

Non-Paper on Strengthening WHO's leading and coordinating role in global health
With a specific view on WHO's work in health emergencies and improving IHR implementation

The COVID-19 pandemic has once again highlighted the need for strong global health capacities. The World Health Organization (WHO) has the central role to play in addressing global health challenges, including prevention, detection and response to outbreaks. WHO's constitution states that it is the mandated leading and coordinating authority in global health.

The expectations regarding WHO's mandate are huge: The organisation is supposed to set up norms and standards and promote and monitor their implementation in a variety of fields, to shape the research agenda, to articulate ethical and evidence-based policy options, to react to outbreaks all over the globe, to provide adequate and timely information for health professionals and populations worldwide as well as to provide technical support. And last but not least WHO has the role to monitor the health situation worldwide and to assess health trends.

However, not only during the current pandemic, it has become clear that the WHO partly lacks the abilities to fulfil this mandate. The international community's expectations regarding WHO's capacities outweigh by far its given financial, structural and legal abilities.

The 73rd World Health Assembly adopted a resolution asking the DG to “*initiate, at the earliest appropriate moment, and in consultation with Member States, a **stepwise process of impartial, independent and comprehensive evaluation**, including using existing mechanisms, as appropriate, to review experience gained and lessons learned from the WHO-coordinated international health response to COVID-19, including: (i) the effectiveness of the mechanisms at WHO's disposal; (ii) the functioning of the IHR and the status of implementation of the relevant recommendations of the previous IHR Review Committees; (iii) WHO's contribution to United Nations-wide efforts; (iv) and the actions of WHO and their timelines pertaining to the COVID-19 pandemic, and make recommendations to improve global pandemic prevention, preparedness, and response capacity, including through strengthening, as appropriate, WHO's Health Emergencies Programme.*”¹

The lessons-learned process following this global health crisis will have to focus in particular on the strengthening of global health security structures including the WHO's Emergency Programme (WHE) and potential updates to the International Health Regulations (IHR).

In this sense, COVID-19 has to be used as an opportunity to strengthen WHO's abilities to fully act as the leading and coordinating authority in global health. Long-term strengthening of WHO overall is key in order to strengthen its role and responsibilities in pandemic preparedness and response.

Three interdependent strains of reform are being proposed:

- (1) WHO reform in general
- (2) WHO's work in health emergencies
- (3) WHO's work under the framework of the IHR

These three reform strains are interlinked with one another: None of these areas can be successfully reformed without having addressed challenges in the other areas.

Furthermore, this reform cannot be envisioned without an upstream evaluation process.

¹ https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf

(1) WHO reform in general

Unlike all other global health actors, the WHO is the only health actor with quasi-universal membership, multilateral legitimacy and an almost unlimited health mandate. Since its creation, WHO has achieved major public health successes. However, while the expectations regarding WHO's mandate are almost unlimited, its funding has remained a major limitation. It is clear that Member States' (MS) expectations vis-à-vis WHO have by far outgrown their willingness to provide funding to the organisation. WHO's overall budget with roughly 5 billion USD per biennium equals the funding of a larger sub-regional hospital. Currently, WHO's assessed contributions account for roughly 20 % of its programme budget (less than 1 billion USD per biennium from all 194 MS together), while the remaining 80 % are raised individually through short-term, unpredictable and largely highly specified voluntary contributions, half of which are provided by non-Member States actors. The current overall funding level of WHO is way below the funding level of partner global health organizations, with limited global and subject-wise scope. Some of these partner global health actors belong to WHO's top donors, as they are using WHO's global structures to implement their specific health goals. WHO's budgeting process follows a fund-raising approach: At the time when WHO's 194 MS, after lengthy negotiations, adopt the programme budget, it is only partly predictably financed (by roughly 20 % assessed contributions). The remaining 80 % remain uncertain and have to be raised. This process has led to major challenges in multilateral priority setting, as the funding coming in is largely based on individual donor interests. The current way of funding WHO has led to a high risk of donor dependency and vulnerability within the UN system, as the top 15 donors contribute to more than 80 % of all voluntary contributions. Due to the fund-raising aspects, the current budgeting process needs to leave room for individual donor interests within the programme budget. Therefore, the programme budget has never been adequately financed leaving major differences between what 194 MS wanted to have implemented and the actual available finances for it. Furthermore, WHO is a knowledge-based organization with its committed staff being its key asset. Due to the financing model (80 % unpredictable finances), more and more functions have had to be outsourced and taken over by external staff (consultants). Key functions such as pandemic preparedness call for a sustainable, highly skilled and adequately sized workforce. All major HR reforms in the past years could not be implemented to the full extent as the current funding mix sets clear limitations.

Regarding global health governance and the fragmentation of the global health architecture with numerous global health actors and unclear mandates, the WHO should be in a position to play a leading and coordinating role, as foreseen by its constitution and outlined in the Global Action Plan (SDG3 Global Action Plan). However, the budgets of WHO's partner organizations have outgrown WHO's budget by far with the consequence that it is questionable whether WHO really is on an equal level playing field, able to defend its leading and coordinating role vis-à-vis these financially far more powerful actors.

