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Policy **Position**

Barriers on the road to achieving the health MDGs

Global Health Governance and Reform of the World Health Organization

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Cover image: Maternity Hospital, Herat, Afghanistan. Supported by World Vision, the maternity unit serves a population of nearly 2 million people, delivering 1,600 babies every month. ©2012 Paul Bettings/World Vision

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Introduction

Over the last two decades, efforts to improve health in the developing world have enjoyed increasing international political support, attention and resources, contributing to significant reductions in child and maternal mortality. However, Millennium Development Goals (MDG) 4 and 5, relating to women's and children's health are the furthest behind and unlikely to be met, leaving millions of mothers and children without access to essential health services.

Three levels of aid and governance play important roles in strengthening the health systems, the weakness of which largely determines whether women and children access health services. Firstly, weakness in national policy and resourcing lead to poorly managed and financed health systems. For example, in the Democratic Republic of Congo, a country with a population similar to the UK and some of the worst health indicators in the world, health accounts for only 9% (or a little under £619m) of their government budget. This contrasts sharply with the budget of just one NHS hospital (Guy's and St Thomas') of £1.3bn. Per capita expenditure by the government on health in the Democratic Republic of Congo is only $7, as opposed to $2,800 per capita in the UK. And there are similar stories across the developing world: the Government of Chad spends $8 per capita on health (only 3% of the Government budget), the Government of Afghanistan spends $7 per capita

Below: A family living in rural Ethiopia, who were referred by a Government Health Extension Worker to a World Vision Community-based Management of Acute Malnutrition (CMAM) Project based in the local health centre. ©2009 Paul Bettings/World Vision

on health (only 2% of the Government budget) and the Government of Myanmar spends $4 per capita on health (only 1% of the Government budget).[1]

Secondly, international support from donors and multilaterals can and should have an important catalytic impact on the development of effective health systems. *Unfortunately, international assistance is unpredictable* and often neither allocated in line with national priorities nor distributed using national systems. The UN Economic Commission for Africa have demonstrated that aid flows are five times more unpredictable than GDP in Africa and have twice the volatility of tax receipts.[2] In addition, *aid has not been directed according to the greatest burden of mortality and need*, particularly with regard to fragile states, meaning that the hardest to reach remain unreached by health services.

Thirdly, and the focus of this paper, *global coordination and leadership is essential if the range of different actors are to work effectively together.* Whilst a growing number of organisations focus on health, there is a lack of effective global coordination resulting in inefficiencies, confusion and weak accountability. The Paris Declaration on Aid Effectiveness committed countries and organisations to seek progress on a set of principles including national ownership, harmonisation, managing for results and mutual accountability, but it lacked precise commitments on which governments could hold each other to account with regard to volume of aid and domestic contributions, and quality of spending.[3] World Vision believes that the cost of the current complexity is the missed opportunity to make further inroads into reducing the nearly 7 million largely preventable child deaths that continue to occur each year.

Amongst the range of health actors, the World Health Organization (WHO) is the United Nations body with responsibility for leading on global health matters and supporting Member States to develop effective health systems and policies. The WHO has been given the mandate by the global community through the UN system 'to act as the directing and coordinating authority on international health work'[4] , as far as nations' sovereignty allows; however, it has not been given the sufficient resources to fulfil that role.

Strong health systems are essential if inroads are to be made towards accelerating and sustaining progress towards the MDGs 4, 5 and 6. A strong WHO, able to lead the development of a global health governance that improves health and achieves equity in health worldwide, is critical to that effort. This paper identifies strengthening the WHO as one of the most pressing challenges in global health governance and argues that a key concern for the reform of the WHO is the lack of core funding it receives from Member States, which has had the effect of reducing the effectiveness of the WHO and stopped it playing its full role in global health governance. It highlights the fact that the WHO is consistently undermined by Member States, including the UK, and is not able to provide the necessary leadership and coordinating role in global health governance.

The paper is, in part, based on the World Vision technical briefing paper, "Improving Global Health Governance"[5] , and goes into more detail around

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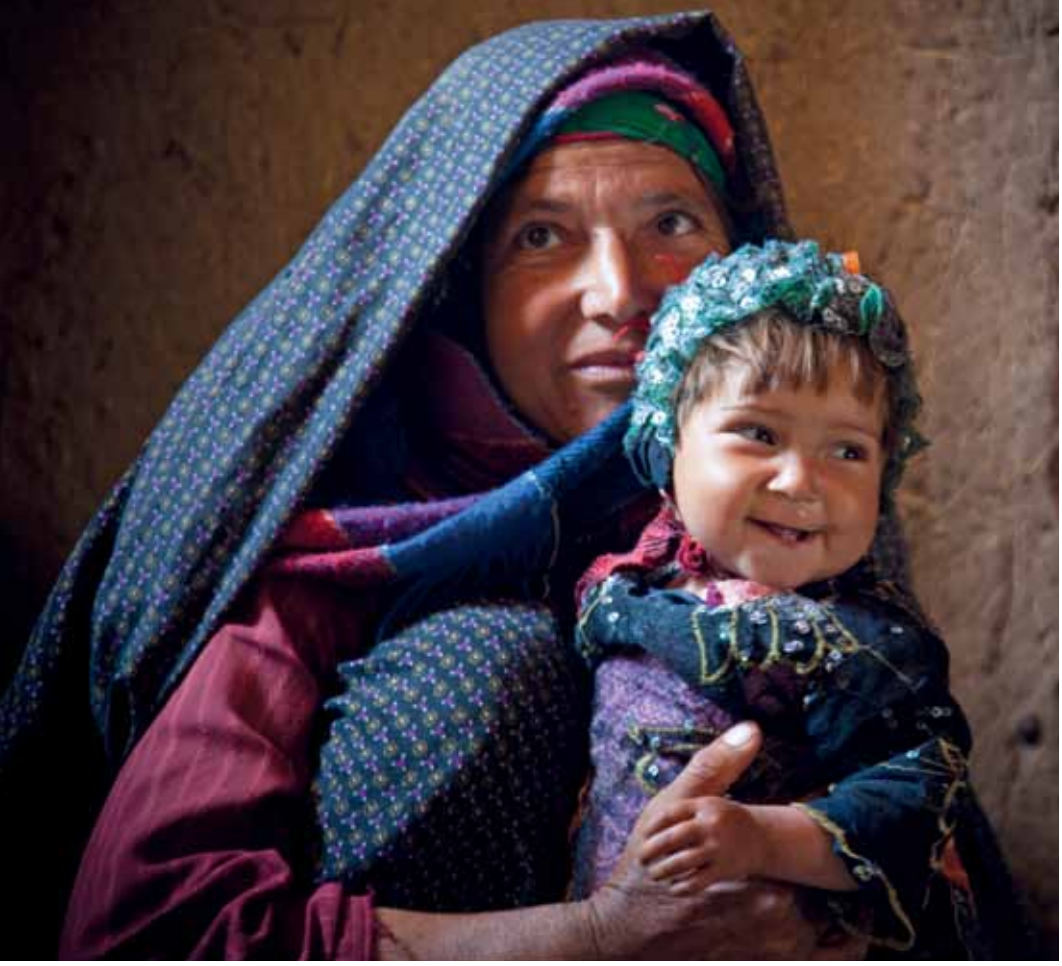
[1] All per capita figures PPP int. $. Taken from: WHO, *Global Health Expenditure Atlas*, (WHO, 2012).
[2] http://www.oecd.org/site/oecdgfd/40718167.pdf, accessed 2 October 2012.
[3] Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. www.oecd.org/dataoecd/11/41/34428351.pdf.
[4] http://www.who.int/about/en/, accessed 23 August 2012
[5] World Vision International, *Improving Global Health Governance: Technical briefing paper for the Child Health Now campaign* (2011)



Left: Fattema and her daughter, Qandigul, aged 2, in Herat, Afghanistan, who have benefitted from a PD Hearth project which aims to educate women and children about proper health and nutrition practices for their families. ©2012 Paul Bettings/World Vision

the financial barriers stopping the WHO from taking the leading role in developing a global health governance architecture that meets the needs of the poor, especially children living in the world's hardest places.

