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World Health Organization (WHO)

Globalization in the nineteenth century made health an international issue requiring greater cooperation among states. This cooperation occurred first through ad-hoc conferences and later through permanent health organizations. Institutionalization of international cooperation on public health led eventually to the establishment of the World Health Organization (WHO) in 1948. The importance and relevance of this organization has been proven and strengthened over the past half century through its active participation in the fight against major infections.

A continuing rapid pace of globalization in the 1980s and 1990s underscored the need for a more global action against the rapid spread of disease, particularly communicable epidemics. The complex nature of the measures that needed to be taken in order to successfully contain or treat diseases compelled WHO in these decades to refocus its activities. Instead of concentrating on intergovernmental cooperation, it began to spearhead more globally driven campaigns and action plans, increasingly relying on partnerships with a wide range of international institutions and governmental and societal actors, including commercial groups. The force of globalization in the late twentieth century made diseases more widespread and potentially more lethal to a greater number of people. Simultaneously, however, the same globalization processes compelled and allowed WHO to enmesh its activities with a global network of multiactor partnerships that could confront challenges related to international public health more effectively.

Historical Overview

The first wave of globalization took place during the nineteenth century as significant improvements in transportation and communication took place. This wave was characterized by rapid growth in both trade and travel, not only among nations within particular regions, but also across continents, particularly Asia, the Americas, and Europe. As the number of interactions between peoples increased, infectious diseases, such as cholera, the plague, and yellow fewer, among others, began propagating much more rapidly than ever before, both across time and geographical space. These changes raised significant concerns about public health and sparked continual debates among state officials about the sorts of international cooperation needed to contain the spread of epidemics and the kinds of measures that could protect populations without hindering international commerce.

In 1851, the representatives of twelve European states gathered in Paris at the first International Sanitary Conference. There, they adopted the International Sanitary Convention, which envisaged international harmonization of diverse requirements for conducting national inspections and imposing quarantines in order to halt the spread of epidemic diseases. The convention, however, did not gain the required ratifications and therefore never came into force. The failure of the ratification process showed the difficulty of finding a proper balance between the need for firmer national measures to stop the spread of

disease, on the one hand, and the desire to maintain a free flow of people and international trade, on the other. It took five more international conferences (Paris in 1859; Constantinople in 1866; Vienna in 1874; Washington, DC, in 1881; and Rome in 1885) before the European states could agree on another International Sanitary Convention, which occurred at the seventh International Sanitary Conference in Venice in 1892. This convention was limited, however, to quarantine measures for cholera. During the tenth International Sanitary Conference, in 1897, and again in Venice (two previous conferences were in Dresden in 1893 and in Paris in 1894), the countries adopted an International Sanitary Convention covering the plague. Six years later, in 1903, the eleventh International Sanitary Conference, held in Paris, agreed on a single consolidated International Sanitary Convention that regulated protective measures against both cholera and the plague. This convention was subsequently amended in 1926 to cover two other diseases: smallpox and typhus.

While participating in these ad-hoc international meetings, the states tightened their regional cooperation, which resulted, among other things, in the creation of the first permanent international health organization, the International Sanitary Bureau (ISB), in Washington, DC, in 1902, and another one, the Office International d'Hygiène Publique (which translates as International Office of Public Health), in Paris in 1907. The fundamental goals of these early organizations were to collect and disseminate information about epidemics and to regulate international efforts in fighting them. The ISB was subsequently renamed the Pan American Sanitary Bureau (PASB) in 1923. Since 1949, the PASB has served as the World Health Organization Regional Office for the Americas. PASB is also the secretariat of the Pan American Health Organization (PAHO), which emerged from the International Sanitary Conferences (the Pan American Sanitary Conferences from 1923 and PAHO after 1958).

The next step in institutionalization of international cooperation on health issues was the creation of the League of Nations Health Organization in 1923, which was responsible for hygiene- and health-related issues as well as the establishment and operation of epidemiological information systems for malaria, tuberculosis, syphilis, cancer, and other diseases. In 1943, the United Nations Relief and Rehabilitation Administration was set up to prevent humanitarian and epidemiological catastrophes in countries devastated by war. The administration was eventually dissolved in 1946. In the same year, the International Health Conference was convened. It drafted the constitution for an international health organization and set up an Interim Commission to assist in the preparation for the first meeting of the World Health Assembly (WHA). The constitution came into force in April 1948, and the WHA meeting took place on June 24, 1948. At this meeting, delegations from fifty-three member states officially established the World Health Organization (WHO) as a United Nations specialized agency.