(2) WHO's work in health emergencies

The WHO is the leading and coordinating authority with regards to pandemic preparedness and response. The world depends on a WHO that has the right capacities in place to fulfil its crucial role in health emergencies. WHO has a sound track record of achievements in responding to health emergencies. However, in the Ebola outbreak in 2014/2015 in West Africa revealed major shortcomings. As part of the lessons-learned-process following the Ebola outbreak, WHO's

Emergency Programme (WHE) as well as the Contingency Fund for Emergencies (CFE) were created. Under DG Tedros, the WHO has given its work in health emergencies even more emphasis by establishing the protection against and the response to health emergencies as one out of four key pillars of WHO's General Programme of Work (GPW).

However, systematic structural deficits still remain as they have not been adequately followed up by the global community during the lessons-learned process after the West-Africa Ebola outbreak. WHO needs to have full personnel, political and financial capacities to lead and coordinate the global work in health emergencies. In this regard, WHO needs to be free from any external interference or dependency. WHO must be a place for all relevant players who are able to contribute to pandemic preparedness and response.

The finalization of the establishment of the WHE has not yet been completed. Until now, it has never reached an adequate funding level with the consequence of many essential posts remaining unfilled. WHO's work in health emergencies, namely pillar 2 of the GPW, remains chronically underfunded. Among the four political goals of the GPW, pillar 2 is the least funded with only 40 % funding compared to amount planned in the programme budget. The WHO is highly dependent on a limited number of donors and thus critically vulnerable. Only 11 key donors currently contribute to almost 80 % of the available funding for WHO's work in health emergencies. This has severe consequences for WHO's ability to lead the global response in health emergencies: the limitation in funding does not allow for the setting up of essential capacities to play a pro-active role in global health preparedness and response nor for the needed convening capacities for essential updates to the legal frameworks on health security.

As highlighted by the current COVID-19 pandemic, leading the world's response to novel infectious diseases needs to be based on solid and outstanding scientific expertise. The establishment of such global expertise is a long-term goal and depends on long-term predictable financing. While WHO's MS successfully established the Contingency Fund for Emergencies (CFE) post-Ebola, they did not establish a sustainable financing mechanism for the fight against health emergencies in general. Only a very limited number of MS has so far financially contributed with the consequence of the CFE regularly running out of resources.

Furthermore, COVID-19 has the potential to profoundly reshape global health governance. While the response to COVID-19 offers the great opportunity to reinforce WHO's leadership role also vis-à-vis other global health actors, it could – if not adequately steered by MS – lead to further fragmentation in particular in global health security structures. Numerous actors are involved in the current response. This increases the challenge of avoiding duplication, competition for funding and mandates. Clear distinction of roles and mandates between the different actors is key, as well as coordination.

(3) WHO's work under the framework of the IHR

The IHR are a key pillar to global health preparedness and response and boosted global health security. This important mechanism must be safeguarded. However, while the IHR are fully recognized by a global membership and widespread initiatives have been calling for full implementation of and compliance with the IHR, still today the world is far from reaching an adequate level of implementation of the IHR core capacities. While other globally legally binding instruments include incentivizing implementation and reporting mechanisms, the IHR currently do not foresee such mechanisms.

WHO's abilities under the IHR remain limited and largely dependent on the relevant MS's willingness to cooperate. Also in this context, other legal frameworks have included concrete procedures more generally allowing the relevant international organization the right to intervene.

Investments in the health sector and in their capacities to prevent, prepare and respond to health events are too often insufficient. One key element of the IHR relies on the role played by the National Focal Points and their ability to communicate with, alert and inform health authorities as well as WHO. In many countries, the National Focal Points are not positioned adequately to trigger decision-making from the health authorities and lack appropriate training and resources. Likewise the National Health Services of countries do not have the capacity to respond adequately.

EVALUATION AND ACTIONS

Preamble: The evaluation process as agreed in the resolution adopted by the 73rd WHA will be crucial to strengthen work on the actions listed below. Objectives include: to support the evaluation process initiated by WHO Director General, notably by facilitating the consultation with Member States; to **ensure the impartiality, transparency, independence and comprehensiveness of the evaluation to review experience gained, and lessons learned from the WHO-coordinated international health response to COVID-19.**

Action 1: Consider general increase of assessed contributions and of core voluntary contributions to cover WHO's core business (base programme). Establish a process to balance out WHO MS's expectations vis-à-vis WHO with the needed overall budget envelope to implement these expectations. Revision of WHO's budgeting process, increasing budget transparency, accountability and clarity. This should go hand in hand with spurring a more integrative and cross-cutting approach by WHO of its activities to foster their impact, including on IHR implementation and on improving global preparedness and response capacities. Alignment and synergy between the action plan of the global health organisations and vertical Funds through the Global Action Plan could help optimize the use of MS contribution across the various Global Actors, and help streamline the process for better efficiency.