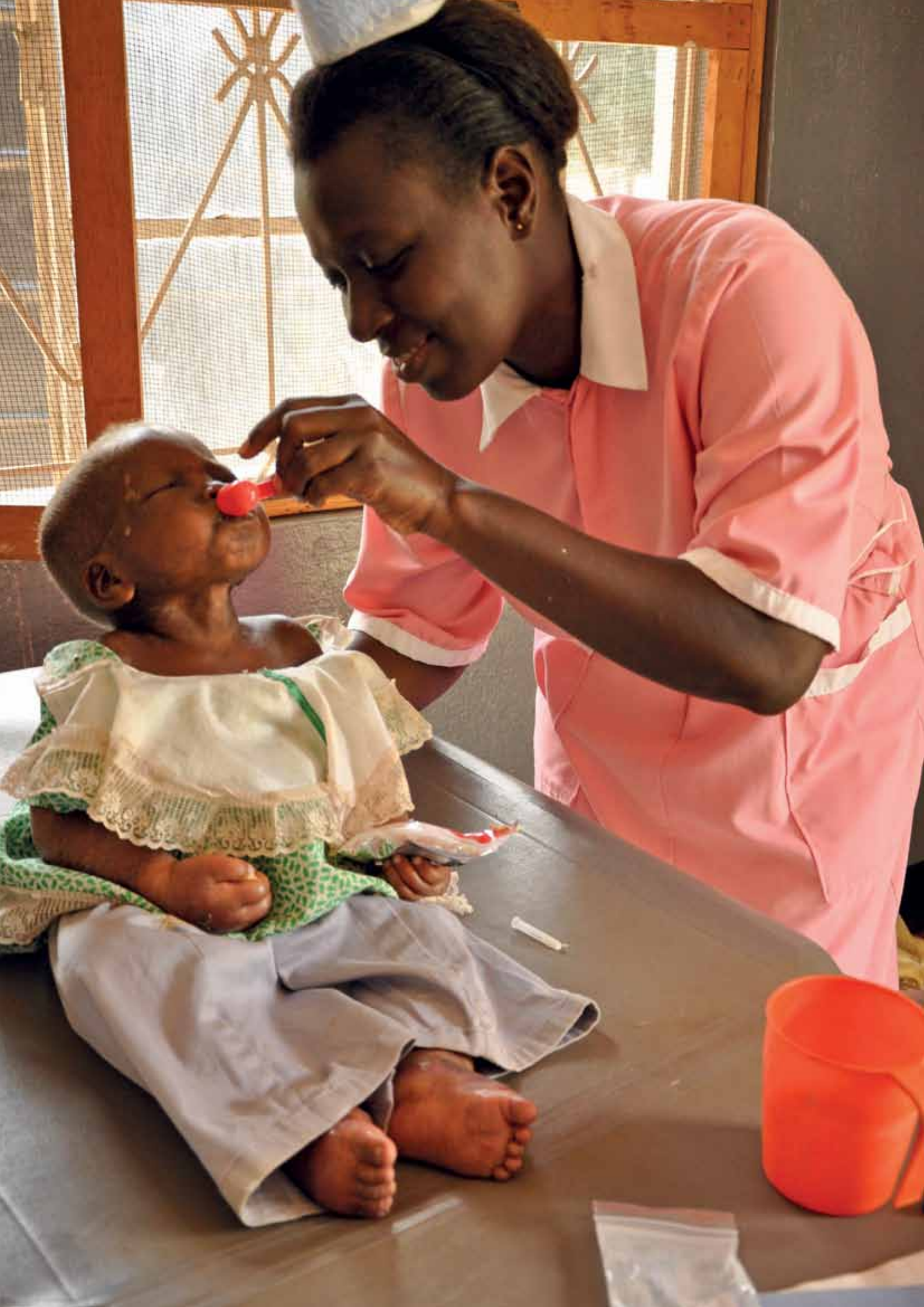
The UK is an important funder of the WHO and a key international aid donor, and, whilst this paper gives the wider context, the recommendations are targeted at the UK Government. We conclude that the UK, whilst supporting WHO reform on one hand, does not provide the predictable financial support to make this a reality.

We recommend that:

- Global health governance should be based on the premise that health is a right as outlined by Article 24 of the Universal Declaration of Human Rights,[6] and this should be reflected in UK aid expenditure on health.
- As recommended by the Independent Evaluation of the WHO[7], 70% of the UK's contribution to the WHO should be predictable and 40% should be core, flexible funding. The UK should work with other donors to the WHO to support them to increase other donor's predictable and core funding.
- The UK should support stronger civil society engagement in global health governance, with a greater voice in the WHO:
    - The UK Government should continue to advocate for reform of WHO, but should back this with appropriate funding modalities.

[6] Universal Declaration of Human Rights: http://www.un.org/en/documents/udhr/index.shtml, accessed 2 October 2012

[7] WHO, *WHO Reform: Independent evaluation report: stage one*, (WHO, 2012), A65/5 Add. 2, brought to before the Sixty-fifth World Health Assembly in May 2012.



Global Health Governance

In the last decade, efforts to improve health in the developing world have enjoyed increasing international political support, attention and resources. Hundreds of different organisations now focus on global health – including 40 bilateral donors, 26 UN agencies, 20 global and regional funds, multilateral institutions, private foundations, philanthropists and more than 90 global health alliances.[8] Although a positive development overall, this multitude of global health stakeholders creates increasing complexity, and at times confusion, which can hamper the efficient spending of finite resources.

Global health governance is, in essence, the coordination of all those working in health to effectively and efficiently achieve agreed collective goals. In policy terminology it is the means to ensure that the multitude of actors in global health "promote collective action and deliver collective solutions in pursuit of common goals"[9]. It is about the actions and means adopted by the global community to improve health and to achieve equitable access to health care. In other words, it is there to stop the huge numbers of agencies, funds and donors undermining national ownership, taking contradictory actions and leaving important areas of health areas underfunded and unsupported. It is a critical part of aid effectiveness, impact and value for money; and essential if there is to be a coordinated response to global health needs.

