

## Structure and Functions of the World Health Organization

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**Abstract:** “WHO Constitution states that ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. WHO, the parent organisation being ECOSOC is a major spoke in the wheel of United Nations common family system. It has been also in the past and in the present actively and symbiotically involved in improving international public health as well as intervening in humanitarian crises on the issues of health and well-being. Its complementary role with other important international and national actors like ICRC, UNCERF, UNDAC, EM-DAT and NDMA in West Asia, Africa, Latin America, South and South East Asia cannot be understated in contemporary times”.

**Keywords:** Alma Ata Declaration-1978, Bamako Initiative, Bare foot Doctors, Beijing Declaration, Central Emergency Response Fund (CERF), Child Survival and Development Revolution-CSDR, Ebola Haemorrhagic Fever, Emergency Medical Teams-EMT, EWARS: The Early Warning Alert and Response System, DNA (Damage and Needs Assessment), Executive Board, Global Alliance for Vaccines and Immunization-(GAVI), Global Strategy for Primary Health Care, Health for All-1979, GOBI, Health Education, Health Promotion, Health Emergencies Programme, HIV/AIDS Pandemic, Hyogo Framework of Action, Influenza A Subtype H1N1(Swine Flu), INSARAG (International Search and Rescue Advisory Group), International Certificate of Vaccination -(ICV), International Classification of Diseases-(ICD), International d' Hygiène Publique, occupied Palestinian territory (oPt), Peace Dividend, People’s Charter for Health, Regional Organization, Subtype H5N1 (Avian Flu), UN OSOCC (UN onsite operations and coordination centre), UNDAC (UN Disaster Assessment and Coordination), WHO Representative (Resident Representative), and World Health Assembly.

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### I. INTRODUCTION

This research paper which is extensively based on secondary sources is divided into three parts. The first part deals with an overview of humanitarian crisis’s in the contemporary world and how WHO is coping up with the situation, the second part which is quite exhaustive deals with the genesis of World Health Organization in the United Nations common family system, its structure and functions which includes the central structure, regional offices, staffing as well as a short note on the constitution of World Health Organization, the second section of the second part elaborates on its global strategy of ‘*health for all*’, primary health care, child survival, development revolution, HIV/AIDS pandemic, Year 2000 and 2020 goals, health promotion and other activities, programs and publishing , aims, health system framework, human resources for health, work force challenge, the Beijing declaration, pandemic preparations, revision of the international health regulations, accomplishments, challenges, success and criticism in the current context, role of the civil society, relations with other international agencies, budget, emergency risk management for health an overview with fact sheets- global platform - May 2013, Hygo framework for action and an short note on emergency medical teams; and the last section deals with conclusion and key recommendations for the up gradation of WHO’s core roles.

### II. OVERVIEW

**WHO is responding on an unprecedented scale in these Grade 3 and 2 humanitarian emergencies.**

For the first time ever, WHO is leading the health response to five major humanitarian crises at the same time. More than 60 million people, from West Africa to Iraq, urgently require a wide range of health-care services. West Africa’s Ebola outbreak, and conflict-inflamed humanitarian crises in South Sudan, Central African Republic, Syria and Iraq, have stretched health services to the limit and caused many to collapse. This has required WHO and its health partners to fill increasingly widening gaps to ensure life-saving and routine care for millions of displaced persons and host communities.

*“We are dealing with an unprecedented number of multiple humanitarian health crises concurrently. These are more complex and affecting more people than at any point of time since the end of the Second World War,”* says Dr. Bruce Aylward, Assistant Director-General of WHO’s Polio and Emergencies Cluster.

The five crises mentioned above have been categorized as Grade 3 (G3) emergencies, the highest grading determined by WHO as part of its Emergency Response Framework due to their scale and the emergency health response required. The ERF grades emergencies across three levels, with Grade 3 being the most serious.

The scale of the emergencies is stark:

- **West Africa Ebola outbreak**  
22 million people living in the three worst-affected countries – Liberia, Sierra Leone and Guinea – are at risk
- **South Sudan**  
5.8 million people need humanitarian assistance, including 1.3 million who have been displaced.
- **Central African Republic**  
2.5 million people are in need, including 425 000 displaced in the African Continent and
- **Iraq and**  
20 million people affected, including 1.8 million who are internally displaced.
- **Syria**  
10.8 million people inside Syria, including 6.5 million people displaced within the country. Another 3 million people have fled the conflict to regional neighbors and beyond like Lebanon, Turkey, Jordan, Iraq and Egypt.

*“Just two years ago, WHO developed the Emergency Response Framework (ERF) to guide our response in all types of emergencies,”* explains Dr. Bruce Aylward. He further states that *“The ERF ensures that the full resources of the organization are made available to support the response to the most severe crises.”*

*“We are dealing with an unprecedented number of multiple humanitarian health crises concurrently.” “We felt comfortable that the ERF would help us manage two Grade 3 emergencies concurrently, and if we were running 3 responses, we expected to be exiting one before entering the next. But 2 years later, we are managing five Grade 3 emergencies based on their scale, complexity, urgency, and political, social or economic impact. This is unprecedented – not only for WHO, but for all humanitarian partners.” “And these will be long-term, sustained crises, not just a time-limited surge period,”* he adds.

WHO’s leaders across the various emergencies testify to the enormity of the challenge that the Organization is responding to within their own country settings, and around the world. In Iraq, WHO Representative, Dr. Syed Jafar Hussain, says: *“With the increasing number of crises, WHO has realized that response to emergencies, whether health or otherwise, is not an isolated effort. It requires an organization well equipped with technical knowledge and mechanisms to deliver.”*

Dr. Francis Kasolo, who runs WHO’s West African Ebola control hub based in the Guinean capital of Conakry, says an Organization-wide response has been mobilized in each of the outbreak-affected countries, drawing in staff from around the world. *“WHO’s internal resource have been over-stretched due to the Ebola outbreak and the response to the other humanitarian emergencies occurring concurrently,”* Dr. Kasolo says. *“We will do everything possible to stop this dreadful outbreak and alleviate human suffering.”*

WHO plays a dual-pronged role in humanitarian emergencies, on one hand; it is the world’s prime technical guidance setting authority on the wide range of health issues. On the other, it is the lead agency for health in humanitarian crises, which involves a major coordination role as lead of the “cluster” of health care providers working in the various emergency settings.

*“We will always be a technical specialized agency, but it must be recognized that we have and need to have a strong foundation to operate in crisis settings,”* says Dr. Aylward. *“In humanitarian crises, our leadership role obliges us to be the provider of health services as a last resort. This can mean anything from coordinating the running of multiple health strategies in communities, such as immunization drives to equipping health facilities, to, even in some situations, delivering actual health care services.”*

This role is increasingly crucial for WHO due to the shrinking number of health-care providers working in emergencies. As security risks increase, especially for healthcare workers, and as costs for operations rise, many organizations that once performed in-country services no longer do so. The case in Iraq provides a telling example. The WHO-led health sector response there involves just 13 partner organizations. More than 40 organizations work in the Water and Sanitation Cluster.

Dr. Rick Brennan, Director of WHO's Department of Emergency Risk Management and Humanitarian Response, says besides these mega-emergencies, the Organization was still responding to multiple crises, including in Afghanistan, the Democratic Republic of the Congo, Gaza, Mali, Pakistan, Ukraine and Yemen.

*“Despite the strains on the Organization, WHO has never worked more effectively across multiple emergencies,” says Dr. Brennan. “By paying the salaries of healthcare workers in CAR and South Sudan so they return to work, or procuring large volumes of supplies for the Ebola outbreak, to delivering medicines and health services in the middle of intense conflict in Syria and Iraq, the implications for us are huge.”*

*“There has never been a time when we are more dependent on the solidarity, generosity and determined commitment of the international community to assist those most in need of humanitarian health support around the world” said Dr. Brennan.<sup>1</sup>*

To begin with, The World Health Organization (WHO) is a specialized agency of the United Nations that acts as a coordinating authority on international public health. Established on 7<sup>th</sup> April 1948, the agency inherited the mandate and resources of its predecessor, the Health Organization, which had been an agency of the League of Nations.

### **The Early Years of World Health Organization**

The WHO's constitution states that its objective *“is the attainment by all peoples of the highest possible level of health.”* Its major task is to combat disease, especially key infectious diseases, and to promote the general health of the people of the world.<sup>2</sup>

The World Health Organization (WHO) is one of the original agencies of the United Nations, its constitution formally coming into force on the first World Health Day, (7<sup>th</sup> April 1948), when it was ratified by the 26th Member State. Prior to this its operations, as well as the remaining activities of the League of Nations Health Organization, were under the control of an Interim Commission following an International Health Conference at New York in the summer of 1946. The transfer was authorized by a resolution of the General Assembly. The epidemiological service of the French Office International d'Hygiène Publique was incorporated into the Interim Commission of the World Health Organization on 1st January 1947.<sup>3</sup>

Earlier on just after the end of World War I, the League of Nations was created to promote peace and security in the aftermath of the war. One of the mandates of the League of Nations was the prevention and control of disease around the world. The Health Organization of the League of Nations was established for this purpose, and was headquartered in Geneva. In 1945, the United Nations Conference on International Organization in San Francisco approved a motion put forth by Brazil and China to establish a new and independent international organization devoted to public health. The proposed organization was meant to unite the number of disparate health organizations that had been established in various countries around the world.

In its constitution, WHO defines health as not merely the absence of disease a definition that subsequently paved the way for WHO's involvement in the preventative aspects of disease.

From its inception, WHO has been involved in public health campaigns that focused on the improvement of sanitary conditions. In 1951, the Fourth World Health Assembly adopted a WHO document proposing new international sanitary regulations. Additionally, WHO mounted extensive vaccination campaigns against a number of diseases of microbial origin, including poliomyelitis, measles, diphtheria, whooping cough, tetanus, tuberculosis, and smallpox. The latter campaign has been extremely successful, with the last known natural case of smallpox having occurred in 1977 and so after over 2 decades of fighting smallpox, the WHO declared in 1980 that the disease had been eradicated - the first disease in history to be eliminated by human effort. The elimination of poliomyelitis is expected any time soon.<sup>4</sup>

Initially, WHO devoted much of its resources to the fight against the major communicable diseases and mass campaigns were waged against malaria, trachoma, yaws and typhus among others. Malaria turned out to be a more complex problem than anticipated and early efforts at eradication had to be scaled back to the level of control. Efforts to improve maternal and child health services included the training of traditional birth attendants—an approach advocated by UNICEF, its close partner in all child-health projects—to reduce infant and maternal deaths. WHO also followed up on the work done by its predecessor organizations on sanitary conditions. It adopted, in 1951, the International Sanitary Regulations, later (in 1971) renamed the International Health Regulations.

In the beginning of the 1960s, WHO began an effort to extend health services to rural populations and by 1974, recognizing the underutilization of existing technologies to fight childhood diseases, WHO launched

an expanded immunization program against polio, measles, diphtheria, whooping cough, tetanus and tuberculosis.