WHO Functions

WHO conducts various types of activities that aim at the "attainment by all peoples of the highest possible level of health" (Article 1, WHO Constitution), where "health" is defined as "not merely the absence of disease or infirmity" but "a state of complete physical, mental and social well-being" (Preamble). Because of this broad mandate, WHO performs several functions that can be grouped into four major task roles:

1. A standard-setting role based on setting guidelines, codes, recommendations, and regulations and establishing monitoring and validating mechanisms to ensure their proper implementation (WHO as a *normative agency*).
2. An operational role based on prevention, treatment, and eradication of communi-

cable and noncommunicable diseases, which requires coordination and harmonization of the work of various governmental and nongovernmental actors with the aim of facilitating, building, and sustaining global partnerships (WHO as an *action agency*).

3. A technical role based on providing assistance to WHO member states through technical and policy support, education, and training in order to strengthen the institutional capacities of their national health systems (WHO as a *service agency*).
4. A research role based on storing, managing, and disseminating information on public health and supporting tests and diagnoses of new technologies and health-related inventions (WHO as an *epistemic agency,* serving as a repository of knowledge on public health).

WHO Governing System

WHO is composed of several governing bodies linked through a web of formal interactions that constitute the WHO governing system. These bodies include WHA, an Executive Board, and regional offices. A director general serves as the chief administrative officer.

World Health Assembly

The World Health Assembly, composed of delegates from 192 member states, is the central political organ of WHO. Although no more than three delegates can officially represent a particular state during WHA meetings, in practice country delegations are often larger because alternates and advisers accompany official delegates. The WHO Constitution (Article 11) recommends that the delegates have a high level of technical competence in a health-related field and, if possible, that they come from the national health administrations of the member states. WHA sessions are also attended by the representatives of multilateral institutions and nongovernmental organizations (NGOs) that have official relationships with WHO. These representatives may make statements, but they do not vote at WHA sessions.

At the sessions, each member state has one vote, and the decisions are taken either by a qualified majority of two-thirds (for example, in the adoption of regulations or of amendments to the WHO Constitution or in the admittance of new members) or by a simple majority. WHA has one regular session a year and may hold special sessions as requested by the Executive Board (see below).

Two procedural and two substantive committees assist WHA. One of the procedural committees, the Committee on Nominations, is responsible for nominating people to serve in various official positions, such as chairmanships for other committees and the WHA president and vice president. The other, the Committee on Credentials, is responsible for determining whether the country delegations have appropriate authorization from their respective governments to participate in WHA or to be elected to its organs. The substantive committees are Committee A and Committee B. Committee A deals with technical programs and policy-oriented issues, and Committee B focuses on administrative and financial matters.

WHA is both a guidance and supervisory body. As such, it makes decisions about the general direction of WHO activities, scrutinizes WHO spending, approves the organization's regular budget (almost $856 million in the 2002–2003 biannual budget), and monitors other extra-budgetary resources (assessed at about $1.4 billion in 2002–2003). WHA adopts regulations, proposes recommendations, and makes agreements with other UN agencies or intergovernmental organizations. It also appoints the director general (DG), who would already have been nominated earlier by the Executive Board. WHA may ask the DG and the Secretariat, as well as the Executive Board, to bring health-related matters to the attention of the delegates of the member states. At its dis-

cretion, WHA may also establish committees or ad-hoc bodies as deemed necessary to facilitate and improve the work of the organization.

The Executive Board

The Executive Board (EB) meets at least twice a year and brings together thirty-two persons designated by their state to fill positions on the board, which are three-year appointments. The states authorized to appoint a representative to this board are elected by the WHA. Each of the delegates must have a specific qualification in the field of health. In order to maintain a balanced geographical distribution of seats, the EB must have no less than three delegates representing each of the WHO's six regions. By informal arrangement, the five permanent members of the UN Security Council—China, France, Russia, the United Kingdom, and the United States—have their representatives to the EB seated for three consecutive years interrupted by a one-year intermission (so-called "semi-permanent memberships"). EB meetings are also attended by the representatives of multilateral institutions and nongovernmental organizations that have official relationships with WHO. These representatives have the right to speak but not to vote at EB sessions.