Global health governance is an issue which is of central import to all dialogue of global health, ranging from flu pandemics, the obesity epidemic to the 6.9 million children under the age of five who die every year. World Vision can attest to the impact of poor health governance on the lives of children. There are many well-intentioned initiatives and interventions by diverse actors, driven by top-down decisions rather than by the needs on the ground, which are not aligned to "collective action... in pursuit of common goals"[10]. For example, the HIV/AIDs project that provides nutritional support for children affected by HIV/AIDs – whilst this is a very beneficial and necessary intervention for those children, when rates of chronic childhood undernutrition are high, this can be divisive for the health centre that has food for some and not for others, all of whom are underweight or stunted. Action for Global Health[11] cite the example of Nepal, where a lack of coordination has led to serious criticism being levelled at donor behaviour. "In an interview with [Action for Global Health], Dr Bharat Pradhan, Executive Director of the Public Health Concern Trust, said, 'everybody in Nepal knows that most of the health programmes are donor-driven. Most of the programmes are vertical, and one can easily see duplication of similar programmes in the same districts supported by different donor organisations.'"[12]

[8] David McCoy, Sudeep Chand and Devi Sridhar, 'Global health funding: how much, where it comes from and where it goes', *Health Policy and Planning*, 24/6 (2009)
[9] Richard Dodgson, Kelley Lee and Nick Drager, *Global Health Governance: A Conceptual Review* (London: London School of Hygiene and Tropical Medicine, 2002; Geneva: WHO, 2002); http://whqlibdoc.who.int/publications/2002/a85727_eng.pdf
[10] Dodgson, Lee and Drager, *Global Health Governance: A Conceptual Review*
[11] World Vision is an active member of the Action for Global Health Network
[12] Action for Global Health, *Aid Effectiveness for Health: Towards the 4th High-Level Forum Busan 2011*, (Action for Global Health, 2011).

Opposite: Nurse Christine giving Brenda, 4, medicine to drink at Aboke Health Centre in Uganda. ©2012 Simon Peter Esaku/World Vision

Health services and interventions need to be more coordinated and effective, and this is something that we can attest to impacting the lives of children. We hope to further the debate on global health governance to ensure that any new mechanisms and processes uphold the right to health as their guiding principle and ensure that the voices of the poor, including women and children, are heard.

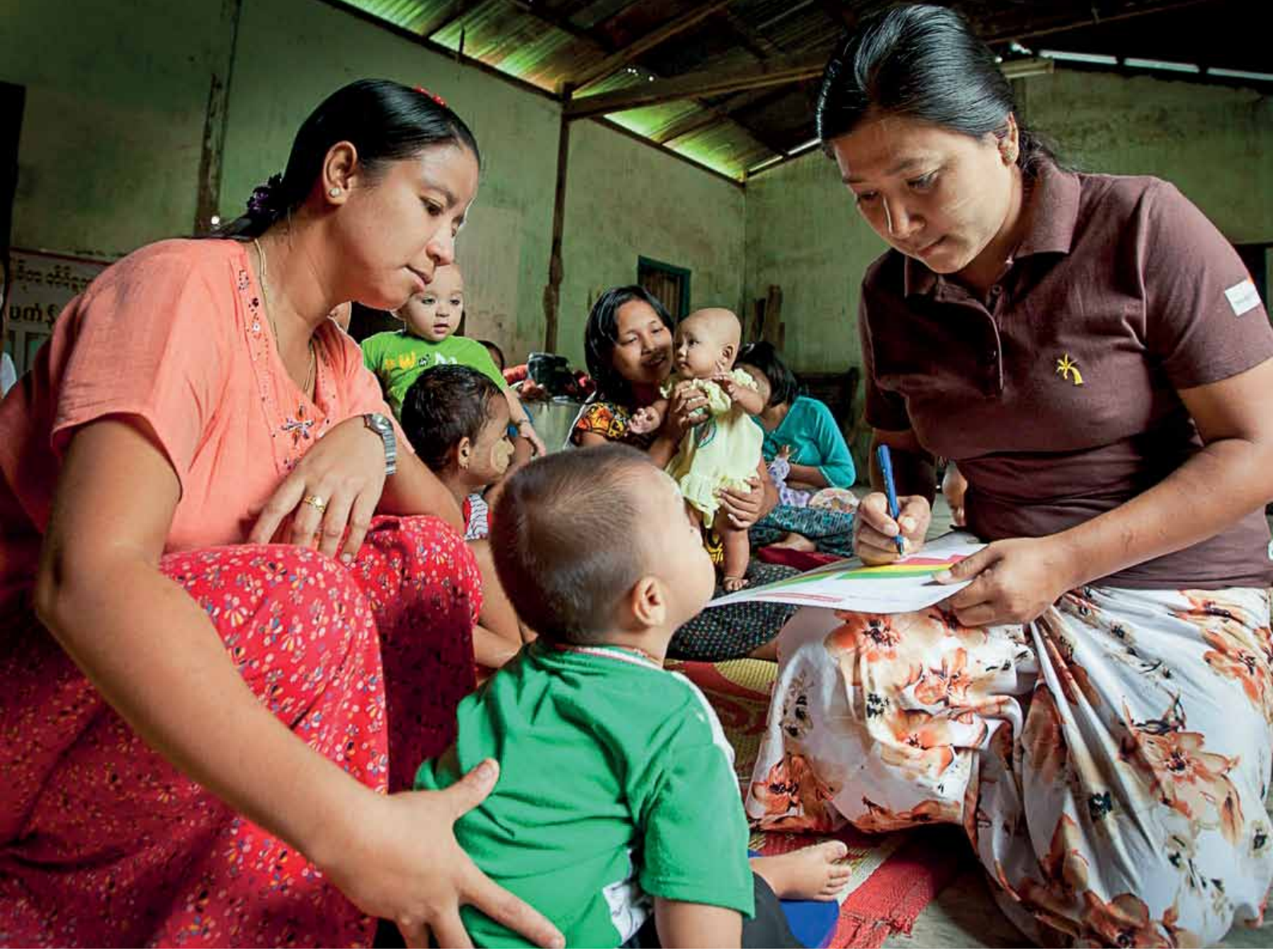
The WHO in Global Health Governance

The WHO was set up in 1946 as part of the United Nations system as the inter-state body designed to provide the leadership and coordinating role in global health issues. 194 countries have, at the time of writing, accepted the constitution of the WHO, making it the legitimate body for providing leadership on global health. However, as the global health environment has developed, and the number of organisations has multiplied, the WHO has not evolved quickly and effectively to reflect the changed environment. As the WHO recognises in their response to the UK Multilateral Aid Review (MAR) that "this new landscape calls for a re-examination of what global leadership means and what the WHO's role should be"[13].

Although reform of the WHO is necessary, it is clear that the role the WHO should perform is as important now as it was in 1946. Coordination and leadership in global health is essential and no other body has the legitimacy required to provide it. As such, WHO reform should be given the necessary priority and Member States, such as the UK, should focus on driving forward the reform agenda.