Another noteworthy initiative of WHO has been the Global Program on AIDS, which was launched in 1987. The participation of WHO and agencies such as the Centre for Disease Control and Prevention is necessary to adequately address AIDS, because the disease is prevalent in under-developed countries where access to medical care and health promotion is limited.<sup>5</sup>

As well as coordinated international efforts to monitor outbreaks of infectious diseases, such as SARS and AIDS, the WHO also sponsors programs to prevent and treat such diseases. The WHO supports the development and distribution of safe and effective vaccines, pharmaceutical diagnostics, and drugs.

### **III. STRUCTURE**

WHO Headquarters is in Geneva. The WHO has 194 Member States, including all UN Member States except Liechtenstein, and 2 non-UN members, Niue and the Cook Islands. Territories that are not UN Member States may join as Associate Members (with full information but limited participation and voting rights) if approved by an Assembly vote: Puerto Rico and Tokelau are Associate Members. Entities may also be granted observer status: examples include the Palestine Liberation Organization and the Holy See (Vatican City).

WHO Member States appoint delegations to the World Health Assembly, WHO's supreme decision-making body. All UN member states are eligible for WHO membership, and, according to the WHO web site, "*Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly.*"

The WHO Assembly generally meets in May each year. In addition to appointing the Director-General every five years, the Assembly considers the financial policies of the Organization and reviews and approves the proposed programme budget. The Assembly elects 34 members, technically qualified in the field of health, to the Executive Board for three-year terms. The main functions of the Board are to carry out the decisions and policies of the Assembly, to advise it and to facilitate its work in general.

The WHO is financed by contributions from member states and from donors. In recent years, the WHO's work has involved more collaboration; there are currently around 80 such partnerships with NGOs and the pharmaceutical industry, as well as with foundations such as the Bill and Melinda Gates and the Rockefeller Foundation. Voluntary contributions to the WHO from national and local governments, foundations and NGOs, other UN organizations, and the private sector, now exceed that of assessed contributions (dues) from the 194 member nations.

Uncharacteristically for a UN Agency, the six Regional Offices of the WHO enjoy remarkable autonomy. Each Regional Office is headed by a Regional Director (RD), who is elected by the Regional Committee for a once-renewable five-year term. The name of the RD-elect is transmitted to the WHO Executive Board in Geneva, which proceeds to confirm the appointment. It is rare that an elected Regional Director is not confirmed.

Each Regional Committee of the WHO consists of all the Health Department heads, in all the governments of the countries that constitute the Region. Aside from electing the Regional Director, the Regional Committee is also in charge of setting the guidelines for the implementation, within the region, of the Health and other policies adopted by the World Health Assembly. The Regional Committee also serves as a progress review board for the actions of the WHO within the Region.

The Regional Director is effectively the head of the WHO for his or her Region. The RD manages and/or supervises a staff of health and other experts at the regional headquarters and in specialized centres. The RD is also the direct supervising authority — concomitantly with the WHO Director General — of all the heads of WHO country offices, known as WHO Representatives, within the region.

#### **The Regional Offices:**

Herein is the list of regional offices: Regional Office for Africa (AFRO), with headquarters in Brazzaville, Republic of Congo. AFRO includes most of Africa, with the exception of Egypt, Sudan, Tunisia, the Libyan Arab Jamahiriya, and Morocco which belong to EMRO. (Somalia is also not counted as it does not have an official government, though it is in the process of getting one); Regional Office for Europe (EURO), with headquarters in Copenhagen, Denmark; Regional Office for South East Asia (SEARO), with headquarters in New Delhi, India. (North Korea is served by SEARO); Regional Office for the Eastern Mediterranean (EMRO), with headquarters in Cairo, Egypt. EMRO includes the countries of Africa, and particularly in the Maghreb, that are not included in AFRO, as well as the countries of the Middle East; Regional Office for Western Pacific (WPRO), with headquarters in Manila, Philippines. WPRO covers all the Asian countries not served by SEARO and EMRO, and all the countries in Oceania. (South Korea is served by WPRO) and Regional Office for the Americas (AMRO), with headquarters in Washington, D.C., USA. It is better known as the Pan American Health Organization (PAHO). Which predates the establishment of WHO, PAHO is by far the most autonomous of the 6 regional offices.

#### **Country Offices**

The World Health Organization operates 147 country and liaison offices in all its regions. The presence of a country office is generally motivated by a need, stated by the member country. There will generally be one

WHO country office in the capital, occasionally accompanied by satellite-offices in the provinces or sub-regions of the country in question.

The country office is headed by a WHO Representative (WR), who is a trained physician, not a national of that country, who holds diplomatic rank and has due privileges and immunities similar to those of an Ambassador Extraordinary and Plenipotentiary. In most countries, the WR (like Representatives of other UN agencies) is de facto and/or de jure treated like an Ambassador - the distinction here being that instead of being an Ambassador of one sovereign country to another, the WR is a senior UN civil servant, who serves as the "Ambassador" of the WHO to the country to which he or she is accredited and hence, the title of Resident Representative, or simply Representative.

The country office consists of the WR, and several health and other experts, both foreign and local, as well as the necessary support staff. The main functions of WHO country offices include being the primary adviser of that country's government in matters of health and pharmaceutical policies.

International liaison offices serve largely the same purpose as country offices, but generally on a smaller scale. These are often found in countries that want WHO presence and cooperation, but do not have the major health system flaws that require the presence of a full-blown country office. Liaison offices are headed by a liaison officer, who is a national from that particular country, without diplomatic immunity.<sup>6</sup>

### **Staffing**

The World Health Organization is an agency of the United Nations and as such shares a core of common personnel policy with other agencies. The Organization has over 8500 personnel's with secretariat itself being served by around 7000 of them.<sup>7</sup>

Today, WHO is structured in eight divisions addressing communicable diseases, non-communicable diseases and mental health, family and community health, sustainable development and health environments, health technology and pharmaceuticals, and policy development. These divisions support the four pillars of WHO: worldwide guidance in health, worldwide development of improved standards of health, cooperation with governments in strengthening national health programs, and development of improved health technologies, information, and standards.

The organization focuses on four main areas, led by health intervention efforts, such as control and prevention of HIV/AIDS, malaria, and tuberculosis. Other WHO priorities include support for government health programs; development of health policies, products, and systems; and efforts related to determinants of health, such as food safety and nutrition.<sup>8</sup>

The WHO operates from six regional offices worldwide and national offices in about 150 countries as earlier discussed. Budget and policy oversight for the organization is provided by the World Health Assembly, which includes representatives of more than 190 countries. Defined by its constitution as the directing and coordinating authority on international health work, "WHO aims at the attainment by all peoples of the highest possible standard of health." Its mission is to improve people's lives, to reduce the burdens of disease and poverty, and to provide access to responsive health care for all people.<sup>9</sup>

In addition to its work in eradicating disease, the WHO also carries out various health-related campaigns — for example, to boost the consumption of fruits and vegetables worldwide and to discourage tobacco use.<sup>10</sup>

### **Responsibilities and Functions of World Health Organization**

WHO's responsibilities and functions include assisting governments in strengthening health services; establishing and maintaining administrative and technical services, such as epidemiological and statistical services; stimulating the eradication of diseases; improving nutrition, housing, sanitation, working conditions and other aspects of environmental hygiene; promoting cooperation among scientific and professional groups; proposing international conventions and agreements on health matters; conducting research; developing international standards for food, biological and pharmaceutical products; and developing an informed public opinion among all peoples on the matters of health.

WHO operations are carried out by three distinct components: the World Health Assembly, the Executive Board, and the Secretariat. The World Health Assembly is the supreme decision-making body, and it meets annually, with participation of Ministers of Health from its 194 member nations. In a real sense, the WHO is an international health cooperative that monitors the state of the world's health and takes steps to improve the health status of individual countries and of the world community.

The founding fathers of the UN's purposely set aside a network of specialized agencies with their own assemblies, intending that technical cooperation among member states would be free of the political considerations of the UN itself. It has not always worked out this way, however. WHO could not escape entirely the political fights that occurred in the specialized agencies, and the assembly's deliberations have often reflected the political currents of the time.

The decentralized structure of WHO has added a political dimension that has its pluses and minuses. Many of the resources are assigned to the regional centres, which better reflect regional interests. On the other hand, the regional directors, as elected officials, can act quite independently—and occasionally they do. This has given rise to the impression that there are several WHO's.

Moreover, because the regional directors are elected, they need to give consideration to the requirements of re-election. Since the regional directors choose country representatives in their regions, the dynamics of personnel interaction in WHO's administration is quite unique in the UN system. Regional control over country offices is strong, leaving the WHO country representatives with limited authority or leeway for program implementation.<sup>11</sup>

### **Constitution of the World Health Organization**

Constitution of WHO has XIX chapters and 82 articles, here in below i am presenting verbatim some of the most important chapters and articles.

#### **CHAPTER I – OBJECTIVE**

##### **Article 1**

The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health.

#### **CHAPTER II – FUNCTIONS**

##### **Article 2**

In order to achieve its objective, the functions of the Organization shall be:

- (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;
- (d) To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;
- (e) To provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;
- (f) To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
- (g) To stimulate and advance work to eradicate epidemic, endemic and other diseases;
- (h) To promote, co-operation with other specialized agencies where necessary;
  - (i) To promote, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;
  - (j) To promote co-operation among scientific and professional groups which contribute to the advancement of health;
  - (k) To propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;
  - (l) To promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;
  - (m) To foster activities in the field of mental health, especially those affecting the harmony of human relations;
  - (n) To promote and conduct research in the field of health;
  - (o) To promote improved standards of teaching and training in the health, medical and related professions;
  - (p) To study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;
  - (q) To provide information, counsel and assistance in the field of health;
  - (r) To assist in developing an informed public opinion among all people on matters of health;
  - (s) To establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices;
  - (t) To standardize diagnostic procedures as necessary;
  - (u) To develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;
  - (v) Take steps for the prevention of accidental injuries and

(w) Generally to take all necessary action to attain the objective of the Organization.

## **CHAPTER IV – ORGANS**

### **Article 9**

The work of the Organization shall be carried out by:

- (a) The World Health Assembly (herein called the Health Assembly);
- (b) The Executive Board (hereinafter called the Board) and
- (c) The Secretariat.

### **Article 18**

The functions of the Health Assembly shall be:

- (a) To determine the policies of the Organization;
- (b) To name the Members entitled to designate a person to serve on the Board;
- (c) To appoint the Director-General;
- (d) To review and approve reports and activities of the Board and of the Director-General and to instruct the Board in regard to matters upon which action, study, investigation or report may be considered desirable;
- (e) To establish such committees as may be considered necessary for the work of the Organization;
- (f) To supervise the financial policies of the Organization and to review and approve the budget;
- (g) To instruct the Board and the Director-General, to bring to the attention of Members and of International Organizations (governmental or non-governmental), any matter with regard to health which the Health Assembly may consider appropriate;
- (h) To invite any organization, international or national, governmental or non-governmental, which has responsibilities related to those of the Organization, to appoint representatives to participate, without right of vote, in its meetings or in those of the committees and conferences convened under its authority, on conditions prescribed by the Health Assembly; but in the case of national organizations, invitations shall be issued only with the consent of the Government concerned;
- (i) To consider recommendations bearing on health made by the General Assembly, the Economic and Social Council, the Security Council or Trusteeship Council of the United Nations, and to report to them on the steps taken by the Organization to give effect to such recommendations;
- (j) To report to the Economic and Social Council in accordance with any agreement between the Organization and the United Nations;
- (k) To promote and conduct research in the field of health by the personnel of the Organization, by the establishment of its own institutions or by co-operation with official or non-official institutions of any Member with the consent of its Government and
- (m) To take any other appropriate action to further the objective of health for all.

