accountable, not politicized or donor driven. While the full impacts of the US withdrawal are yet to be determined, the accompanying America First Global Health Strategy includes emphasis on capacity strengthening and building of self-sufficiency in recipient partner countries consistent with fundamental public health principles prominent in the early decades of the WHO and the recommendations of this report.

The pushback against early drafts of the Pandemic Agreement and recent IHR amendments signals a similar recognition by low- and middle-income States of a persisting and arguably increasing imbalance of power along colonial-era lines, with increasing centralisation, authoritarian approaches and vested interests risking the welfare and health of their peoples. An IHO basing its headquarters and largest campus in one of the world's wealthiest States, increasingly dependent on private and State-derived directive funding, looks inconsistent with aspirations of national autonomy and sovereignty. The world increasingly has a need, and an opportunity, to rethink the way it cooperates on health.

Principles for IHO structure and governance

Based on the approach followed in this report, reiterating the human rights and public health principles upon which ethical international public health cooperation must follow, and recognising the short-comings and drift of current approaches to multilateral cooperation in health, the governance and structure of an effective and appropriate IHO would differ from the current WHO. The following requirements are emphasised:

Constitution

- Embed fundamental human rights based on individual sovereignty and consequent medical and public health ethics discussed in this report into the constitution as inviolable guiding principles for policy and implementation.

- Codify the equality of States, the organisation's independence from non-State actors, and establish better checks and balances to prevent capture.

- Require super-majority approval for amendments, ensuring stability of purpose and immunity from political or commercial manipulation.

- Explicit conflict-of-interest clauses and financial transparency requirements.

Structure

- Decentralised organisation: Regional offices hold operational responsibility, consistent with existing regional WHO or sub-regional groupings [e.g., the Pan-American Health Organization (PAHO), the South-East Asia Regional Office (SEARO), West, Central, and East African].

- Smaller, modular staffing: Focus resources at regional and national levels rather than a dominating Geneva-style headquarters, ensuring equitable staffing that emphasises regional experience. Improve cooperation with regional bodies to mobilise local insight and increase localised capacity.

- Direct country representation: Smaller voting blocs to balance influence among large and small States.

- Streamlined secretariat: Leadership limited to coordination, knowledge management, and facilitation.

Staffing

- Enforce term limits, rotation, and periodic external service to avoid institutional ossification.

- Prioritise technical competence and field experience over political patronage.

- Create clear conflict-of-interest disclosure and cooling-off requirements for staff moving to or from private industry.

Funding

- Base funding of all staffing and operations on assessed national contributions to preserve independence.

- If voluntary or private funds are accepted, they must remain unspecified and within capped, transparent limits.

- Budget formulas should allocate resources to reflect needs of high-burden, low-income regions with emphasis on time-bound capacity-building programmes structured to achieve self-reliance and national ownership.

- Require full public disclosure of all donors and earmarked contributions.

Based on these structural requirements, an IHO should emphasise certain long-term approaches to programme development:

Long-term vision

1. Build an IHO that acts primarily as a forum and facilitator, not a governing authority.

2. Emphasise capacity-building over control, and sovereignty over supranational control.

3. Design time-limited programmes that strengthen local systems rather than perpetuate dependency.

4. Measure success not by the expansion of the IHO but by its progressive redundancy as national capacities mature.

Transition to an appropriate IHO structure

Noting the need for an IHO, the panel also recognises obstacles to reforming or replacing the WHO:

- Centralised structures and ossified bureaucracy will resist power redistribution.

- A dense ecosystem of public-private partnerships, State and non-State actors, and an entrenched global health workforce, which has vested interests in the existing model.

- Leadership culture steeped in close private-sector collaboration has normalised opacity and fear-based communication.

It is not the subject of this report to predict whether or how soon a new IHO would replace the WHO, or serious reform be undertaken; the transition entirely depends on international relations dynamics. However, much of the current direction of travel, as noted in this report, is contrary to the improvements required. We therefore propose different scenarios and the applicable international legal norms, without entering into technical and political details.