The underpinning principal for the WHO's role in global health governance is supporting the universal right to health. This is formulated in the WHO constitution and other international treaties[14] underpinned by universally recognised moral values and reinforced by legal obligations. To realise health as a right, it must be seen as the primary responsibility of all states towards their citizens first, then as a complementary responsibility of regional states, donors, philanthropic organisations and the private sector towards countries unable to realise even the minimum level of the right to health.[15] Specifically in maternal and child health, this responsibility is present in the Member State commitments to the UN Secretary General Global Strategy for Women's and Children's Health and in delivering this through Every Woman, Every Child. The WHO led the process of developing the accountability framework

[13] DFID, *Multilateral Aid Review*, http://www.dfid.gov.uk/Documents/MAR/who-response.pdf
[14] *International Covenant on Economic, Social and Cultural Rights*, 1966;45 ; Convention on the Rights of the Child, 1989:46
[15] Gorik Ooms and Rachel Hammonds, "Taking Up Daniels' Challenge: The Case for Global Health Justice", *Health and Human Rights*, 12/1 (2010)



Above: San San, a community health worker in Myanmar, records the growth of children in a World Vision supported project. ©2012 Khaing Min Htoo/ World Vision

for Every Woman Every Child, through the Commission on Information and Accountability for Women's and Children's Health. However, this initiative needs to be coordinated and integrated with other global health governance frameworks and, as such, World Vision believes that addressing the problems of global health governance, and therefore supporting a strong and effective WHO in all areas of global health governance is critical in ensuring the sustainability and integration of new initiatives like Every Woman Every Child.

The WHO is designed to ensure that there is common purpose in global health issues between sovereign states. Coordination among sovereign states, even when they have a common objective, has not been self-evident. Every country, whether it acts predominantly as an international assistance donor or as an implementer of internationally co-financed efforts, wants to preserve its autonomy. Nonetheless, we live in a world that is increasingly affected by global challenges, in health and far beyond health, and important benefits can be expected from increased and improved coordination; for example, in the management of global responses to new diseases such as SARS. The WHO has an important role to play in coordinating and tackling health issues that do not respect borders.

The supreme decision making body for the WHO is the World Health Assembly (WHA), to which member states send representatives of their respective health ministries. Decisions are taken by consensus and this assembly is intended to be the governing body for the activities of the WHO. In principle, this system is intended to form the bedrock of global health governance – ostensibly "the actions and means adopted by 'global society' to improve health and to achieve equity in health worldwide."[16]

However, the proliferation of new actors global health such as GAVI or the Bill and Melinda Gates Foundation, the need for reform of the WHO (especially the funding arrangements), and the competing priorities of Member States, has led to a weak and fractured system of global health governance. World Vision believes that the poor, vulnerable and marginalised are those that suffer because of this weak system, and our experience of working in communities has shown the ill effects of a divided and stagnant global health governance system on the children we serve. WHO reform is critical if we are to ensure that any new mechanisms and processes uphold the right to health as their guiding principle and ensure that the voices of the poor, including women and children, are heard.[17]

Why a stronger and reformed WHO is critical to achieving the Health MDGs

In the maternal and child health area alone there is clear evidence that approximately 6 million lives can be saved each year if health systems can be strengthened to the extent that they are able to effectively deliver proven and cost-effective interventions.[18] Whilst there have been new and welcome innovations to support the development of these health systems, such as International Health Partnerships (IHP+) and Every Woman, Every Child, they cannot and should not be expected to fulfil the role of the WHO in coordinating and directing global health governance. It is therefore important that the WHO is enabled to both coordinate international initiatives and support momentum in countries seeking to build and strengthen their health systems.

The WHO has recognised the critical importance of fragile and conflict affected states, but does not provide enough tailored support to fragile contexts. In fact the MAR rates the WHO "weak" in their attention to fragile contexts.[19] These are states that, DFID and World Vision define, as being unable or unwilling to meet the needs of their citizens.[20] As World Vision has

[16] World Vision International, *Improving Global Health Governance*
[17] World Vision International, *Improving Global Health Governance*
[18] The Lancet, Volume 372, Issue 9648, Pages 1473 - 1483, (25 October 2008)
[19] DFID, *Multilateral Aid Review: Assessment of the World Health Organisation (WHO)*; http://www.dfid.gov.uk/Documents/publications1/mar/WHO.pdf
[20] Nick Chapman and Charlotte Vaillant , *Synthesis of Country Programme Evaluations conducted in Fragile States*, (DFID, 2010)

shown,[21] in order to build sustainable health systems in these contexts, it is critical that aid efforts are coordinated, predictable and long-term. They also require strong leadership. The WHO should play a crucial role in supporting the development of health systems in these contexts; however, without the resources or structure to play this role effectively, World Vision continues to have significant concerns that the WHO does not have the capacity to provide sufficient support for the development of sustainably funded health systems in fragile states. Furthermore, as the MAR notes, the WHO lack the specific policies and data collection to work effectively in fragile contexts.[22]

It should be understood that investing in health systems, without predictable long term support, represents a significant risk for governments; this is a risk that they may be reluctant to take when it involves long-term spending such as staffing and maintenance of equipment and systems. For example, in Mali, donors have announced funding two to three years in advance, allowing the government to effectively and securely plan the health budget in advance, without the concern of significant shortfalls in a country where external resources make up 26% of health expenditure.[23] However, this does not allow for the development of longer term infrastructure projects and many countries have far worse aid predictability – indeed, in Mozambique, aid predictability is weak beyond one year, making long term investment almost impossible.[24]

In 2001, African Union countries committed to spend at least 15% of their national budget on health.[25] This remains very much an aspiration in most counties, for example in countries like Kenya where only 7.3% of government spending is allocated to health.[26] As a result, the majority of spending on health comes from household budgets, often from some of the poorest communities in the world. For example, in Sierra Leone, 79% of all health expenditure comes from personal household budgets. This is often through the charging of direct users fees or for covering the cost of medicines. While some low-income countries have increased their domestic health funding, on average, domestic government health expenditure in relation to GDP only increased 0.1% between 2000 and 2008.[27]

Whilst aid for health has increased over the past 10 years, it can only contribute a limited amount to redressing this imbalance. However, as the WHO has stated, "aid needs to be provided and spent more effectively, and programmed in line with need. In particular, aid must be more predictable."[28] Aid flows for health are often volatile, with a disparity between what is

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[21] Annemarie ter Veen and Stephen Commins, *From services to systems: Entry points for donors and nonstate partners seeking to strengthen health systems in fragile states*, (World Vision Canada, 2011)

[22] DFID, Multilateral Aid Review

[23] OECD, *Aid Effectiveness in the Health Sector: Progress and Lessons*, (OECD, 2012); and the WHO Global Health Expenditure Atlas

[24] OECD, *Aid Effectiveness in the Health Sector*

[25] Abuja Declaration: http://www.un.org/en/africarenewal/vol15no1/151aids5.htm

[26] *WHO Global Health Expenditure Atlas*

[27] Calculated as total health expenditure minus external resources, minus out-of pocket private health expenditure. Between 2000 and 2008 low-income countries health expenditure increased from 1.7 per cent of gross domestic product (GDP) in 2000 to only 1.8 per cent of GDP in 2008, while external resources increased from 0.5 per cent of GDP to 0.9 per cent of GDP.