### **Article 21**

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, cause 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 and
- (e) Advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

### **Article 28**

The functions of the Executive Board shall be:

- (a) To give effect to the decisions and policies of the Health Assembly;
- (b) To act as the executive organ of the Health Assembly;
- (c) To perform any other functions entrusted to it by the Health Assembly;
- (d) To advise the Health Assembly on questions referred to it by that body and on matters assigned to the Organization by conventions, agreements and regulations;
- (e) To submit advice or proposals to the Health Assembly on its own initiative;
- (f) To prepare the agenda of meetings of the Health Assembly;

- (g) To submit to the Health Assembly for consideration and approval a general programme of work covering a specific period;
- (h) To study all questions within its competence and
- (i) 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, to participate in the organization of health relief to victims of a calamity and to undertake Studies and Research (the urgency of which has been drawn to the attention of the Board by any Member or by the Director General).

**Article 47**

Regional committees shall be composed of representatives of the Member States and Associate Members in the region concerned. Territories or groups of territories within the region, which are not responsible for the conduct of their international relations and which are not Associate Members, shall have the right to be represented and to participate in regional committees. The nature and extent of the rights and obligations of these territories or groups of territories in regional committees shall be determined by the Health Assembly in consultation with the Member or other authority having responsibility for the international relations of these territories and with the other Member States in the region.

**Article 50**

The functions of the regional committee shall be:

- (a) To formulate policies governing matters of an exclusively regional character;
- (b) To supervise the activities of the regional office;
- (c) To suggest to the regional office the calling of technical conferences and such additional work or investigation in health matters as in the opinion of the regional committee would promote the objective of the Organization within the region;
- (d) To co-operate with the respective regional committees of the United Nations, with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;
- (e) To tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;
- (f) To recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allotted to that region is insufficient for the carrying-out of the regional functions and
- (g) Such other functions as may be delegated to the regional committee by the Health Assembly, the Board or the Director-General.

**Article 58**

A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies.

**Article 59**

Each Member shall have one vote in the Health Assembly.

**Article 60**

- (a) Decisions of the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations, Inter-governmental organizations and Agencies in accordance with Articles 69, 70 and 72 and amendments to this Constitution;
- (b) Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the Members present and voting and
- (c) Voting on analogous matters in the Board and in committees of the Organization shall be made in accordance with paragraphs (a) and (b) of this Article.

**CHAPTER XVI – RELATIONS WITH OTHER ORGANIZATIONS**

**Article 69**

The Organization shall be brought into relation with the United Nations as one of the specialized agencies referred to in Article 57 of the Charter of the United Nations. The agreement or agreements bringing the Organization into relation with the United Nations shall be subject to approval by a two-thirds vote of the Health Assembly.

#### **Article 70**

The Organization shall establish effective relations and co-operate closely with such other inter-governmental organizations as may be desirable.

#### **Article 76**

Upon authorization by the General Assembly of the United Nations or upon authorization in accordance with any agreement between the Organization and the United Nations, the Organization may request the International Court of Justice for an advisory opinion on any legal question arising within the competence of the Organization.<sup>12</sup>

#### **Health for All and Primary Health Care**

Widespread dissatisfaction with health services in the late 1960's and early 1970's led to an effort to find an alternative approach to standard health care, and eventually the joint WHO/UNICEF conference was held in Alma-Ata in 1979.

The goal of Health for All (HFA), adopted by member states at the 1977 World Health Assembly, called for the attainment by all people of the world of a level of health that will permit them to lead a socially and economically productive life. In 1978, WHO and UNICEF co-sponsored the historic International Conference on Primary Health Care (PHC) in Alma-Ata, at which the international development community adopted PHC as the key to attaining the goal of "Health for All" by the year 2000.

PHC, as defined at the Alma-Ata conference, called for a revolutionary redefinition of health care. Instead of the traditional "from-the-top-down" approach to medical service, it embraced the principles of social justice, equity, self-reliance, appropriate technology, decentralization, community involvement, inter-sectorial collaboration, and affordable cost. The Alma-Ata Declaration on PHC envisaged a minimum package of eight elements: (1) education concerning prevailing health problems and the methods of preventing and controlling them; (2) promotion of food supply and proper nutrition; (3) an adequate supply of safe water and basic sanitation; (4) maternal and child health, including family planning; (5) immunization against the major infectious diseases; (6) prevention and control of locally endemic diseases; (7) appropriate treatment of common diseases and injuries; and (8) provision of essential drugs. Where appropriate, the employment of lay health workers from the community should be trained to tackle specific tasks, including education, and to provide first-level care, with appropriate referrals to secondary and tertiary health facilities.

Though few, if any, countries have successfully followed all the precepts of PHC as enunciated at Alma-Ata, PHC has since provided the philosophical linchpin for virtually all subsequent international health activities. In the 1960's and early 1970's, community health workers and traditional birth attendants were grudgingly accepted by many, though only as second-class health care providers, and they were scorned by others, especially by some traditionally trained allopathic medical practitioners. With Alma-Ata, however, plus the exemplary success of the work of "barefoot doctors" in China, PHC precepts and programs became respectable.

#### **Global Strategy for Health for All**

In 1979 the World Health Assembly adopted the Global Strategy for HFA, which was subsequently endorsed by the UN General Assembly. The UN resolution was the health community's attempt to mobilize the world community at large to take collaborative actions to improve the status of the world's health. The main thrust of the strategy was the development of a health-system infrastructure, starting with PHC, for the delivery of countrywide programs that would reach the entire population. The strategy called for the application of the principles of the Alma-Ata Declaration and the development of the minimum package of the eight PHC elements.

HFA was conceived as a process leading to progressive improvement in the health of people and not as a single finite target, though some indicators were recommended. It aims at social justice, with health resources evenly distributed and essential health service accessible to everyone, with full community involvement.

While all the member states voted to adopt HFA via PHC, implementation lagged far behind, as economic crises loomed and political and military conflicts flared. Natural disasters also intervened. The rapid rise of the urban poor and weaknesses in the organization and management of health services resulted in wastage and misuse of meagre resources. Above all, poverty, its deep-rooted causes unresolved, undermined various efforts in the slow march towards HFA.

#### **Child Survival and Development Revolution, Bamako Initiative and Acute Respiratory Infections**

In the early 1980's, UNICEF launched its Child Survival and Development Revolution (CSDR) with four inexpensive interventions: growth monitoring, oral re-hydration, breastfeeding, and immunization programs

(commonly referred to as GOBI). After some initial reservation, and with assurances that GOBI efforts would be within the context of PHC, WHO became an active player in CSDR, which has made impressive inroads in reducing infant deaths, especially through the immunization campaign and the oral re-hydration program for the control of diarrhoea, which also benefited from water and sanitation programs.

WHO also joined UNICEF in launching the Bamako Initiative in the 1980's, which aimed at the provision of essential drugs and their rational use in the context of PHC, initially in African countries but later expanded to other regions. The initiative introduced the element of cost recovery as well as community management of drug supplies and sales. Indeed, in spite of the retrogressive economic situation in Africa south of the Sahara in the 1980's, infant mortality and life expectancy continued to improve gradually in Africa. These gains, however, have since been brutally reversed by the spread of HIV/AIDS.

The 1980's also saw WHO initiating a broad-scale attack against acute respiratory infections (ARI), a major cause of child mortality, and implementing the Safe Motherhood program, designed to reduce maternal deaths—which stood at 500,000 avoidable deaths, almost all in the developing countries. In these efforts, WHO was joined by UNICEF and the World Bank, which had begun to turn some of its attention to the social aspects of development. In the late 1990's, the Integrated Management of Childhood Illness program was launched to bring together a number of programs for a more rational approach.

Though there was progress, the PHC implementation was found to be limited to a number of countries and some specific areas. The principles of PHC, however, were found to be the only viable option even in the most difficult circumstances, with some adjustment of the approaches and strategies necessary in country-specific situations. The effort to introduce district-level PHC did succeed in bringing the services closer to the people who needed them.

### **The HIV/AIDS Pandemic**

Although HIV/AIDS first raised its ugly head in the public eye in North America, it soon became clear that the AIDS epidemic was to become a pandemic. Under pressure from WHO, a number of governments, various development agencies, and the pharmaceutical industry has agreed to allow the price of AIDS treatment drugs to drop from around \$15,000 a year per patient in the industrialized countries to \$350 in the developing countries. This will encourage more people to come forward for screening in some countries, and in other countries, with help from international organizations, programs of treatment are now a possibility. However, the principal way to fight AIDS is still prevention through education and behavioural change, as work towards an effective vaccine is making very slow progress. While no part of the world is free of the AIDS threat, AIDS spread fast and wide in Africa, especially in countries south of the Sahara. In Asia, where the population pools are much greater, the number of HIV/AIDS cases is expected to exceed that of Africa.

In fighting AIDS, development agencies of the UN system have joined together to form UNAIDS, in which WHO plays the lead technical role. The pandemic is now such a serious threat to entire societies that it has been brought to the UN Security Council as a matter of grave security concern.

### **Year 2000 Goals**

In 1990, WHO joined with UNICEF in urging the UN Summit for Children to set Year 2000 goals. These goals included increased immunization rates; reduction of infant (under five) and maternal mortality rates; water and sanitation, as well as education for all; the reduction of malnutrition; and the elimination of micronutrient disorders.

After the end of the Cold War, the hope for a "*peace dividend*" from disarmament did not materialize. On the contrary, with a few exceptions, since that time the volume of development funds from the industrialized countries has shrunk. The 2001 session of the UN General Assembly was disappointing in its review of the summit goals. There is still hope, however, for the elimination of polio and guinea worms, as well as the virtual elimination of iodine deficiency disorders.

### **Year 2020 Goals**

The World Health Assembly has adopted the following set of new goals to be reached by, or before, 2020:  
By 2005, health equity indices will be used within and between countries as a basis for promoting and monitoring equity in health;  
By 2005, member states will have operational mechanisms for developing, implementing, and monitoring policies that are consistent with the HFA policy;  
By 2010, appropriate global and national health information, surveillance, and alert systems will be operational; research policies and institutional mechanisms will be operational at global, regional, and country levels; and all people will have access throughout their lives to comprehensive, essential, quality health care, supported by essential public health functions;

By 2010, transmission of Chagas disease will be interrupted, and leprosy will be eliminated;

By 2020, maternal mortality rates will be halved; the worldwide burden of disease will be substantially decreased by reversing the current trends of incidence and disability caused by tuberculosis, malaria, HIV/AIDS, tobacco-related diseases, and violence; measles will be eradicated; and lymphatic filariasis eliminated and

By 2020, all countries will have made major progress in making available safe drinking water, adequate sanitation, food and shelter in sufficient quantity and quality; all countries will have introduced and be actively managing and monitoring strategies that strengthen health-enhancing lifestyles and weaken health-damaging ones, through a combination of regulatory, economic, educational, organization and community-based programs.