Action 2: Strengthen WHO's normative role. Strengthen the Chief Scientist Office and support the development of the WHO Academy in order to strengthen WHO capacity to elaborate and disseminate its guidance, including through training of WHO staff, health personnel and countries' officials, in particular IHR National Focal Points.

Action 3: Establish robust and sustainable governance structures allowing WHO MSs to provide adequate oversight and guidance to WHO's work in health emergencies (GPW pillar 2). Consider creating a sub-committee of the Executive Board focusing on pillar 2 and WHO's pandemic preparedness and response activities. The sub-committee would be constituted by representatives of regions, reporting and providing recommendations to the Executive Board. This sub-committee shall be able to follow crises and emergencies, when necessary, on a daily basis, hold meetings with the emergency committee and provide guidance to the DG.

Action 4: Consider ensuring sustainable financing of WHO's work in health emergencies (pillar 2 of the GPW) by all 194 MS through an increase of assessed and core voluntary contributions with the aim to fully finance the GPW pillar 2 and thus ensure WHO's ability to act in crisis without immediate need for funding appeals by strengthening the Contingency Fund for Emergencies (CFE). Increase funding substantially to ensure WHO's operational readiness and independency in health emergencies. Establish an adequate accountability mechanisms dedicated for compliance of WHO's work in conflict and crisis environment. Implement a sustainable funding and replenishment mechanism for the CFE. WHO must be able to initiate and perform crisis response operations, free from the need to rally funding to fully kick off and sustain response operations for a certain period of time.

Action 5: Enable WHO' mandated international experts to independently investigate and assess (potential) outbreaks as early as possible. Based on the results of the evaluation of the WHO-coordinated international health response to COVID-19, this could consist in strengthening WHO's network and teams to immediately perform outbreak investigation and allowing WHO-led multinational teams to access territories of States Parties to investigate any potential outbreak or health emergency at any time. This would allow the WHO to alert the world about a potential global emergency sooner.

Action 6: Strengthen operationalization of a WHO-facilitated Coordinated Global System for health emergency preparedness and response. Ensure coordinated action between WHO and other global organisations and thus strengthen WHO's leadership in pandemic preparedness and response. This should include promotion and reinforcement of the implementation of the One-Health Approach, through the collaboration between the WHO, the World Organisation for Animal Health (OIE), the Food and Agriculture Organization of the United Nations (FAO) and the United Nations Programme for Environment (UNEP), to reduce further risks of emergence and transmission of zoonotic diseases. This existing collaboration could be strengthened in the field of human, animal and environmental health and options should be explored to give more visibility to this crucial issue. Strengthen engagement with existing networks and partnership platforms, including the Global Alert and Response Network (GOARN), the Emergency Medical Teams Initiative, the Inter-Agency Standing Committee (IASC) and the global health cluster. Make more use of technical expertise of WHO collaborating centres around the world, expert networks such as technical advisory bodies and public health institutions.

Action 7: Revisit terms of reference and composition of relevant bodies to the IHR, including for regular lessons-learned processes. Depending on the results of the WHO-coordinated international health response to COVID-19 evaluation, this could consist in a transparent expansion of IHR Emergency and IHR Review Committees' membership and remit to ensure public accounting proceedings, or the creation of an independent advisory group (or the expansion of the remit of the IHR review committee or the Independent Oversight and Advisory Committee (IOAC) for the WHE to perform after action reviews of all grade 3 health emergencies and declared Public Health Emergencies of International Concern (PHEIC).

Action 8: Reform PHEIC declaration mechanism. Revise the PHEIC declaration mechanism to allow for a gradual PHEIC declaration and a stepped level of alerts. Establish a traffic light system to foster transparency on measures and communication about present public health threats. Follow up on the study requested by the 73rd WHA in the resolution on "Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005)"² on possible complementary mechanisms to be used by the DG to alert the global community about the severity and or magnitude of a public health emergency in order to mobilize necessary support and to facilitate international coordination.

Action 9: Increase transparency on national compliance with the IHR & establish a review of country-based levels of preparedness. a) Based on existing IHR review mechanisms and

² https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_R10-en.pdf

frameworks, establish a review mechanism for IHR compliance, including for early reporting and sharing of information and promote IHR Article 44 requiring MS to collaborate for IHR implementation. b) Review whether existing metrics for public health preparedness reflect the needed core capacities to handle a large scale pandemic like the Covid-19 pandemic. c) Streamline the reporting process and support countries in strengthening capacity to report on the information required under the IHR. d) Strengthen the support and assistance provided to countries in need, in the broader scope of health system strengthening.

Action 10: Mandate an existing committee or an ad hoc time-limited panel / expert group to follow up on the implementation of the reform, taking into account the status of implementation of the recommendations of the previous IHR Review Committees and other relevant reports (notably from the IOAC and from the Global Preparedness and Monitoring Board). Strengthen WHO and Member States' accountability on strengthening global preparedness and response.