[28] For the consensus points see WHO, *The High-Level Forum (HLF) on the Health Millennium Development Goals,* (Geneva: WHO, 2006), http://www.hlfhealthmdgs.org/HLF5Paris/060829HLF_briefing_AFRORC.pdf.

promised and what is given. As illustrated above, poor governments are therefore "understandably reluctant to take the risk of relying on increasing aid to finance the necessary scaling up of public expenditure."[29]

"Aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments", and "aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care".[30] As a result, despite increases in aid and the impact of debt relief, many governments have not gambled on investing in health systems. Developing sustainable health systems should be a partnership between governments and donors, and without a long term commitment from donors it is understandable that governments fail to commit to system strengthening.

An effective WHO, coordinating global health governance, is critical to ensuring that aid for health is spent in as effective as way as possible. If countries are to move away from aid dependence, there needs to be a greater focus on developing sustainably funded national health systems, and the WHO has an important role to play in coordinating and supporting aid and technical efforts to achieve this. The WHO can provide support to countries building coordinated and efficient health systems, and work with them on strategies for financing them, whilst coordinating donors to ensure that there is enough predicable funding to cover the gap between what poor governments can spend on health and what is needed.

If we want to end aid dependency rather than just achieve short term results, then the proliferation of Global Health Partnerships (GHP), such as the Global Fund to fight Aids, TB and Malaria (the "Global Fund" of GFATM) or the GAVI Alliance (formerly, the Global Alliance for Vaccines and Immunisation) is of particular concern, especially as these initiatives are timebound to the MDGs. Although they can offer short term and tangible results, donors should resist the temptation to just support GHPs, as their commoditised approach does not do enough to support longer term solutions that end aid dependency.

The restricted mandate of these GHPs can create particular challenges when it comes to compliance with the 'aid effectiveness' principles. The Paris Declaration on Aid Effectiveness of 2005 and the Accra Agenda for Action of 2008 are based on the assumption that alignment of international assistance with developing countries' plans leads to increased effectiveness and efficiency.[31] The "New Deal for Fragile States", endorsed by most donors at the Fourth High-Level Forum on Aid Effectiveness in Busan, states that donors "commit to build mutual TRUST by providing aid and managing resources more effectively and aligning these resources for results."[32] Within this is the commitment to use, strengthen and support country led plans and systems.

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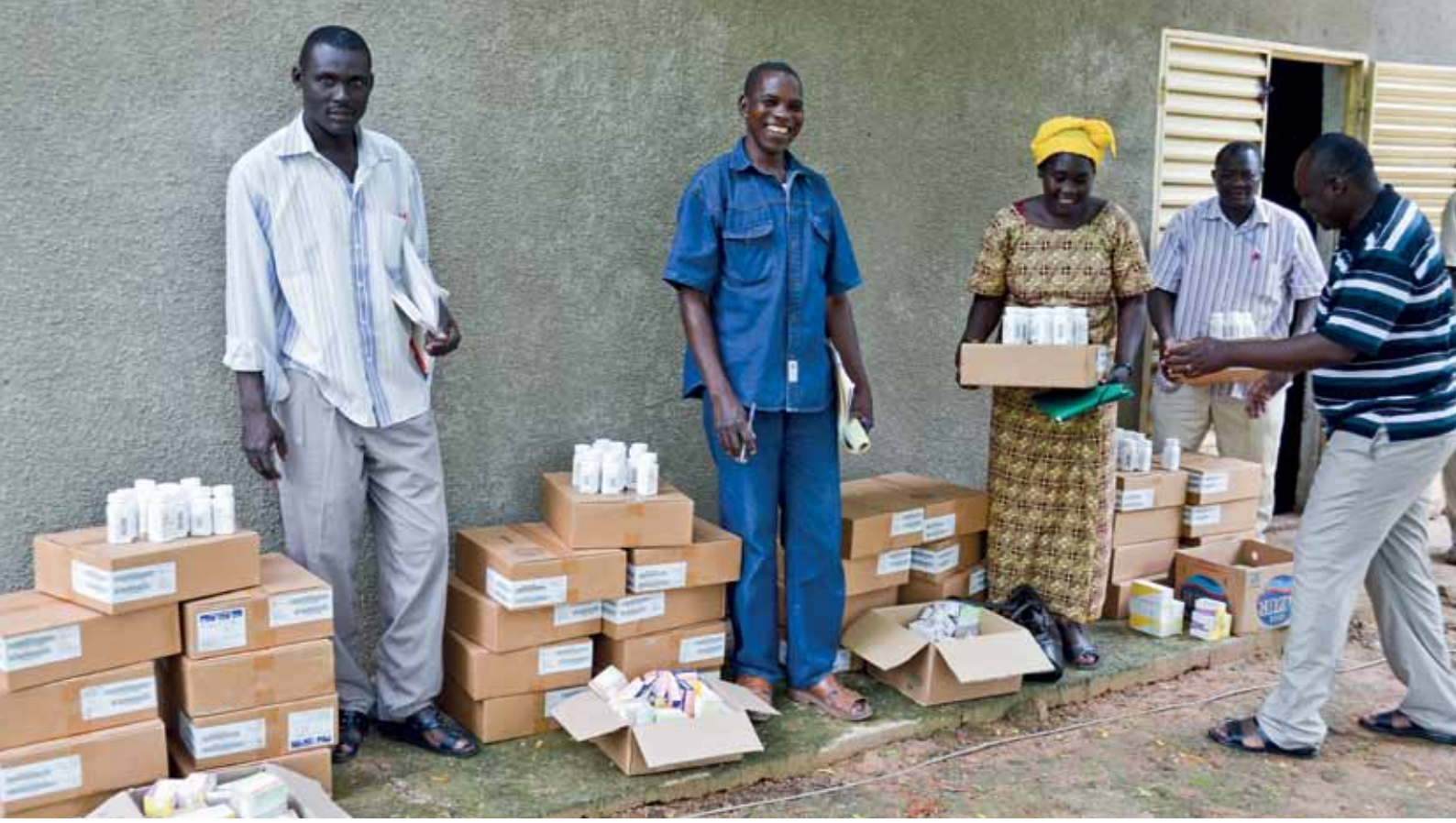
[29] Mick Foster, "Fiscal Space and Sustainability: Towards a Solution for the Health Sector", in *High-Level Forum for the Health MDGs, Selected Papers 2003–2005* (Geneva: WHO, 2005; Washington, DC: World Bank, 2005). http://www.who.int/hdp/publications/hlf_volume_en.pdf

[30] Christopher Lane and Amanda Glassman, Smooth and Predictable Aid for Health: A Role for Innovative Financing? (Washington, DC: Brookings Institution, 2008): http://www.brookings.edu/~/media/Files/rc/papers/2008/08_global_health_glassman/08_global_health_glassman.pdf

[31] WHO, *The High-Level Forum (HLF) on the Health Millennium Development Goals*, (Geneva: WHO, 2006) p. 3

[32] A New Deal for Engagement in Fragile States, http://www.oecd.org/international%20dialogue/49151944.pdf



Above: Health centere managers receive medicines in Chad. ©2012 Djimte Salomon/ World Vision

Determined by the context, health aid can be utilised in many ways, such as through the distribution of mosquito nets, vaccination programmes or through treatment programmes in health centres. However, there is a difference between explicit system strengthening and merely supporting a health system with drugs and other commodities. Many health programmes support and are delivered through, but are not strengthening, the health system. This is the particular challenge for GHPs, that while they only finance segments of the health service, they need to help strengthen country systems to cover the entire range of health challenges. While these new initiatives are still young, there are serious attempts being made to improve the 'aid effectiveness' of GHPs, such as the Health Systems Funding Platform, which involves the GAVI Alliance, Global Fund and World Bank. However they need a strong WHO, leading efforts to coordinate and direct the GHPs to support developing countries' plans and health systems strengthening, consistent with aid effectiveness principles.