WHO has also launched a series of initiatives, including programs to roll back malaria, stop the spread of tuberculosis, fight the AIDS pandemic, and curtail tobacco use. A breakthrough in the drastic reduction of the cost of AIDS treatment drugs is likely to impact the AIDS fight. Negotiation for a tobacco-control convention may lead to greater success for WHO's Tobacco-Free Initiative. With additional resources from private foundations, WHO, in partnership with the World Bank and UNICEF, has launched an ambitious Global Alliance for Vaccines and Immunization (GAVI). Malnutrition, which accounts for nearly half of the 10.5 million deaths each year among pre-school children, will continue to be a priority item in the years to come.

WHO has also undergone a number of reorganizations, the latest resulting in nine clusters, each covering a number of programs and in addition to the two clusters on management and governing bodies, the other program clusters are: communicable diseases, non-communicable diseases, sustainable development and health environment, family and community health, evidence and information for policy, health technology and pharmaceuticals, and social change and mental health.

### **Health Promotion and Other Activities**

In 1982 WHO undertook a reorientation of health education, designed to expand its community approach and include communication theories and practice. In 1987 the term "*health education*" was changed to "*health promotion*" to denote a broader, ecological approach to the work of facilitating "*informed choices*" by people on health matters.

The first international consultation on this subject was held in Ottawa in 1986, followed by consultations in Adelaide in 1988, Sundsvall in 1991, and Jakarta in 1997. WHO's new approach calls for broader societal involvement, and in the eastern Mediterranean region, member nations adopted social mobilization as the strategy for health promotion. Individual programs, such as the tuberculosis and micronutrient elimination programs, adopted similar stances.

Every year, World Health Day is observed on April 7<sup>th</sup>, the day, in 1948, when WHO came into being (as per the directive of the First World Health Assembly). Each World Health Day is devoted to a particular theme that highlights a priority area of concern for WHO, and materials is made available for member states to commemorate the day with a program focus. World Health Day is a worldwide opportunity to focus on key public health issues that affect the international community and launches longer-term advocacy programmes that continue well beyond April 7<sup>th</sup>.

Noteworthy, but less publicized, activities of WHO include its worldwide efforts in mental health, oral health, food safety (including the FAO/WHO Codex Alimentarius Commission), health in the work place, elder care, chemical safety, veterinary health, cancer, cardiovascular diseases, health and the environment. Its essential drug program has had a major impact on the rational use of medicines in developing countries.

WHO maintains a network of collaborating centres, which engage in work in various specific fields. It also maintains a working relationship with a large number of non-governmental organizations involved in health and development. These organizations are accredited and approved by the World Health Assembly.<sup>13</sup>

### **Programs**

The main programs associated with WHO are:

- The Yellow Card or *Carte Jaune* which is an international certificate of vaccination (ICV). It is issued by the World Health Organisation. It is recognised internationally and may be required for entry to certain countries where there are increased health risks for travellers. The Yellow Card should be kept in the holder's passport as it is a medical passport of sorts and<sup>14</sup>
- Global Initiative for Emergency and Essential Surgical Care.<sup>15</sup>

### **Publishing**

WHO publishes a number of technical journals, the most important of which is the WHO Bulletin, and it also maintains a media and public relations unit. International Classification of Diseases (ICD) is a widely followed publication. The annual World Health Report, first published in 1995, is the WHO's leading

publication. Each year the report combines an expert assessment of global health, including statistics relating to all countries, with a focus on a specific subject. The World Health Report 2007 - A Safer Future: Global Public Health Security in the 21st century was published on August 23, 2006.<sup>16</sup>

According to the WHO Programme on Health Statistics: The production and dissemination of health statistics for health action at country, regional and global levels is a core WHO activity mandated to it by its Member States in its Constitution; WHO produced figures carry great weight in national and international resource allocation, policy making and programming, based on its reputation as "*unbiased*" (impartial and fair), global (not belonging to any camp), and technically competent organization (consulting leading research- policy institutions and individuals).<sup>17</sup>

### **Aims**

**The major specific aims of the WHO are as follows:**

- (1) To strengthen the health services of member nations, improving the teaching standards in medicine and allied professions, and advising and helping generally in the field of health;
- (2) To promote better standards for nutrition, housing, recreation, sanitation, economic and working conditions;
- (3) To improve maternal-child health and welfare;
- (4) To advance progress in the field of mental health and
- (5) To encourage and conduct research on problems of public health.

In carrying out these aims and objectives the WHO functions as a directing and coordinating authority on international health. It serves as a centre for all types of global and health information, promotes uniform quarantine standards and international sanitary regulations, provides advisory services through public health experts in control of disease and sets up international standards for the manufacture of all important drugs. Through its teams of physicians, nurses and other health personnel it provides modern medical skills and knowledge to communities throughout the world.<sup>18</sup>

### **The WHO Health Systems Framework**

The six building blocks of a health system, aims and desirable attributes are:

- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources;
- A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given the available resources and circumstances. i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive;
- A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status;
- A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use;
- A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them and
- Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

### **Human Resources for Health**

Health workers are indispensable- the cornerstone of health care delivery system, influencing access, quality and costs of health care and effective delivery of interventions for improved health outcomes, including progress towards the achievement of the Millennium Development Goals like '*Health for All*'.

### **Workforce Challenges and How They Can Be Met**

1. Health worker shortages;
2. Imbalances in skill-mix and distribution;
3. Low salaries and poor incentives;
4. Attritions, including urban and external migration;
5. Vital strategic measures to overcome workforce challenges;
6. Country/context specific strategic actions;
7. Effective partnerships and resource investments and
8. Strong political commitment and leadership.<sup>19</sup>

Key areas of WHO support to Member States is in building and sustaining adequate, competent, productive and supported health workforce to meet population health needs which include, but are not limited to: generate evidence, technical tools /guides for policy and strategy development, planning and management; education and training of health workers (both quantity and quality); improve standards of practice and ethics; enhance workforce performance and retention; advocacy, effective partnerships and networking.<sup>20</sup>

### **The Beijing Declaration**

The current and emerging climate change-related health risks in Asia and the Pacific include heat stress, water and food-borne diseases (e.g. cholera and other diarrhoeal diseases) associated with extreme weather events (e.g. heat waves, storms, floods, droughts and glacial lake outburst floods), vector-borne disease (e.g. dengue and malaria), respiratory diseases due to air pollution, aero-allergens, water and food security, and psycho-social concerns from displacement.

There is still limited political commitment to the health, meteorology, and environment sectors to mitigate and adapt to climate change at national and international levels in the region. There is also insufficient awareness among the general public about climate change and its health impacts. The availability of weather, climate, water-air quality, socio-economic and health data is limited, and available data are often not well integrated. Furthermore, there is insufficient capacity for assessment, research, and communication on climate sensitive health risks in many countries.

### **Pandemic Preparedness**

An influenza pandemic occurs when a new influenza virus capable of causing severe disease transmits easily among humans. Since there is no immunity to a newly emerging virus in the human population, it can cause a pandemic – an epidemic on a global scale. With the continuing spread of the avian influenza (H5N1) virus in poultry and wild birds, swine flu(H1N1) as well as the myriad number of human infections, there is a growing risk of an influenza pandemic in humans.

While it is impossible to predict with accuracy when a pandemic might occur or its exact impact, the potential for widespread human infection – accompanied by severe illness and death – cannot be dismissed. An avian influenza pandemic also would cause catastrophic social and economic disruption. In fact, a pandemic is more than a health crisis; it is a challenge that must be met by all sectors of society.

Preparation can mitigate the direct health, social and economic impacts of a pandemic. WHO recommends that each country and area have in place a pandemic preparedness plan. The planning process should involve a broad spectrum of government ministries and agencies, as well as civil society. WHO has the responsibility to assist its Member States in developing their preparedness plans.

WHO has drafted conventions for preventing the international spread of disease, such as sanitary and quarantine requirements. WHO is also authorized to issue global health alerts and take other measures to prevent the international spread of health threats.

The organization contributes to international public health in areas including disease prevention and control, promotion of good health, addressing disease outbreaks, initiatives to eliminate diseases (e.g., vaccination programs), and development of treatment and prevention standards.

In 2003, WHO began to coordinate global efforts to monitor the outbreak of the virus responsible for Severe Acute Respiratory Syndrome (SARS). WHO officials also directed aspects of research efforts to identify the specific virus responsible. In addition, WHO officials issued specific recommendations with regard to isolation and quarantine policy and issued alerts for travellers.<sup>21</sup>

### **What are Millennium Development Goals?**

Here a small note on The Millennium Development Goals (MDGs) would be pertinent which provides a clear agenda to improve the lives of the world's poor. First laid out in the UN Millennium Declaration, they were approved by 189 governments in September 2000, in one of the biggest gatherings of world leaders. The eight goals provide a roadmap for development, setting out targets to be achieved by 2015, with 1990 as a baseline. Although ambitious, the MDGs are mutually reinforcing. Seven goals address issues needing urgent attention in developing countries—poverty, hunger, primary education, gender equality, child and maternal mortality, HIV/AIDS, malaria, tuberculosis, sanitation, water supply and the environment. Health is a top priority. Three goals relate directly to health. Three others also relate indirectly to health. One other goal recognises the role of developed nations and addresses aid, debt relief, technology transfer and global partnerships.

While the MDGs provide a more complete vision of development than previous agendas for growth, they do not cover all health and development issues comprehensively. They make no mention of effective health systems or non-communicable diseases. However, many countries will inevitably have to address weak, inefficient or inequitable health systems if they are to meet the goals which are not met as off now and have been rechristened as Sustainable Development Goals. The best strength of the goals is that they concentrate on

the essentials to improve human development, set out a plan to reduce poverty and offer a yardstick for development, with measurable targets and indicators to track progress.<sup>22</sup>

### **Revision of International Health Regulations**

Revision of the International Health Regulations decides that, for the purpose of paragraph 1 of Article 14 of the revised International Health Regulations, the other competent inter-governmental organizations or international bodies with which WHO is expected to cooperate and coordinate its activities, as appropriate, include the following: United Nations, International Labour Organization, Food and Agricultural Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, World Trade Organization, Office International des Epizooties, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, and International Shipping Federation(See document A58/4); Member States urge:

- (1) To implement fully the revised International Health Regulations so as to ensure as far as possible the establishment of a uniform international legal regime for the prevention of, protection against, and control of the international spread of disease;
- (2) To build, strengthen and maintain the capacities required under the revised International Health Regulations, and to mobilize the resources necessary for that purpose;
- (3) Actively to collaborate with each other and the Secretariat in accordance with the relevant provisions of the revised International Health Regulations, so as to ensure their effective implementation;
- (4) To provide support to developing countries and countries with economies in transition if they so request in the building, strengthening and maintenance of the public health capacities required under the revised International Health Regulations;
- (5) To take all appropriate measures, pending entry into force of the revised International Health Regulations, for furthering their purpose and eventual implementation, including development of the necessary public health capacities and legal and administrative provisions;
- (6) To take all appropriate actions to facilitate the universal application of the revised International Health Regulations;
- (7) To ensure that the revised International Health Regulations are implemented in an effective and comprehensive manner and
- (8) To initiate, pending entry into force of the revised International Health Regulations, the process for introducing use of the decision instrument contained therein for the assessment and notification of events that may constitute a public health emergency of international concern.<sup>23</sup>

### **Accomplishments and Challenges**

The second half of the twentieth century saw remarkable gains in global health, spurred by rapid economic growth and unprecedented scientific advances. WHO has played a very pivotal role in setting health policies, as well as providing technical cooperation to its member states. Life expectancy rose from 48 years in 1955 to 69 years in 1985. During the same period, the infant mortality rate fell from 148 per 1000 live births to below 59 per 1000. Population growth has been slowed dramatically in many of the most populous countries. Smallpox, the ancient scourge, has disappeared. Other successes include the control of lice-borne typhus and yaws. Polio and guinea worms are on the verge of total elimination. A number of other communicable and tropical diseases are in retreat. With universal salt iodization in place, the prospect of virtually eliminating iodine deficiency disorders (IDD), the major cause for brain damage among young children, is also in sight.