The EB executes the tasks that WHA delegates to it and supervises the implementation of WHA decisions and the provisions of WHO regulations and recommendations. It adopts the agenda for WHA sessions; supervises financial and budgetary assessments prepared by the director general; and sets up, changes, or closes its committees. The EB is composed of five substantive committees: (1) a Programme Development Committee, which is responsible for reviewing all aspects related to planning, budgeting, and evaluation of WHO activities; (2) an Administration, Budget and Finance committee, charged with supervision of WHO's activities in these areas; (3) an Audit Committee, which conducts internal audits of all WHO financial operations with the aim of enhancing their accountability and transparency; (4) a Coordinating Committee on Health, which aims to increase coordination on the health-related policies and programs carried out by WHO, the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA); and (5) a Standing Committee on Nongovernmental Organizations, which evaluates the work conducted jointly by WHO and other nongovernmental organizations and considers requests for admittance of new nongovernmental organizations into official relations with the organization. Additionally, the EB runs committees on nonsubstantive issues. Its foundation committees (for the Darling Foundation, the Leon Bernard Foundation, the Jacques Parisot Foundation Fellowship, the Ihsan Dogramaci Family Health Foundation, Sasakawa Health Price, and the United Arab Emirates Health Foundation), for example, consider the nomination and selection of individuals for WHO awards and fellowships.

The Director General and WHO Secretariat

The director general (DG) is nominated by the EB and elected by the WHA. The DG is "the chief technical and administrative officer of the Organization" (WHO Constitution, Article 31). Throughout its history, WHO has had six DGs: Brock Chisholm (Canada),1948–1953; Marcolino Gomes Candau (Brazil), 1953–1973; Halfdan Mahler (Denmark), 1973–1988; Hiroshi Nakajima (Japan), 1988–1998; Gro Harlem Brundtland (Finland), 1998–2003; and Jong Wook Lee (Korea), 2003 to the present. Since the end of the 1980s, the DG has been limited to a five-year term, renewable only once. The DG heads the WHO Secretariat, located in Geneva, a permanent administrative and operational organ of WHO.

The Secretariat is composed of nine clusters, seven of which deal with substantive technical issues and research on various aspects of health care. One of the two remaining clusters is responsible for the Secretariat's contacts with WHA and the EB and its external relations with UN bodies. The last cluster is charged with administrative support and internal management of the Secretariat itself. The DG and

Secretariat are responsible for the day-to-day activities of the organization, implementation of technical programs, coordination of work on health-related matters among various governmental and nongovernmental actors, management of information and expertise on public health, and preparation of the organization's budget.

The DG appoints the staff of the Secretariat, which in the performance of its duties is expected to maintain independence and integrity and not to seek any instructions from the member governments. In accordance with the United Nations common system of grades and salaries, the WHO staff is divided into two general categories: professional and general services. Professional service staff (from P1 to P6 and D2) is responsible for the substantive and policy-oriented work of the organization, whereas general service staff (from G1 to G7) performs administrative and Secretariat support duties. The Secretariat staff also includes nongraded high-level officials such as the deputy director general and assistant directors general. At the end of 2002, the total WHO professional and general staff numbered 3,510, including 1,411 professionals and 2,099 general service personnel, according to WHO human resources reports.

Regional Offices

WHO has six regional health organizations around the world headed by regional directors and regional executive committees assisted by subcommittees. The Pan American Health Organization, mentioned above, is an exception and has a complex structure that includes a directing council, an executive committee, the Pan American Sanitary Conference acting as the WHO regional committee, and the Pan American Sanitary Bureau, with headquarters in Washington, DC, serving as the WHO Regional Office for the Americas. The other regional offices (ROs) are as follows: the Regional Office for Europe, with headquarters in Copenhagen; the Regional Office for the Western Pacific, with headquarters in New Delhi; the Regional Office for Africa, with headquarters in Brazzaville; the Regional Office for the Eastern Mediterranean, with headquarters in Cairo; and the Regional Office for South-East Asia, with headquarters in Manila.