1. Deep transitional reform. The first scenario - a newly-structured IHO could replace the current WHO as a coordinated, deliberative transition process – essentially a deep organisation-wide reform. History has witnessed the dissolution of the League of the Nations and the creation of the UN at the end of World War Two, which might be seen as a transformation under the banner of "replacement". This scenario would necessarily implicate the dissolution of the WHO by its deliberative body (the World Health Assembly) and the creation of a new IHO by a group of sponsoring States. A new organisation can retain valuable assets – such as national and regional office networks – while resetting governance and purpose. Regional structures could be rationalised (e.g., dividing

Africa into more coherent West, East, Central, and Southern blocs; decoupling Central Asia from Europe), in order to achieve meaningful subsidiarity and ensure local context and control is paramount.

2. Development of an alternate organisation. In the second scenario, the IHO could be constituted solely by States that are no longer WHO members (exclusive membership), while the WHO will continue to function as a central health organisation within the UN system. It would then be unlikely that the new IHO would also be part of the UN system, at least until it has gained a sufficient weight of membership, due to perceived competition of mandate with the WHO. This will depend somewhat on how far their work overlaps, versus being viewed as complementary.

3. Development of a parallel, overlapping organisation. In the third scenario, the IHO will count not only States that are no longer WHO members but also States that prefer to continue to be WHO members (dual membership). A gradual increase of membership will open the possibility for the IHO to replace the WHO in the UN system, were it so decided by the UN membership.

Alternatively, such an organisation could remain complementary to a more focused WHO. It could replace certain functions such as emergency preparedness and management less compatible with an IHO whose core mandate is to address determinants of health, normative guidance and support for capacity building on which a global IHO such as the WHO should be concentrated.

Critical in any transition period, it would be necessary to:

1. Pursue reform through an external, State-led process rather than internal WHO mechanisms.

2. Ensure that leadership, staffing, and decision-making are independent of non-State (e.g. private sector or philanthropic foundation) direction.

In any scenario, it would clearly be preferable for State(s) to retain useful components of WHO's current architecture (e.g., country offices and potentially staff) but reconstitute governance and finance. This would be more readily implementable under scenario 1 above, but would come with potential baggage of deficiencies of the current organisation. It is also crucial to note that scenario 2 and 3 above could also have significant and foreseeable downsides, including increased transaction costs, policy duplication, increased fragmentation, opportunity costs, and resource dilution. Moreover, the idea that the creation of any new institution would nullify undue power by the act of its creation alone is suspect, since there will remain the threat that any new institution could be captured with even worst affect. As a result, regardless of scenario, the panel insists that the principles and recommendations outlined in this report must be understood as being foundational, action guiding, and as performance guardrails.

Moreover, it should be noted that UN membership is not a requirement for WHO membership. Currently, the Cook Islands and Nieue are members of the WHO but not the UN, and Liechtenstein a member of the UN but not the WHO (though party to the IHR). The United States and Argentina, on leaving the WHO, also remain in the UN. Sponsoring States of any new IHO will need to address the political matter of the potential participation of self-governing territories such as Taiwan and selfdeclared independent entities such as Somaliland. This issue will ultimately be decided by sovereign States, weighing pros and cons regarding public health benefits, but also political consequences.

Conclusion

The Right to Health Sovereignty concludes that the restoration of trust in international health governance depends on rediscovering the moral foundations of medicine and the sovereign responsibilities of the nation State to promote the health of its people. The WHO's current model – centralised, donor-captured, and ideologically driven – may not be able to meet that challenge. This deterioration in the world's key multilateral health agency is a result of both internal and external pressures, but has occurred under the oversight of its Member States. Fixing the problem, whether reform or replacement, will require action from States, who ultimately bear responsibility for the failures of multilateral agencies. Current reductions in WHO funding and realignments after the United States' exit present an opportunity and imperative to get this done. No human institution, whether at State or international level, is going to be free from the reality of differing agendas, vested interests and even the reality of human greed. Priorities will differ between people and peoples for a range of reasons that make consensus challenging to achieve but consultation essential. It is essential, therefore, that any institution fostering international health cooperation is

structured to minimise these risks, ensure representativeness and reflect the will of the populations it is developed to serve, as the States that form it should also be structured.

The future of global health lies in an ethical and decentralised architecture designed to serve people through their States, not to govern them. An International Health Organisation built on sovereign responsibility, subsidiarity, and ethics would integrate universal moral principles (beneficence, nonmaleficence, patient confidentiality, voluntary informed consent) and consequently a set of public health principles derived from these, including an architecture of accountability, national ownership, local capacities and decentralisation. It would preserve the benefits of cooperation while upholding the freedoms of individuals and sovereign States.