Absolute poverty is still spreading in many parts of the world, however. Disparities in health and wealth are growing between and within countries. More than one billion people are without the benefits of modern medical science. One out of five persons in the world has no access to safe drinking water. Infectious diseases alone account for 13 million deaths a year, most of them in the developing countries. Seventy per cent of the poor are women and the chance of an expectant mother in the world's poorest country dying of childbirth are 500 times greater than her counterpart in the richest country.

Excessive consumption and pollution practices have produced profound climatic changes that impact on the environment and the health of human beings. Globalization of trade and marketing has led to a sharp increase in the use of tobacco, alcohol, and high fat foods, along with unhealthy lifestyles.

The strategic importance of the WHO as the UN's specialist health agency, its many influential programmes and policies at global, regional and national and community levels, and perhaps above all, its humanitarian mission, earn it worldwide authority and guarantee it a central place. While it may be seen as the leading global health organization, it does not have the greatest impact on health. As many trans-national corporations and other global institutions particularly the World Bank and International Monetary Fund have a growing influence on population health that outweighs WHO's. Furthermore, some of these institutions, the Bank in particular, now operate in direct competition with WHO as the leading influence on health sector

policy. The rise of neo-liberal economics and the accompanying attacks on multilateralism led by the US have created a new, difficult context for WHO's work to which the organization, starved of resources and sometimes poorly led and managed, is failing to find an effective response.

WHO's objective is the attainment by all peoples of the highest possible level of health, defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Its constitution also asserts that health is a fundamental human right and that governments are responsible for the health of their peoples, bold statements treated warily by governments who equated social equity and socialized medicine with '*the Communist threat*'. Thus politics and health were inseparable even at WHO's birth. The importance of health to the global political agenda of the day was reflected in the decision to give WHO its own funding system and a governing body of all member states that is still unique among UN specialist agencies. Its basic composition and overall organizational structure have changed little since 1948. Like other UN non-subsidiary specialist agencies its governing body makes its own decisions, but reports annually to the UN. All UN member states and others may join it.<sup>24</sup>

### Current Context: Recent Successes

Even the harshest critics admit that WHO can claim many important achievements since 1948. In disease prevention and control WHO led the global eradication of smallpox. It is making good progress towards eradication of poliomyelitis, leprosy etc. and on-going efforts to tackle malaria, cholera, tuberculosis and HIV/AIDS (albeit inadequately funded and unlikely to reach the desired targets). Its leadership role in collecting, analysing and disseminating health evidence is unrivalled. It is the leading global authority preparing guidelines and standards on numerous issues, and the foremost source of scientific and technical knowledge in health.

In many countries it remains the best trusted source of objective, evidence-based, ethically sound guidance and support on health. During Lee's appointment as DG it regained some of its reputation as the world's health conscience, and facilitation of an effective global response to the severe acute respiratory syndrome (SARS) outbreak has underlined its critical public health holding to account. '*It is for all (this) work that the world recognises the need for WHO as a cornerstone of international relations*'. Many formal and informal evaluations and commentaries on WHO mention its traditional strengths (for example *Godlee 1997, Lee 1998, Lerer and Matzopoulos 2001, Wibulpolprasert and Tangcharoensathien 2001, Buse and Walt 2002, DFID 2002, Minelli 2003, Selbervik and Jerve 2003, Kickbusch 2004, Murray et al. 2004*).

These include:

- Advocacy for marginalized population groups such as the poor, people with AIDS and people with mental illness;
- Performing important global communicable disease surveillance and control functions, as with SARS;
- Production of authoritative guidelines and standards that support excellent practice;
- Global, regional and national health reports and cross-country studies providing evidence base for policy, practice and advocacy;
- Technical expertise and international health experience of an excellent staff are unsurpassed;
- Provision of effective technical support in some countries, within tight resource constraints;
- Promotion of agendas that are value-based, knowledge-based and support health, rather than ideologically driven or politically motivated;
- Innovative inter-sectorial programmes such as Healthy Cities. There is also praise for recent work, some of which builds on these traditional strengths, and some of which is taking WHO into new areas of work;
- Returning health to the international development agenda;
- Good practical and analytical work on key areas such as violence, health and complex emergencies;
- The gradual renaissance of primary health care and health promotion, including challenges to commercial interests that damage health;
- Inter-agency alliances such as the Partnership for Safe Motherhood and New-born Health;
- Active support for a greater investment in relevant and applied health systems research;
- Emerging innovative approaches to knowledge management using new technology;
- More active and transparent engagement in WHO reform processes with some influential member states, such as the Multilateral Organizations Performance Assessment Network of eight leading donor countries;
- Stronger internal focus on performance management and results;
- Better training of WHO staff, for example on human rights and
- Effective advocacy for global tobacco control and access to medicines. A controversial review of its partnership with WHO by the UK Department for International Development pronounced it '*an improving organization*' (DFID 2002), while others note how WHO has begun to '*refashion and reposition itself as the coordinator, strategic planner, and leader of "global health" initiatives*'. Much of this praise, however, has a ritual air, run through rapidly as an appetiser to the main dish.

### Current Context: Major Criticisms

In the often contradictory accusations and criticisms of WHO reflect the existence of a wide range of critics, with different agendas. A number of criticisms emanate from interests that want to weaken WHO's mandate and capacity to tackle urgent global health problems, especially poverty, or to challenge the hazard merchants (commercial enterprises profiting from products that damage health). Other criticisms reflect frustration over WHO's lack of political will and strength to tackle the drivers of poverty and health inequity, and its inefficiencies. Of the latter group, the following points represent a selection of the more common criticisms:

- WHO's 'vertical', single-focus disease control programmes, reflecting the continued domination of bio-medical thinking, are said to lack impact or sustainability and to hinder systemic, inter-sectorial approaches;
- The balance between normative, global standard-setting activities and technical cooperation with countries is said to be wrong;
- Its priorities are constantly skewed by intense political pressure from member states;
- Its multiple and sometimes conflicting roles as advocate, technical adviser, monitor and evaluator limits its ability to discharge functions such as independent global reporting;
- It has not built effective partnerships with civil society;
- Its relations with other major international agencies, such as the Global Fund for AIDS, TB and Malaria, are dogged by turf wars;
- It is said to be compromising on values and moral principles by entering into public-private partnerships with business interests whose activities it should be condemning rather than courting;
- Its leadership is accused of being ineffective and is beset by rumours of corruption and nepotism. Holding to account is almost non-existent;
- Its management is top-heavy, hierarchical, overpaid and centralized, ruling autocratically over an entrenched, bureaucratic sub-culture and
- Its staff is dominated by professionals from developed countries with insufficient experience of conditions in poor countries.

These criticisms and others appear in hundreds of books, articles and speeches and their range and scope is enormous. They may appear unbalanced simply because of the tendency to focus on bad news rather than good news. Some are diametrically opposed. Some reveal a tendency to use WHO as a scapegoat and a desire for quick-fix solutions. Strong critiques come from member States, often off the record, who then vote differently in WHO fora, act in ways that undermine or manipulate the organization, and fail to support the progressives within. The criticisms made by WHO staff and consultants are usually at least as tough as those of external academic observers, but also more rounded as their experience perhaps makes them more aware of the positives. The problems laid at WHO's door are not just many, but are often way beyond its control. It is tempting to underestimate the complexity of the challenges, or to view the problem as the failures of an individual organization rather than a collective global one. Moreover, similar criticisms are being levelled at other international agencies in the prevailing mood of widespread discontent with the UN system and weak international governance.

A recent survey commissioned by leading donor countries found the performance of WHO, UNICEF and the World Bank perceived to be broadly similar by its informants (*Selbervik and Jerve 2003*). Finally, and perhaps crucially, the critiques are long on description and accusation, and short on practical solutions. There is little consensus about what needs to be done beyond indisputable statements about tackling poverty and inequality and the most powerful group of commentaries call for stronger global health governance. According to *Buse and Walt (2002)*, globalization requires novel arrangements for health governance in which partners work together – international organizations; nation states; and global and local private, for-profit and civil society organizations. They ask how the present patchwork of alliances and partnerships in health can move towards a system of good global governance without losing their energy and creativity. *Kickbusch (2004)* says this means strengthening WHO and giving it a new and stronger mandate, including ensuring 'transparency and accountability in global health governance through a new kind of reporting system that is requested of all international health actors', even taking countries to an international court for crimes against humanity if they refuse to take action based on the best public health evidence and knowledge.

### Civil Society:

One way of circumventing inappropriate pressure from member states and other global institutions is to promote transparency and greater accountability to civil society. However, civil society's role in WHO is quite restricted. Around 200 civil society organizations are in 'formal' relations, meaning they can participate in WHO meetings, including those of the governing bodies (the Assembly and the Executive Board) where they have a right to make a statement although not a vote. Another 500 organizations have no formal rights but

'informal' relationships with WHO, mostly through contacts made on work programmes. Both private for-profit and private non-profit NGOs are included in the WHO definition of civil society, raising controversy about conflicts of interest and highlighting the need for policy-makers to distinguish between public-benefit and private-benefit organizations. Perhaps mindful of her battles with member States during the row over the 2000 World Health Report, the higher profile of CSO's in securing access holding to account WHO and the People's Health Movement the idea of a People's Health Assembly emerged in the early 1990s when it was realized that WHO's World Health Assembly was unable to hear the people's voices. A new forum was required. The first People's Health Assembly in Bangladesh in 2000 attracted 1500 – health professionals and activists from 75 countries. A common concern was the side-lining by governments and international agencies of the goals of 'Health for All'. The dialogue led to a consensus on People's Charter for Health, the manifesto of a nascent People's Health Movement, which is now a growing coalition of people's organizations, civil society organizations, NGOs, social activists, health professionals, academics and researchers. Its goal is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities.

The assembly agreed that the institutional mechanisms needed to implement comprehensive primary health care had been neglected. The dominant technical approach – medically driven, vertical and top-down was reflected in the organizational structure of many ministries of health and of WHO itself and since then, the links between the Movement and WHO have grown stronger, boosted by the interest of then incoming Director-General Dr Lee. 'Grassroots movements are enormously important, especially in the health field,' Dr Lee told PHM representatives at a meeting in 2003 he also said "These movements bring the views, feelings, and expressions of those who really know. It seems almost hypocritical for WHO people here in Geneva to be talking about poverty, as we pay \$2 for a cup of coffee, while millions struggle to survive and sustain their families on \$1 a day. For this very reason, we urgently need your input. We need to hear the voices of the communities you represent. It is vital for WHO to listen to you and your communities."