Regional directors (RDs) are nominated by the regional committees and appointed by the WHO EB for a five-year term that is renewable once. Since the RDs are not appointed by the DG and have a strong affiliation with their regional constituents, they enjoy a considerable degree of autonomy vis-à-vis the DG. The regional committees, with their subcommittees, are regional assemblies that are responsible, among other things, for formulating and implementing policies that have an exclusively regional character; supervising the work of their administrative and executive organs, namely the ROs and RDs; nominating the RDs; and providing advice to the DG on health issues that have both regional and international impacts.

WHO Programs

The Fight against Communicable Diseases

From its inception, most of WHO's institutional energies and financial resources were committed to the fight against communicable diseases. In 1951, WHA adopted the International Sanitary Regulations, which were legally binding upon WHO member states. They were revised, consolidated, and renamed the International Health Regulations (IHRs) in 1969. The purpose of the IHRs was to facilitate the establishment of effective control and monitoring measures against the spread of four infectious diseases: smallpox, cholera, plague, and yellow fever. The IHRs set up a global notification system; installed certain types of disease surveillance at the maritime ports, airports, and border control posts; and specified health certificate requirements for people who traveled from infected to noninfected states. In order to maintain free trade and travel while strengthening provisions against disease pro-

liferation, the IHRs enumerated permissible sanitation and disinfection measures allowed to be implemented at arrival and departure points to protect national populations. Since 1995, the IHRs have been under revision with the purpose of expanding their legal scope. Since the eradication of smallpox in 1980, the regulations have covered only three communicable diseases; they do not apply to new important epidemics such as AIDS or Serious Acute Respiratory Syndrome (SARS). The revision process is to be concluded in May 2005.

At the end of the 1990s, the fight against communicable diseases gained renewed importance with international recognition that diseases are both caused by poverty and also in many cases the reason for poverty. In order to increase its institutional capacity to deal with communicable diseases, WHO set up a Global Outbreak Alert and Response Network in 1998, which became fully operational two years later. This global network brings together various governmental and nongovernmental actors to facilitate compilation of information about various diseases and to aid in the verification of epidemics and the coordination of the international response toward confirmed epidemic outbreaks. The network proved its effectiveness in containing the spread of SARS and was further strengthened in June 2003 with the adoption of two WHA resolutions. The resolutions, though not legally binding, officially conferred onto the Secretariat and the DG the power to issue global alerts regarding public health threats. They emphasized the duty of states to report infectious diseases promptly and to cooperate in good faith with other states and WHO on disease-related matters. These resolutions also acknowledged the increasing role of nongovernmental organizations as significant data-gathering and data-disseminating sources.

The Campaign against Smallpox. The eradication of smallpox is a WHO success story in the fight against communicable diseases. WHO embarked on its efforts to eliminate smallpox in 1967, when the twentieth meeting of the World Health Assembly charged the Secretariat with the implementation of the Intensified Smallpox Eradication Programme. At this time, smallpox accounted for almost 2 million deaths annually. The fight against the disease was two-pronged and included both a mass vaccination campaign and the establishment of a sound surveillance system to track new outbreaks of the disease.

In 1980, the Global Commission for Certification of Smallpox Eradication announced that smallpox had been eradicated and recommended ending routine vaccinations against the disease. The success of the smallpox campaign is usually attributed to several factors: an effective vaccine; good management of vaccine delivery; clear diagnostic and epidemic-identification tools; and relatively straightforward methods of controlling disease transmission. Still, WHO involvement, which greatly facilitated international cooperation and, more notably, contributed to sustaining that cooperation over a long period of time, was a significant if not essential factor in the eradication of the disease. Given the possibility that smallpox could be reintroduced, WHO has begun the process of stockpiling the smallpox vaccine in the event of an emergency since May 2005.

Work to Eradicate Malaria. In 1955, WHA directed the Secretariat to embark on the Malaria Eradication Program and to establish proper verification mechanisms in this program. Despite important achievements in scaling back malaria in the 1950s and at the beginning of the 1960s, WHO faced technical, administrative, and financial difficulties that had significant implications for the effectiveness of these efforts. By the end of the 1960s, the campaign had lost its initial momentum, and the program implementation strategy was substantially changed in favor of a greater involvement of the national health services. Such a shift of emphasis was partly a confirmation of the enormous complexity of malaria prevention and treatment as well as an acknowledgment

of failure for WHO's centrally led campaign against the disease.