There is also an increasing global effort, with DFID playing a leading role, to ensure both value for money and aid accountability. However, accountability for aid does not necessarily translate into more effective domestic accountability. World Vision and ODI have shown that the focus of donors in country has predominantly been at the national level, but if this agenda is to increase accountability to recipients it needs to take into account local domestic processes.[33] Transparency to recipients and the development of local accountability mechanisms are key. This is critically important in developing health systems in fragile contexts, as demonstrated by a World Vision report into health governance in South Sudan.[34]

[33] Leni Wild and Pilar Domingo, *Aid and accountability in health: key themes and recommendations,* (World Vision UK and ODI, 2010); http://www.odi.org.uk/resources/docs/5952.pdf
[34] Sebastian Taylor, *Beyond the Health Governance Gap: Maternal, newborn and child health in South Sudan*, (World Vision, 2012)

More needs to be done on aid effectiveness for health. Strengthening national systems is critical to ensuring aid effectiveness in the long term, with the real impacts being felt by the people in communities like those that World Vision work with. Since 2005, the OECD have looked at health in order to assess and trace the aid effectiveness principles outlined by the 2005 Paris Declaration. The OECD sponsored "Health as a Tracer Sector" (HATS) Final Report argues that the increased complexity of health, the proliferation of donors and funding streams, means that increased focus on governance is crucial.[35] Ensuring country oversight, making aid more predictable and reducing the percentage of off-budget project funding are central to increasing the effectiveness of aid in progress towards the MDGs. The OECD HATS Taskforce argue that this does not require new structures or processes, but rather for the existing global health governance architecture to work more effectively. The role of the WHO in this underlines how an ineffective WHO impacts upon the lives of children, and therefore how critical WHO reform is.

How the WHO needs to change

In order to reach the Millennium Development Goals on health, there is a need for a strong global health governance architecture and for the WHO to fulfil its mandate as "as the directing and coordinating authority on international health work". However, in the multi-polar world of global health governance, the WHO cannot be seen as the preeminent actor. The system of funding has undermined the sovereignty of the WHO, meaning that it cannot fulfil the mandate of directing and coordinating the multitude of actors in health. World Vision believes that in order for the WHO to play its important role in supporting and leading better governance of health, the reform agenda needs to take this issue of financing much more seriously and Member States should commit to providing more predictable and long-term funding.

The WHO has had significant problems with management and leadership, but the root cause of many of these issues is that it is unable to develop long term and sustainable plans because of the lack of core funding. Member States, instead, have ensured the WHO has a hand to mouth existence through short term, project linked funding.

The main concern with the WHO's inability to play a strong role in global health governance in directing and coordinating international health is the lack of sufficient predictable funds, known as the "funding crisis". At the 65th WHA, in May 2012, the countries that comprise the European Union argued that the WHO should not have the remit to stray outside the outlined and agreed Twelfth General Workplan of the WHO, agreed by the WHA, and that

[35] Working Party on Aid Effectiveness Task Team on Health as a Tracer Sector, *Progress and challenges in aid effectiveness: What can we learn from the health sector?*, (OECD, 2011), http://www.oecd.org/dac/aideffectiveness/48298309.pdf

they should have sufficient funding to carry it out. In essence this means that the work of the WHO should be set out clearly in the Workplan, agreed by all Member States and financially supported. However, this is not the case, with Member States agreeing the Workplan, but not giving sufficient funds to support it, instead directing funding of the WHO towards their own 'pet' projects and asking WHO to deliver them.

All Member States agreed that the sovereignty of the WHA to set the agenda of the WHO, but this unanimity is not borne out in the actions of individual member states in their funding of the WHO. In other words, despite formal assurances from donor countries that they support the sovereignty of the WHO, their actions demonstrate that the political will to see an effective and independent WHO is lacking.

The root of the WHO's funding crisis is that it receives very little core funding; instead donors have preferred short term project orientated funding, reducing the WHO to a hand-to-mouth existence, rather than the financially secure and independent leader in global health governance that is needed. Furthermore, a significant proportion of core funding is spent on administering the project specific funding.

Member States fund the WHO through two mechanisms. Their Assessed Contribution (AC) comprises about 25%, whilst 75% of funding is through Voluntary Contributions (VC). The majority of voluntary contributions are given for specified projects (only 10% of VCs are allocated to core funding).[36] This has resulted in a WHO whose activities are directed by the highly specified project funding they receive from donors, and not the Workplan agreed by the WHA.

The WHO has a fundamental role in supporting a "horizontal" approach to development – which essentially are activities that are focused on strengthening health systems to ensure that it is able to tackle multiple health issues – as opposed to a "vertical" approach – which targets a specific intervention or disease, such as malaria, without the explicit objective of building the wider health system. "Horizontal" approaches to health are long-term, often led by the country rather than the donor, and are, as such, badly suited to the short term nature of project funding that the WHO receives from donor Member States.

The current funding arrangement, as a result, has two main problems:

a) Funding is not aligned to the role as defined by the governing body, the WHA, leaving the WHO unable to target proportionate funding at agreed objectives; and

b) The unpredictability of the voluntary contributions seriously hampers the ability of the WHO to plan for the long term or respond quickly to emerging crises.

[36] WHO, *Financial report and audited financial statement for the period 1 January 2010-31 December 2011*, (WHO, 2012), A65/45

Impact of funding shortfall and WHO reform agenda

The WHO has come under a significant amount of criticism, related to poor performance. The MAR rated the WHO as "Adequate" and raised a significant number of areas which need addressing to improve both the organisational strengths of the WHO and the contribution it makes to the UK's development objectives.[37] However, whilst a lot of attention has been focused at the symptoms of the WHO's organisational weaknesses, there has not been a significant attempt to deal with the funding crisis as the causal factor.