Since 2000, PHM has called for a radical transformation of WHO so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures inter-sectorial work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests. It has made a wide-ranging series of recommendations to WHO, summarized in the Charter and available at <[www.phmovement.org](http://www.phmovement.org)>.

#### **Relations with other International Agencies:**

The diminished power of WHO in relation to the World Bank has been noted elsewhere in this text. The controversial nature of the Bank's policy advice to developing countries has barely been challenged in public by WHO, and for a period in the 1990's they often sang from the same hymn sheet. At other times WHO has been forced to take a weakened position: for example, its guide to the health implications of multilateral trade agreements was watered down under pressure from the World Trade Organization (*Jawara and Kwa 2003*). At country level WHO officials often find themselves in competition with the Bank: while the World Bank has a mandate that also includes influencing and interacting with the more powerful trade and financial ministries, WHO's mandate tends to be restricted to the health sector.

There have recently been signs of a change, with WHO making statements about restrictions on health spending imposed by the Bank and the International Monetary Fund. However, it is woefully lacking in social policy specialists, economists, and trade and intellectual property lawyers who could help create an alternative agenda. The headquarters department of health and development which should be responsible for these efforts has been reorganized twice in three years. Yet WHO understanding of health and health systems must be rooted in a strong analytical framework in which social, economic, cultural and political determinants are taken into account. The present techno-managerial analysis, predominantly bio-medical rather than social, is inadequate and leads to weak or skewed solutions. In also some ways woefully inadequate resources, poor management and leadership practices, and the power games of international politics are just some of the forces holding and hindering sustainable change in WHO. The obstacles to change are powerful and in many ways are similar to the difficulties of achieving lasting change in the international order or in successfully reforming health care systems. Dialogue with key actors can clarify and re-energize WHO's specific contribution to global health improvement and governance. Ways must be found to overcome the barriers of competitive rivalry that are destabilizing efforts to tackle the world's health problems. There is more than enough for everyone to do without wasting time and resources in turf wars. Links with civil society must be strengthened so that the top table, around which the rich and powerful gather becomes an open, democratic, global decision-making forum where all can meet, speak their minds, listen and be heard. That will move us closer to WHO's noble objective, as set out in its constitution – *'the attainment by all peoples of the highest possible level of health'*.

#### **Budget**

It is often mistakenly assumed that WHO is a donor agency. When hoping to start a new training programme for nurses, say, or an advocacy campaign on de-stigmatizing mental illness, people often say, 'Let's ask WHO for money.' In fact, in order to function, WHO itself has to take its begging bowl to countries, other agencies and charitable foundations and is increasingly turning to public-private partnerships (Buse and Walt 2002). The rich countries prefer to exert greater control over their money by giving WHO extra-budgetary funds earmarked for specific projects, rather than more core funding. Competition for such money is cut-throat and requires excellent internal coordination, as well as intensive input from professionals whose sole function is fundraising. Both are lacking in WHO with so much time and effort wasted. Programmes compete against each other for funds, internally and externally, while staff hired for their technical knowledge reluctantly finds themselves fundraising. Thus the donors help to sustain an incentive system by which WHO must compete with itself, and with other organizations, for scarce funds, resulting in inefficiency and waste of human resources.

The most important negative consequence, however, is that health priorities are distorted and even neglected to conform with the desires of donors and the requirement to demonstrate quick results to them and their political paymasters. WHO has felt obliged to side-line the primary health care approach and is in favour of so-called 'vertical' programmes that focus on controlling specific diseases to specific targets – 'a case of the tail wagging the dog so vigorously as to make it almost dysfunctional and disoriented' (Banerji 2004). This epidemic of donor-driven programmes is not cost-effective, not sustainable, and may damage health system infrastructures. WHO cannot fairly be blamed for it, since it is so often undermined by big global health initiatives, the focus of major donors on NGOs, and the policies of government donors and huge foundations like Gates; but it does stand accused of not fighting hard enough against the trend.

Other problems arise from the trend towards public-private partnerships: first, the way in which WHO's ability to safeguard the public interest is potentially compromised by greater interaction with the commercial sector. Programmes jointly funded and implemented by a consortium of public and private partners may, if care is not taken, inappropriately benefit the private partners rather than the target populations. Yet safeguards against conflicts of interest are underdeveloped in WHO. Second, there has been little consideration of whether it would be better to find alternatives to partnerships with business, given the fragmentation caused by adding further institutional partners to the international health aid mix (Richter 2004).

Most WHO programmes and departments have to spend their budget allocation on salaries and overheads rather than programme activities. This has far-reaching negative implications in the absence of adequate programme funding, or good coordination between or even within departments, or properly resourced central functions (for example, translation, interpretation and publishing). In one important and fairly typical HQ department, the biennial cost of employing over 30 staff runs into several millions of dollars while the regular programme budget is only US\$ 500,000, supplemented by very few extra-budgetary funds and thus staffs runs essentially separate programmes that are scarcely funded from the regular budget, and in some cases barely funded at all.

All this has a strong impact on the organizational climate and staff development. While some motivated staff move elsewhere, many of those who remain for many years, often described as 'dead wood', have few other attractive options. Too many are stuck in a honey trap – they cannot afford to leave as similar employment back home may not pay so well, especially in developing countries. WHO staff members in professional grades in headquarters and regional offices have tax-free salaries, an excellent pension scheme and many other benefits, although they often also pay for two residences, one at home and one in their duty station, and other expenses such as school fees for the kids.

The hundreds of staff who work for long periods in WHO offices on a series of rolling short-term contracts are by contrast poorly paid and have few benefits. This saves the organization money and gives it greater power to hire and fire, but it damages the security and often productiveness of the individual worker, while undermining the effectiveness and sustainability of many programmes.

Many member states, particularly developing countries, would like WHO to play a stronger stewardship role in bringing together and helping coordinate the role of international and bilateral agencies, international NGOs and World Health Organization to develop a unified, purposeful health strategy and activities to implement it. They see WHO as the natural international leader here, a trusted, and independent and honest broker with strong humanitarian values that advocates adherence to key principles and international agreements. Strengthening WHO's presence in countries technically, financially and politically could be a means of helping countries to develop a policy framework for better health that enables them to decide what donor assistance they want and to control it effectively. The countries that are most in need of WHO support are usually, however, those with the least power and influence. The US and other OECD countries exert tight control over WHO, not least because of their control of funding. Recent public discussions have shown how the US in particular continually pressurizes WHO to steer clear of 'macro-economics' and 'trade issues' that it says are outside its scope, and to avoid such terminology as 'the right to health'. The lack of consensus among member States about WHO's mandate naturally reflects the conflicts within the international order.<sup>25</sup>

The proposed budget of the WHO for 2014-15 was about USD 4 Billion of which about 930 million USD was to be provided by member states with a further 3 billion USD to be from voluntary contribution.

**Strings attached to the donations**

Strings Attached	Funding available*(\$ million)	%-age of total
Projection(promised funds)	231,059	4.3
Assessed contributions	929,000	17.5
Core voluntary contributions(untied)	296,190	5.6
Specified voluntary contribution(project specific)	3,855,484	72.6
Total	5,311,733	100

\*As on April 30<sup>th</sup>, 2015. Source: **The Times of India, New Delhi/ Gurgaon May 20, 2015, p-20.**

Over 30 civil society organizations and several member states of the World Health Organization (WHO) have raised objection to the framework for engagement of the WHO with non-state entities, holding that the issue of conflict of interest in such engagement is not adequately addressed. At the World Health Assembly in Geneva, the drafting group on framework for Engagement with Non State Actors(FENSA)-the Non state actors were defined as entities like philanthropic foundations, business associations, academic institutions and non-profit, non-governmental organizations(NGO’s) that are not part of any state or public institution.

Currently, WHO funding comes from two main sources- the mandatory assessed contributions from every member country and voluntary contributions from member countries or non-state actors.

Since the 1990s, there is a freeze on assessed contributions due to pressure from the USA, which has led to untied funds being reduced to a fifth of WHO’s total budget. In the meantime, voluntary contributions have risen steadily to become 80% of the WHO’s funds. As much as 93% of such voluntary funds are tightly earmarked for specific programs that the donor supports, leaving the WHO with no say over how the money is spent.

Almost half the voluntary funds are controlled by three countries-the US,UK, Canada- and the Gates Foundation, along with a couple of organizations like GAVI and Global Fund to fight AIDS,TB and Malaria(Malaria Project), for which the Gates Foundation is a major funder.

Civil society groups have expressed concern that rich member-state donors have been deliberately undermining the WHO and weakening its capacity to promote global health by underfunding, tight earmarking of donor funding and opening spaces for corporate influence. They pointed out that for the WHO to fulfill its constitutional mandate, the assessed contributions would have to be unfrozen.

The erstwhile Director General of WHO couple of years back Margaret Chan (note: Currently Tedros Adhanom Ghebreyesus of Ethiopia is the DG-WHO since 1<sup>st</sup> July 2017) proposed a 5% increase in assessed contributions. *“While 5% is a relatively small increment, much less than the big donors contribute as voluntary contributions, it is of huge symbolic value and a crucial step towards breaking the logjam of freeze on assessed contributions. Predictably, certain large donor countries are gearing up to oppose the increase and refuse to adopt the budget,”* said a joint statement from civil society organizations.

*“Many proposals by rich countries in draft FENSA text are promoting corporate capture of WHO in the name of promotion of engagements without discussion on any comprehensive mechanism to avoid conflict of interest. These proposals if accepted would institutionalize the undue corporate influence on WHO,”* said Lida Lhotska of International Baby Food Action Network (IBFAN).

Several African countries too have stressed that *“WHO should proceed with caution in developing a policy on engagement with non-state actors”* and specifically called for a *“clear policy on how WHO will manage its conflicts of interest”*.

*“The refusal to increase the assessed contribution is the technique deployed to force WHO to open up to corporate influence,”* said Dr. David Legge of Peoples Health Movement. *“The comprised flexibility in financial resources forces WHO to look for resources from donors with profit motives and endanger the constitutional mandate of WHO,”* he added.

*“If the framework is adopted without addressing this request, any much needed budget increase may end up in the pockets of pharmaceutical trans-nationals while allowing Big Food to continue undermining marketing regulation of junk food, which causes so much harm in terms of human health, lives and public health economies,”* said a statement issued by IBFAN.<sup>26</sup>

**Emergency Risk Management for Health Overview:**

Emergencies and disasters often result in significant impacts on people’s health, including the loss of many lives. Every new threat reveals the challenges for managing health risks and effects of emergencies and disasters. Deaths, injuries, diseases, disabilities, psychosocial problems and other health impacts can be avoided

or reduced by emergency risk management measures involving health and other sectors. Emergency risk management for health is multi-sectorial and refers to: the systematic analysis and management of health risks, posed by emergencies and disasters, through a combination of (i) hazard and vulnerability reduction to prevent and mitigate risks, (ii) preparedness, (iii) response and (iv) recovery measures. The traditional focus of the health sector has been on the response to emergencies. The ongoing challenge is to broaden the focus of emergency risk management for health from that of response and recovery to a more proactive approach which emphasizes prevention and mitigation, and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems based on primary health care at community level can reduce underlying vulnerability, protect health facilities and services, and scale-up the response to meet the wide ranging health needs in disasters.