Since then the WHO position has evolved from its initial desire to eradicate malaria toward a more feasible approach focusing on controlling the disease. This shift occurred in the background of a significant rise in reported malaria cases in the 1980s and the first half of the 1990s. In response to the increase, in 1992 WHO adopted the Global Malaria Control Strategy, which stressed decreasing the burden of the disease and reducing its geographical scope through better diagnosis, stronger national research capacities, and enhanced monitoring and preventive measures. In order to improve global coordination and involve a greater number of actors in the fight against malaria, WHO, in partnership with the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), and the World Bank, launched Roll Back Malaria (RBM) at the end of 1998. This campaign was soon joined by other multilateral institutions, donor governments, representatives of affected nations, NGOs, academic centers, and private enterprises, turning it into a global partnership. The goal of the RBM is to scale back the "malaria burden" by 50 percent by the end of 2010. Although significant political commitments to reduce the malaria burden were made at the first ever summit on malaria, held in 2000 in Abuja, Nigeria, it is too early to judge whether a broad-based effort to fight the disease will reach its 2010 objective.

Polio Immunization. Although polio was a long-standing concern for WHO, the organization did not have a centrally coordinated policy for polio eradication until the end of the 1980s. In 1985, the Pan American Health Organization announced an initiative to eradicate polio in both Americas by 1990. This goal was eventually achieved in 1994 when the Americas were certified to be polio-free. Subsequently, in 1988, the World Health Assembly adopted the Global Polio Eradication Initiative, which called for elimination of the disease by the year 2000. Though the goal of complete eradication of the disease has not been reached, significant progress has been made.

Today, the initiative brings together various donor governments, governments of countries affected by the disease, development banks, private foundations, research centers (including the U.S. Centers for Disease Control and Prevention), and international and nongovernmental partners such as UNICEF and Rotary International. In 1992, the Global Polio Laboratory Network, consisting of more than 140 national and regional laboratories, was set up to assist in establishing a worldwide surveillance network of polio outbreaks. WHO's efforts included massive and well-coordinated immunization campaigns throughout the 1990s, which brought about a substantial decrease in reported polio cases. During 2004 there was the most significant progress towards polio eradication with a 99 percent reduction in polio incidence over the previous year. There were only 1264 cases in 2004, which were limited to six countries: Nigeria, Niger, India, Pakistan, Afghanistan, and Egypt.

Poliovirus, for which there is no cure, has a tendency to reemerge unexpectedly and infect unimmunized populations. The most recent example was the polio outbreak in Nigeria in the second half of 2003, which spread quickly to neighboring areas that were previously declared polio-free. As a result of this tendency, WHO set a new goal of eradicating the disease by the end of 2005.

Control of Tuberculosis. WHO has been in the forefront of the fight against tuberculosis. In 1982, with the International Union Against Tuberculosis and Lung Disease (IUATLD), WHO announced the first World TB Day, which has been held each year since then on March 24 to commemorate Robert Koch's discovery of the TB bacillus in 1882. This event is aimed at raising public awareness of the destructive impact of TB on the health and lives of millions of people.

The fight against TB gained a new impor-

tance in the 1990s when the spread of HIV infections, combined with a further deterioration of national health systems, particularly in developing countries, contributed to a rapid increase in TB cases. TB has become one of the most lethal infectious diseases worldwide. According to WHO statistics, it claims the lives of approximately 2 million people each year. In 1991, WHO recommended that member states strengthen the institutional capacities of their national tuberculosis-control programs, which were seen as essential tools in the speedy detection and cure of TB.

In 1993, the effort to fight tuberculosis was again given a new urgency when TB became the first disease ever to be declared "a global emergency" requiring a quick and coordinated worldwide response. This declaration was followed by the establishment in 1995 of a worldwide TB surveillance and monitoring program. Its aim was to provide a comprehensive measurement of the effectiveness of TB control on the global level. In 1997, WHO released its first global tuberculosis control report, which has been published on an annual basis since then. Finally, in 2001 WHO launched a new campaign, "Stop TB," which has rapidly developed the global partnership to stop TB. The aim of this partnership is to decrease morbidity and mortality resulting from TB by half by the end of the decade.

Response to the HIV/AIDS Pandemic. The identification of Acquired Immunodeficiency Syndrome (AIDS) in 1981, which is caused by the Human Immunodeficiency Virus (HIV), led initially to the establishment of a small program on AIDS within the Secretariat of WHO. Because there was no effective vaccine against HIV/AIDS, this program was focused on containment rather than treatment of the disease and aimed at coordinating national research on cure development, the dissemination of information about the disease, and its causes and patterns of development. In 1987, the WHO DG began to take a much more robust approach to the rapidly spreading disease and created the Global Program on AIDS, accompanied by the Global AIDS Strategy.