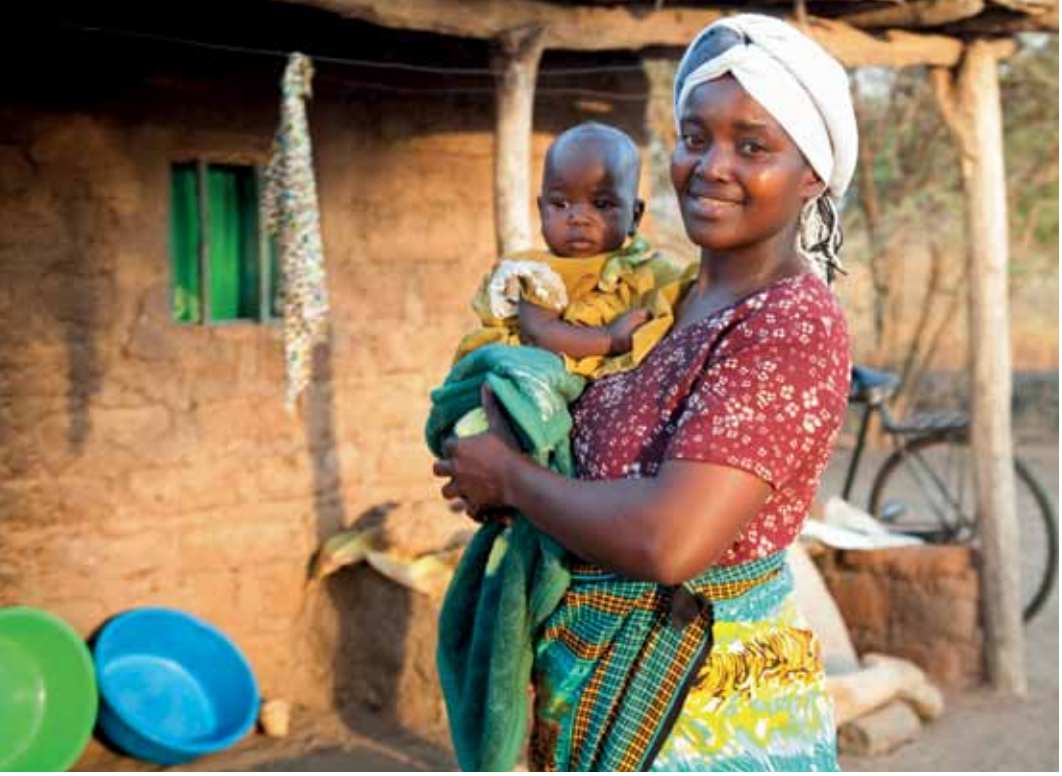
The imbalanced funding arrangement has a crippling effect on the effectiveness of the WHO as the mandated body to oversee global health governance. Member States point to the serious managerial, internal governance and financial management challenges facing the WHO as a rational for not increasing core funding. Whilst World Vision accepts that increasing core funding to the WHO carries significant short term risks, the long term effectiveness of the WHO in global health governance, and its ability to positively impact the lives of the children we work with, depends upon a solution to this impasse.

Margaret Chan, the Director General of the WHO, has responded by instigating a reform programme intended to address the various challenges faced by the WHO. These challenges have a real impact on the lives of children. An effective WHO, performing its role in supporting and coordinating global health, would have significant benefit to the children World Vision works with. Independent evaluation reports,[38] echoing the concerns raised by many Member States including the UK,[39] have highlighted the main issues, some of which, World Vision feels, are particularly important to ensuring the WHO is as effective as possible. These include:

a) **Human resources:** As noted in an external auditor's report the WHO have claimed that their "strength lies in [their] staff".[40] However, the independent evaluation shows that the lack of core predictable finances has resulted in a failure by the WHO to both "attract and retain the best professionals in global health".[41] Human resources account for 50% of the WHO budget, and because of the reliance on voluntary contributions, staff are recruited for specific time bound projects, and there is little-to-no human resource planning. The staffing model, however, was initially designed to be inflexible and encourage staff to seek long term employment. This mismatch between the intended approach to human resources and the reality has an impact on the quality, motivation and organisation memory of staff at the WHO.

b) **Siloed working:** the project nature of the work and the lack of clearly defined priorities have resulted in parallel structures and a fragmented and uncoordinated approach to resource allocation. This has a significant impact on the value for money that the WHO is able to leverage, as parallel structures and uncoordinated procurement mean project costs are higher and a reduced return on investment for donors.

[37] DFID, *Multilateral Aid Review*
[38] WHO, *WHO Reform: Independent evaluation report*
[39] DFID, *Multilateral Aid Review*
[40] WHO, *WHO Reform: Independent evaluation report*
[41] WHO, *WHO Reform: Independent evaluation report*



Left: Elizabeth, 32, a World Vision supported community health worker in Tanzania, with her 6 months old daughter, Christina. ©2011 Paul Bettings/World Vision

c) **Administration costs:** the external auditor's report into WHO reform notes that "the cost of administrating projects funded out of voluntary funds is not being recovered fully".[42] Indeed only 40% of administrative costs are funded from project funding.[43] In practice this means that the real cost of administrating projects is borne by the meagre core funding, further reducing the ability of the WHO to follow the priorities set out by the WHA, engage in long term planning and flexibly respond to emerging issues.

d) **Transparency and accountability:** The MAR states that the WHO "needs to improve its strategic focus and delivery at country level, as well as results reporting, cost consciousness, financial management and transparency."[44] However, the reliance on project funding and the siloed nature of the WHO, as a de facto intergovernmental consultancy agency, results in an organisation with a deficit in transparency and accountability and therefore operational weakness. The WHO should be ultimately accountable to Member States through the World Health Assembly and Regional Committees, not to project funders like the Bill and Melinda Gates Foundation.

e) **Voice of civil society:** whilst the Member States at the WHA have recognised the importance of civil society, little has been done to integrate civil society into decision making processes. Independent analysis shows that WHO would benefit from increased engagement from civil society, especially in the multi polar and political world of global health governance.[45] Whilst funding is mainly derived for specific projects, the WHO does not have sufficient incentive to engage with non-funding but expert groups, as the limited capacity is targeted at developing relationships with the Member States who are initiating the projects and therefore providing the funding to keep the WHO functioning.

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[42] WHO, *WHO Reform: Independent evaluation report*
[43] WHO, *Financial report and audited financial statement for the period 1 January 2010-31 December 2011*
[44] DFID, *Multilateral Aid Review*
[45] WHO, *WHO Reform: Independent evaluation report*

Above: World Vision's Midwifery Education programme, in Herat, Afghanistan. This project aims to provide an effective, high quality education program for the training of competent community midwives, which will address the problem of maternal and child mortality. Upon graduation from the program, these trained community midwives are the deployed to health clinics in rural districts of Herat to help service and educate the 1.7 million people in the province. This program has an 87% employment rate. ©2012 Paul Bettings/World Vision

UK's role in WHO reform

Work for strong and effective leadership on global health through strengthened and reformed international institutions such as the World Health Organisation (WHO).

Guiding principle 7 for UK Government Health is Global Strategy

In 2006, the Department of Health recognised that this state of affairs "makes it increasingly difficult for WHO to plan for and resource effectively over the longer term the full range of priorities set by its member states. The UK recognises the importance of increasing levels of predictable, multiyear, unearmarked funding if WHO is to take forward the actions set out in [WHO plans]".[46] At the 2012 World Health Assembly, the UK supported reform in the WHO, including the need for the WHO to be less controlled by Member States (including and particularly with regards to funding) in order to play a strong role in global health governance.