### **Emergency Risk Management for Health Fact Sheets- Global Platform - May 2013.**

Advocating for emergency risk management for health, these advocacy materials are an introduction for health workers engaged in emergency risk management and for multi-sectorial partners to consider how to integrate health into their emergency risk management strategies. Why is there a need for emergency risk management for health? Natural, biological, technological and societal hazards put the health of vulnerable populations at risk and bear the potential to cause significant harm to public health. Examples of these hazards are as follows: Natural: earthquake, landslide, tsunami, cyclones, flood or drought. Biological: epidemic disease, infestations of pests. Technological: Chemical substances, radiological agents, transport crashes. Societal: conflict, stampedes, acts of terrorism. Emergencies, disasters and other crises may cause ill health directly or through the disruption of health systems, facilities and services, leaving many without access to health care in times of emergency. They also affect basic infrastructure such as water supplies and safe shelter, which are essential for health. International consensus views emergencies as barriers to progress on the health-related Millennium Development Goals (MDGs), as they often set back hard earned development gains in health and other sectors. Emergency risk management for health is *"EVERYBODY'S BUSINESS"* this overview places emergency risk management for health in the context of multi-sectorial action and focuses on the generic elements of emergency risk management, including potential hazards, vulnerabilities of a population, and capacities, which apply across the various health domains.

Fact sheets developed by the World Health Organization, Public Health- England and Partners Country Capacities and Needs states that progress has been made at global, regional, national and community levels, but the capacity of countries for risk reduction, emergency preparedness, response and recovery remains extremely variable, the global assessment almost a decade back found that less than 50% of national health sectors had a specified budget for emergency preparedness and response. Some factors affecting capacity include: Weak health and disaster management systems, lack of access to resources- know-how and continuing insecurity due to conflict. But a number of high-risk countries have strengthened their disaster prevention, preparedness and response systems; in some countries, the health sector has led initiatives developing multi-sectorial approaches to emergency and disaster risk management.

**Emergency risk management for health in context of Sustainable development:** Emergency risk management has emerged as a core element of sustainable development and an essential part of a safer world in the twenty-first century. Reducing risk is a long-term development process, managed by communities and individuals working together.

**Health Systems:** Health care systems provide core capacities for emergency risk management for health. Some countries affected by emergencies have limited basic health services and infrastructure, which in itself hugely compounds the challenges of disaster response. Countries with well-developed systems are often much more resilient and better prepared for disasters. Primary health care (PHC) focuses on basic services to improve health status, which in turn builds community resilience and provides the foundation for responding to emergencies. Policies and strategies focusing on PHC can contribute to decreasing vulnerability and preparing households, communities and health systems for emergencies. Following an emergency, focus is often given to acute care needs and specialist interventions; whilst important, it is usually chronic and pre-existing conditions that prove the largest burden of disease.

**Community-based actions are at the front line of protecting health in emergencies because:** local knowledge of local risks is used to address the actual needs of the community. Local actions prevent risks at the source, by avoiding exposure to local hazards. A prepared, active and well-organized community can reduce risks and the impact of emergencies. Many lives can be saved in the first hours after an emergency through community response before external help arrives.

**Hospitals and health infrastructure:** Health systems are composed of public, private and non-governmental facilities which work together to serve the community; these include hospitals, primary health care centers, laboratories, pharmacies and blood banks. Safe hospitals programs ensure health facilities are built to withstand hazards and to remain safe and operational in emergencies.

**Developing adaptable and resilient health care systems surge capacity:** Health care systems need to prepare to cope with large numbers of patients. This may require mobilizing staff around the country to aid affected areas.

**Flexibility in health care systems:** Flexibility to deliver different functions is an essential component of health care delivery. This may mean reducing some services in order to increase others.

**Business continuity planning:** Plans to maintain the continuity of health sector operations includes identifying priority services, mechanisms for response coordination and communicating with staff and partner organizations and

**Multi-sectorial action in order for the health of the population to be protected during and after a disaster:** wider determinants of health such as water, sanitation, nutrition, and security also need to be adequately addressed through multi-sectorial working. Essential infrastructure such as communications, logistics, banking facilities, energy-water supplies, and emergency services need to be protected through multi-sectorial working to ensure the continuity of health services.

**Hyogo Framework for Action: 5 Priorities for Action.**

The Hyogo Framework for Action identifies 5 priorities for action towards strengthening community and country's resilience to disasters. The application of these 5 priorities for health and the health sectors are described below.

**Priority 1:** Emergency risk management for health as a national and local priority; Development and implementation of health and multi-sectorial policies; Strategies and legislation to provide direction and support for emergency risk management, especially at local levels; Health sector and multi-sectorial coordination mechanisms at local and national levels to facilitate joint action on risk reduction, response and recovery by the various health and non-health actors and Commitment of sufficient resources to support emergency risk management for health.

**Priority 2:** Health risk assessment and early warning; Assessment of risks to health and health systems; Determining risk management measures based on risk assessments; Surveillance and monitoring of potential threats to health, particularly from natural, biological, and technological (such as chemical and radiological hazards) sources to enable early detection and warning to prompt action by the public, health workers and other sectors. There are three to four broad elements, which are usually considered in risk assessment: 1. Hazard Analysis: Identification of the hazards and assessment of the magnitude and probability of their occurrence. 2. Vulnerability Analysis: Analysis of vulnerability of individuals, populations, infrastructure and other community elements to the hazards. 3. Capacity analysis: Capacity of the system to manage the health risks, by reducing hazards or vulnerability, or responding to, and recovering from a disaster and lastly 4. Reducing vulnerability to emergencies: A public health priority.

Risks can be understood in terms of hazards and people's vulnerability to that hazard. Human vulnerability to emergencies is a complex mix of issues that includes social, economic, health and cultural factors. In many situations it is not the hazard itself that necessarily leads to an emergency, but the vulnerability and inability of the population to anticipate, cope with, respond to and recover from its effects. The burden of emergencies falls disproportionately on vulnerable populations, namely the poor, ethnic minorities, old people, and people with disabilities. Worldwide, the loss of life from climate related emergencies is far higher among the less-developed nations than it is in developed nations. Within each nation, including developed nations, poor people are the most affected. Poverty reduction is an essential component of reducing vulnerability to emergencies. High risk populations must be prioritized in targeted efforts to mitigate human vulnerability. Various risk factors for human vulnerability to disaster-related morbidity and mortality include the following: • Low income • Low socio-economic status • Lack of home ownership • Single-parent family • Age: older than 65 years and younger than 5 years • Female sex • Chronic illness • Disability and Social isolation or exclusion. In the context of emergency risk management, public health programs build capacities and resilience of individuals and communities to risks, to reduce the impact, cope with and to recover from the effects of adversity. They also address issues related to health disparities that arise between the general population and the most vulnerable groups.

**Priority 3:** Education and information to build a culture of health, safety and resilience at all levels through education, training and technical guidance; Strengthen the knowledge, skills and attitudes of professionals in health and other sectors for managing the health risks of disasters and Information, education and risk communication for households and communities at risk to promote healthy behaviors to reduce risks and prepare for disasters. This may be through raising awareness through the media and community-based emergency and disaster risk management programs.

**Priority 4:** Reduction of underlying risk factors to health and health systems; Poverty reduction measures and systems aimed at improving the underlying health status of people at risk of disasters; New hospitals are built with a sufficient level of protection and existing health care infrastructure is strengthened to remain functional and deliver health services in emergency situations; Protection of other vital infrastructure, and facilities that

have the potential to generate risks to public health, such as water and sanitation systems and chemical facilities, should also apply risk management measures; Adherence to building standards and retrofitting of vulnerable health infrastructure, protection of eco-systems, and ensuring effective insurance regimes and micro-finance initiatives to ensure business continuity across all health care settings and

**Priority 5:** Emergency preparedness for effective health response and recovery at all levels; Emergency preparedness, including response planning, training, pre-positioning of health supplies, development of surge capacity, and exercises for health care professionals and other emergency service personnel, is critical for the effective performance of the health sector in the response.

**Development of capacities for emergency risk management for health:** The health sector requires capacities and relationships with other sectors which span across the spectrum of emergency risk management measures at community, sub-national, national and international levels. The health risks of an emergency can be mitigated by decreasing exposures and the human susceptibility to the hazard, and building resilience of individuals, communities and the country to protect health, respond and recover effectively from the impact of the hazard.

An all-hazards emergency risk management for health program could be expected to have the following groups of components: 1. Policies, legislation and strategies • Defines the structures, roles and responsibilities of governments and other actors for ERM-H; includes strategies for strengthening ERM-H capacities which includes (a) policies and legislation, (b) capacity development strategies, and (c) monitoring, evaluation and reporting. 2. Resource management • Describes financial and workforce management requirements for implementing ERM-H and includes (a) financing, and (b) human resource management. 3. Planning and coordination • Emphasizes effective coordination mechanisms for planning and operations for ERM-H; Includes (a) coordination mechanisms, (b) ERM units in MOH, (c) prevention and mitigation planning and coordination, (d) response planning and coordination, (e) recovery planning and coordination, (f) business continuity management and (g) exercises. 4. Information and knowledge management • Includes a) risk assessment, (b) early warning and surveillance, (c) research for ERM-H, (d) knowledge management, including technical guidance, (e) information management and (f) public communication. 5. Health infrastructure and logistics • Includes (a) logistics and supplies and (b) safer prepared/functional health facilities to support ERM-H and 6. Health and related services • Recognizes the wide range of health-care services and related measures for ERM-H. Includes (a) health care services, (b) public health services and (c) specialized services for specific hazards.<sup>27</sup>

### **Emergency Medical Teams and World Health Organization**

Emergency Medical Teams (EMTs) are an important part of the global health workforce and have a specific role. Any doctor, nurse or paramedic team coming from another country to practice healthcare in an emergency needs to come as a member of a team.

- EMTs are groups of health professionals (doctors, nurses, paramedics etc.) that treat patients affected by an emergency or disaster. They come from governments, charities (NGOs), militaries and international organizations such as the International Red Cross/Red Crescent movement. They work to comply with the classification and minimum standards set by WHO and its partners, and come trained and self-sufficient so as not to burden the national system.
- EMTs historically have had a trauma and surgical focus, but Ebola scourge has shown us their value in outbreak response and other forms of emergency.
- The Ebola response was the largest deployment of EMTs for an outbreak, which pales in comparison to the 151 teams deployed to respond to Typhoon Haiyan in November 2013 and the nearly 300 teams deployed to Haiti following the earthquake.
- Requirements for emergency health response are broader than those required for sudden onset disasters and trauma. They must include the ability to care for diseases such as Cholera, Shigella and Ebola, as well as teams to support populations affected by flood, conflict and protracted crises such as famine.
- Emergency medical teams have a long history of responding to sudden onset disasters (SOD) such as the Haiti earthquake, the Indian Ocean Tsunami and the floods in Pakistan and
- EMTs work under the guidelines of the WHO Classification and Minimum Standards for Foreign Medical Teams in sudden onset disasters guidance. These guidelines discuss the principles and core standards of how registered EMTs must function and declare their operational capabilities.