The strategy, like the previous program on AIDS, relied more on preventive measures than on treatment and focused mainly on improving dissemination of information about disease transmission, with educational campaigns addressing safe sexual conduct in the forefront, and on strengthening international research and political cooperation in the fight against the pandemic. World AIDS Day was commenced on December 1, 1988, and has been held on that date every year thereafter. Progress in strengthening multilateral cooperation among international institutions led WHO and UNDP to form in 1988 a common initiative, the Alliance to Combat AIDS. Later, in 1996, the Joint UN Program on HIV/AIDS (UNAIDS) was set up to bring together UNICEF, UNDP, UNFPA, WHO, the World Bank, donor governments, the most HIV/AIDS-affected states, and various NGOs in the fight against HIV/AIDS. This global advocacy coalition adopted the main objectives of the previous WHO Global Program on AIDS and rallied behind two main principles: prevention of HIV transmission through educational campaigns and offers of technical assistance to communities affected the most by the pandemic. In order to fight HIV/AIDS more effectively, WHO introduced internal changes within its Secretariat, consolidated its human and financial resources, and transformed its small unit on HIV/AIDS and sexually transmitted diseases in 2002 into a new HIV/AIDS department within the HIV/AIDS, Tuberculosis and Malaria (HTM) Cluster of the Secretariat. The new department was made responsible for enhancing WHO's overall strategic approach in dealing with the disease by expanding and improving the coverage as well as the impact of WHO technical support in the countries most affected by HIV/AIDS.

From the mid-1990s onward, medical advances such as antiretroviral (ARV) drugs have been slowly shifting the fight against AIDS toward treatment of people infected with HIV. Although ARV drugs do not provide a cure, they

have significantly reduced death rates, prolonging the lives of many and turning this lethal disease into a sickness that people can have and live with for a longer period of time than used to be possible. The shift toward HIV treatment has placed greater emphasis on better distribution and access to affordable ARV medicines, leading WHO to announce, in September 2003, the "3 by 5" target plan—the goal of enabling 3 million out of 6 million people in urgent need of anti-HIV treatment to receive access to ARV therapy by 2005. The "3 by 5 " target required stepped-up efforts to train national medical workers to implement the measures, with a goal of having at least 100,000 trained HIV/AIDS medical professionals worldwide. The plan is viewed as a significant step toward an overall objective of universal access to ARV therapy for all who need it.

The Fight against Noncommunicable Diseases

The Case of Tobacco Control. In recent years, WHO has given strong attention to the campaign to control tobacco use. In 1996, WHA requested the DG to draft a framework convention on tobacco. In May 2003, WHA adopted the Framework Convention on Tobacco Control (FCTC), the first legally binding international treaty negotiated under Article 19 of the WHO Constitution.

The FCTC set a framework to facilitate the development of national tobacco-control legislation. It enumerates measures to decrease both the demand for and the supply of tobacco by stipulating information/awareness-raising campaigns about the dangers of tobacco, encouraging states and others to take criminal and civil liability actions against tobacco industries, and calling for worldwide cooperation against tobacco use, along with support for the development of tobacco-control research and surveillance involving governments and civil society groups. The success of the FCTC may have important ramifications for WHO work, leading the organization to rely more than in the past on international, legally binding instruments in order to enhance the effectiveness of its fight against both communicable and noncommunicable diseases.

WHO Research Activities

WHO as a scientific organization has been in the forefront of research on public health. Its research responsibilities were written into the organization's constitution, where Article 2 stipulated that WHO would promote and conduct research in the field of public health. The constitutional provision became operationalized only in 1959 with the establishment of the Advisory Committee on Medical Research (ACMR), which was renamed the Advisory Committee on Health Research (ACHR) in 1986. ACHR has provided guidance for national and international biomedical research, evaluated and identified new technologies and scientific knowledge that could be utilized in the fight against disease, and exercised control over various research policies carried out by WHO to enhance coordination among different entities.