[46] HM Government, *World Health Organisation: UK Institutional Strategy 2008-13*, (HM Government, 2009)

Whilst World Vision UK recognises and welcomes the UK's vocal support for the WHO reform agenda, the UK is as culpable for the funding crisis at the WHO as any other donor despite recognising the serious implications of undermining of the WHO on global health governance. Core funding as (either the assessed contribution or voluntary funding designated to core WHO expenses) only comprises 22% (£71.68m) of the UK contribution, with 78% (£248m of the £320m the UK contributes) earmarked for specific projects.[47]

Recommendations

The imperative to improve global health governance stems from the continued reality that current resources are inadequate and/or poorly utilised to meet the challenge of addressing the preventable deaths of women and children. World Vision calls for the recognition of a shared responsibility to ensure the right of health for all people, regardless of where they happen to be born.

In doing so, it is critical that the structure of global health governance should recognise and empower the leadership and authority of the WHO to coordinate the effective participation of all major stakeholders in setting the normative framework, establishing standards, encouraging further commitments, promoting compliance and highlighting gaps in efforts to promote improved health outcomes.

World Vision proposes to the UK Government, as a large donor to the World Health Organisation, the following recommendations.

- Global health governance should be based on the premise that health is a right as outlined by Article 24 of the Universal Declaration of Human Rights,[48] and this should be reflected in UK aid expenditure on health. In practice this will include:
    - Working with aid recipient governments to support long term planning for health system strengthening;
    - In accordance with recipient government health plans, outline predictable funding until 2020;
    - The UK government should increase predictable, multiyear funding for health to fragile contexts, with specific support for health system strengthening and the WHO's role in coordination.

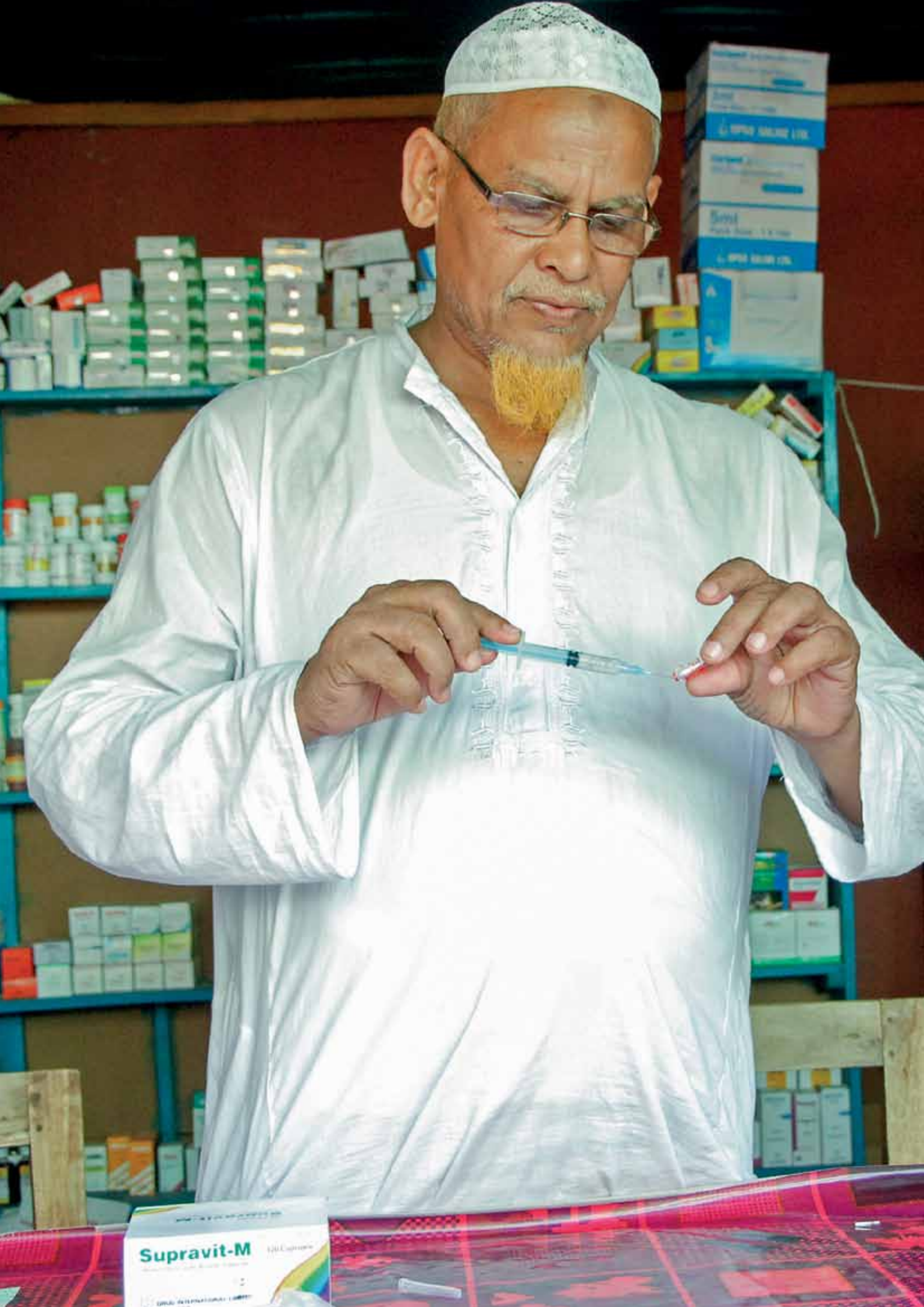
[47] WHO, *Statement of Account for UK as of January 2012*, (WHO, 2012) and *Voluntary contributions by fund and by donor for the financial period 2010-2011*, (WHO, 2012), A65/29 Add. 1

[48] Universal Declaration of Human Rights: http://www.un.org/en/documents/udhr/index.shtml, accessed 2 October 2012

- As recommended by the Independent Evaluation of the WHO,[49] 70% of the UK's contribution to the WHO should be predictable and 40% should be core, flexible funding.
    - The UK should work with other donors to increase the core and flexible component of the WHO budget from all sources;
    - The UK should support the right of the WHO to say no to funding from donors which does not align to their agreed work plan. This should include contributions from philanthropic organisations and other non member-state-governments donors;
    - All specified project funding should cover the administrative costs associated with their activities, at least the WHO official rate of programme support (13%).
- The UK should support stronger civil society engagement in global health governance, with a greater voice in the WHO. This would include:
    - More systematic opportunities to feed into existing consultation and decision-making processes of the WHO;
    - The development of a non-binding global health charter that emphasises shared responsibility, mutual accountability and alignment of international assistance with developing countries' priorities;
    - Considering the results of the final report of the OECD's Task Team on Health as a Tracer Sector, working together on opportunities at country level to promote the effectiveness of international and domestic resources through mechanisms such as the International Health Partnership (IHP+).
- The UK Government should continue to advocate for reform of WHO, but should back this with appropriate funding modalities. The WHO reform agenda should include developing:
    - Clarified roles and responsibilities;
    - Stronger results chains;
    - A more realistic budget;
    - Stronger accountability and transparency mechanisms.

Opposite: Shah Alam, age 58, is one of the 20 village doctors who participated in the two-day long training provided by the World Vision in Bangladesh. ©2012 Xavier Sku/World Vision

[49] WHO, *WHO Reform: Independent evaluation report: stage one*, (WHO, 2012), A65/5 Add. 2, brought to before the Sixty-fifth World Health Assembly in May 2012.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