### **What is the work of the World Health Organization to date in this area?**

- Classification and minimum standards were published in mid-2013.  
A new EMT unit was set up in the department of Emergency Risk Management & Humanitarian Response, WHO, Geneva, in February 2014. Their work has included:

- i. Building a new global registration system that will allow EMTs to register their capacity and be classified and
  - ii. Closer collaboration with UNOCHA, INSARAG (International Search and Rescue Advisory Group), UNDAC (UN Disaster Assessment and Coordination) teams and use by FMTs of the UNOSOCC (onsite operations and coordination centre) mechanisms.
- Training national ministries of health, in countries likely to suffer natural disasters, to be aware of the capacities of FMTs, and establish arrangements for the reception and coordination of teams on arrival.
  - Development of best practice guidance and standards for FMTs to respond to the care of children, pregnant women, patients with disabilities, older people, and those with pre-existing health issues who have lost access to their medication during the disaster etc. and
  - WHO has developed a global registration system where emergency medical teams can be verified and classified ready to be deployed to health emergencies. A global registry of all EMTs that meet the WHO EMT minimum standards for deployment in sudden onset emergencies from all-hazards provides time-limited surge clinical capacity to the affected populations. It serves as a deployment and coordination mechanism for all partners who aim to provide clinical care in emergencies such as tsunami, earthquake, flood, and more recently, in large outbreaks, such as the West Africa Ebola outbreak, which require a surge in clinical care capacity. It allows a country affected by a disaster or other emergency to call on teams that have been pre-registered and quality assured.

#### **What are its aims?**

- Improve the quality of care provided;
- Improve coordination between clinical care teams;
- Provide a predictable and timely response to affected governments and populations;
- Serve as a quality improvement forum, with working groups developing minimum standards, best practice guidance, and sharing best practice between partners as well as to
- Provide a forum for interaction between EMT providers and potential recipient countries, including allow countries to inform EMTs of the specific standard operating procedures (SOPs) and requirements for access to their country in the event of an emergency. (E.g. rules on importation of pain relief, registration as a doctor, etc.)

#### **What does the Global Registry enable countries to do?**

- It enables countries to improve their own national capacity, which they are then able to use to assist other countries in emergencies and
- Each team has unique individuals with various skill sets. Identifying these differences and placing them into the field requires coordination and communication to ensure the correct gaps are filled. EMT staff helps facilitate and coordinate this placement.

#### **EMTs in the Ebola Response:**

- Traditionally, EMTs were used for sudden onset disasters like earthquakes and typhoons, with a trauma and surgical focus. Ebola care during this multi-country outbreak has necessitated unique medical knowledge and equipment, and has carried unique risks for health care workers. The progress made against Ebola is part thanks to the response by the national and international teams that run the 72 Ebola Treatment Centres (ETCs) across three countries.
- WHO and the world have learned important lessons from the Ebola response that have a wider application to the agency and the global health response community. These lessons have been used to improve coordination, quality and predictability of clinical response teams deploying with surge capacity as EMTs.
- Over 40 organizations, including international NGOs, military, faith-based organizations and governments have deployed EMTs throughout the recent Ebola Response and
- Countries that have sent EMTs to West Africa include Australia, China, Cuba, Democratic Republic of the Congo, Denmark, Ethiopia, France, Germany, Kenya, Korea, New Zealand, Nigeria, Norway, Russia, South Africa, Sweden, Uganda, United Kingdom and United States of America.<sup>28</sup>

### **CONCLUSION**

*"Of all the forms of inequality, injustice in health care is the most shocking and inhumane." — Martin Luther King, Jr.*

To recapitulate article 1 of the WHO constitution covers the objective of WHO while article 2 elaborates the functions of WHO, Article's 9,18,21,28,47,50,58,59,60 deals with the organs of WHO and articles 67,69,76 deals with its relation with other organizations.

**The Key Recommendations for the up gradation of WHO's core roles** which can be debated and fleshed out in the future are:

- Acting as the world's health conscience, promoting a moral framework for health and development policy, and asserting the human right to health;
- Promoting the principles of the Alma Ata declaration on '*Health for All*';
- Establishing, maintaining and monitoring global norms and standards on health and health care;
- Strengthening its role as an informed and trusted repository and disseminator of health information and experience;
- Conducting, commissioning and synthesizing health and health systems research, including research on the health impact of economic activities;
- Promoting and protecting the global commons, including the creation of trans-national goods such as research and development capacity, and control of trans-national externalities such as spread of pathogens;
- Providing a mechanism for coordinating efforts to curb trans-national/cross-boundary threats to health;
- Strengthening WHO's presence in countries to play a stronger stewardship role in coordinating and bringing together international and bilateral agencies and international NGOs to develop a unified, purposeful multi-sectorial health strategy and activities to implement it;
- Take measures to position WHO as an organization of the people as well as of governments. This involves representation of broader groups of interests including civil society, and processes that ensure a wide range of voices is heard and heeded;
- Support and expand the Civil Society Initiative at WHO. Southern civil society organizations need support to have a more direct voice. Public-interest organizations must be differentiated from those representing commercial interests, including front organizations funded by trans-national corporations;
- The politicized nature of the elections of the director-general and regional directors needs to be tempered. Possible solutions include a wider franchise, perhaps with an electoral college of international public health experts to complement the member states' votes, including representatives from civil society organizations. Candidates should be required to publish a manifesto and WHO should facilitate widespread debate about them, with holding to account open selection criteria that reflect the roles of leadership and management requirements and
- There should be a strategic assessment of where WHO should be influential in the interests of health in relation to other multilateral bodies, and the existing liaison mechanisms between WHO and the international trade and financial institutions.

**Funding and programming:**

- Donors should strive to increase their overall donations towards an agreed target;
- Donors should shift a proportion of their funding of extra-budgetary programmes into the regular budget. The aim should be a roughly equal apportioning of funding between the two arms of the budget, without any corresponding decline in the total budget;
- WHO should work on fewer priorities and ask donors to match their resources to them, to shift the balance between staff costs and activities and avoid '*project-chasing*'; these priorities should be followed through in collaborative agreements with member states;
- Programmes (and the organization's structure) should be organized around the Primary Health Care Approach, resulting in the strengthening of systems- oriented units and divisions;
- Extra-budgetary donations should follow agreed overall priorities – donors should avoid tying them too tightly to specific programmes and outputs;
- Explicit resource allocation formulae should be developed to encourage better balances between core/extra-budgetary and staff/programme costs;
- The benefits, risks and costs of global public-private partnerships in health should be openly debated and compared to alternatives and
- WHO should develop strong safeguards against conflicts of interest in funding, priority-setting and partnerships.

**Leadership and management:**

Actions that WHO leaders can take to change the culture and improve their management and leadership:

- Revisit WHO's mission with all staff to renew their collective ownership and commitment: clarify priorities, agree comparative advantages, and from that develop a strategy, allocate funds and stick to it, including sufficient funding for core infrastructure functions;
- Recruit more diverse staff from different backgrounds and cultures, including more women, more people from the South. Doctors and more people with experience in a variety of settings in developing countries, inter-sectorial action and project management;

- Require proof of effective leadership and management experience as a criterion for staff recruitment, especially at senior levels;
- Make WHO a learning organization with a culture committed to continuous improvement, through giving all staff excellent continuing professional development opportunities; high-level management training for all senior staff; learning from good practice and sharing ideas, approaches and information; and regular, meaningful, non-blaming collective and individual performance review;
- Introduce regular rotation of staff to avoid stagnation and gain experience at global, regional and country levels;
- End casualization of the workforce, including reducing number of staff employed for long periods on a series of short-term contracts;
- Stop unstructured consultancies, internships and secondments that have little benefit for the individual, WHO or Countries;
- Make better use of the expertise of senior WHO-friendly practitioners, academics, policy-makers and researchers, including short-term secondments;
- Review and streamline administrative processes and procedures;
- Strengthen the capacity and independence of WHO personnel departments, and introduce/enforce robust personnel policies with mechanisms for rapid response and staff support, and zero tolerance of corruption, nepotism and abuse of staff and
- Strengthen mechanisms to represent staff interests, including a staff association organized on trade union principles with collective bargaining powers and a properly resourced secretariat.<sup>29</sup>

#### **Key considerations of emergency risk management for health:**

Development of national and community health emergency risk management systems with emphasis on primary prevention, vulnerability reduction and strengthening community, health facility, and health system resilience by reinforcing a community-centered primary health care approach. Stimulate development of further evidence-based technical guidance and training programs for the advancement of emergency risk management for health capacities, including priority technical areas. Strengthen partnerships, institutional capacities and coordination mechanisms among health and related sectors for global, regional, national and community emergency risk management for health.

#### **Health and related services will include:**

• Injury prevention and trauma care • Communicable diseases prevention, control and care • Mental health and psycho-social support • Sexual and reproductive health • Child health • Non-communicable diseases • Environmental health • Food and nutrition • Management of dead and missing • Primary health care services with Community ERM-H capacities focusing on strengthening local health workforce capacities and community-centered planning and action.

#### **Developing a robust evidence base:**

The establishment of an evidence base is necessary to provide support for establishing or strengthening of multi-sectorial and multidisciplinary emergency risk management programs in at-risk countries. This may best be achieved by: • A multi-sectorial forum promoting and coordinating the development of research methodologies in emergency risk management • Enhanced multi-sectorial and coordinated communication and data sharing. • Development of multi-functional instruments to collect a minimum data set of information. • Ensuring learning is used to influence decision making at all levels of civil society. Here in a mention of important publications of WHO is of note: *Health in 2015: From MDG's to SDG's (Sustainable Development Goals) and Global Health Watch 2005-06: An Alternative World Health Report, pp-269-292*

Further Emergency Response Framework (ERF) roles to clarify WHO's roles and responsibilities and to provide a common approach for its work in emergencies.<sup>30</sup>

WHO's new Health Emergencies Programme is designed to deliver rapid, predictable and comprehensive support to countries and communities as they prepare for, face or recover from emergencies caused by any type of hazard to human health, whether disease outbreaks, natural or man-made disasters or conflicts.

The development of the new Programme is the result of a reform effort, based on recommendations from a range of independent and expert external reports, involving all levels of WHO - country offices, regional offices and headquarters. The new Programme unifies WHO's standards and processes to strengthen the Organization's response to health emergencies across the full risk management cycle of prevention, preparedness, response and early recovery.<sup>31</sup>

As Syria's armed conflict grows, WHO aid to the region is unrelenting. WHO is also responding to increasing health needs in Yemen as health facilities continue to shut down. Health services have also shut down as funding shortfall cripples humanitarian operations in Iraq in this way.<sup>32</sup>

WHO is undergoing substantial reform to ensure the Organization's emergency capacities are fit for purpose which include reform of its emergency capacities. WHO's emergency reform process is focused on strengthening and consolidating the Organization's capacities and partnerships to respond to and prepare for all crises that impact on people's health and disrupt the delivery of health care services. WHO is undertaking a thorough review and reform of its capacities in emergency risk management and response to outbreaks and emergencies with health and humanitarian consequences. WHO is committed to saving lives and reducing suffering in times of crisis. Yet organization can only carry out this important work if it has the resources to do so.<sup>33</sup>

It needs the support of the international community to achieve the aspiration – a WHO that is well-equipped to respond quickly and effectively to any emergency which threatens the lives and health of people anywhere in the world.<sup>34</sup>

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