WHO research activities have been carried out primarily within the framework of two programs: The Special Programme for Research, Development and Research Training in Human Reproduction, established in 1972, and the Special Programme for Research and Training in Tropical Diseases, set up in 1975. These initiatives, though concentrating on different areas of health care, are based on common objectives aimed at broadening scientific knowledge, enhancing the institutional capacities of national health systems, and developing instruments that are more effective in dealing with the identified problems. The strategies to reach these objectives have relied on education, training, and publication of pertinent materials.

Over the years, WHO research activities have also been given impetus by expert committees and study groups run by eminent academic specialists and practitioners from various medical fields. Examples include expert

committees on biological standardization, food additives, malaria, and SARS. The importance of WHO as a research-driven organization was further enhanced in 1998 when the former director general, Dr. Brundtland, established a separate Cluster on Evidence and Information for Policy within the Secretariat. This cluster is responsible for collecting and analyzing data and managing information and research on the performance of health systems as well as studying ways to improve services and delivery mechanisms of health systems. One result of the work of this cluster was a major study on the Global Burden of Disease published in 2000.

The complexity and magnitude of health-related problems that easily crisscross national boundaries has compelled WHO to shift from simple intergovernmental and interstate-based cooperation on research toward global networks. In its research activities, WHO started increasingly relying on global partnerships and networking involving numerous actors, such as policymakers, scientists, health-care providers, clinicians, multilateral institutions, international health research NGOs, and other civil society groups and coalitions engaged in public health studies.

Cooperation with International Groups

Because of the intricacy of health issues, WHO has had to expand its cooperation not only to other multilateral organizations, governments, and coalitions of nongovernmental organizations but also to universities, research institutes, and other societal groups, such as consumer associations, human rights advocacy organizations, and nonprofit international charity foundations (for example, the Rockefeller Foundation and the Bill and Melinda Gates Foundation). During the 1980s and the 1990s, WHO gradually transformed itself from an interministerial and intergovernmental organization to an entity whose global policy agendas are driven as much by governments as by diverse coalitions of private-sector and societal actors. WHO is still de jure an intergovernmental organization, but de facto it communicates, designs, and implements its policies through worldwide, complex, multiactor networks that stretch both vertically, cutting across international, regional, national, and local levels, and horizontally, involving simultaneously various different aspects of public health and forming networks or coalitions of diverse interest groups around each of these concerns.

With a progressing globalization of WHO activities, the organization is entering into closer collaboration with the private sector through public-private partnerships (PPPs). PPPs are seen as providing WHO with specific benefits, such as facilitating universal access to medicine and health services based on substantial reductions in costs; enabling WHO and private-sector entities to share expertise and knowledge on health-related issues; and stimulating research leading to discoveries of new vaccines. At the same time, WHO needs to maintain its integrity and guard itself against partnerships dominated by wealthy corporations that could dictate its priorities and strategies. With WHO policies that increasingly promote reliance on private-sector involvement in the organization's work, WHO needs to find a healthy balance between its public-driven programs and the commercial interests of powerful companies.

WHO's New Objectives

For many years, WHO's guiding principle was "Health for All by the Year 2000," as stated in the Alma Ata Declaration of 1978. In practice, this objective meant that all people should have reached a level of health allowing them to lead socially and economically viable lives by the end of the twentieth century. The goal was to be reached through the coordination of international and national efforts to establish more effective primary health care, particularly in the

developing states. Although health for all was not achieved by 2000, and the phrase ceased to be the organization's main slogan, the principle of health for all continues to be a powerful notion as viewed from a long-term perspective.

WHO draws its new objectives from the United Nations Millennium Development Goals, which call for halving poverty among 1.2 billion of the world's poorest people—those living on less than a dollar per day—by 2015. The UN and WHO see the WHO's work to improve health standards as a cornerstone in this battle. WHO, however, faces a dilemma over what direction it should take to address poverty. By narrowing its focus to the fight against major communicable diseases, WHO seems to have adopted the view and expectations of its major donors. There is, however, a danger that in taking on this agenda WHO could disregard more important instruments of poverty alleviation that, in the long run, could better serve the interests of the world's poorest, such as building effective public health systems, a strategy viewed by many as the key to sustainable improvement and maintenance of appropriate health standards and thus, to progressive eradication of poverty. WHO will therefore need to strike a fine balance in the strategies it uses to realize its new objectives.

Maciej Bartkowski

See Also Pharmaceuticals; Food Safety; Population Growth; Public Health

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