A Special Role for the World Health Organization in the Creation of a Living, Breathing Global Health Governance Constitution

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This article argues for a "living, breathing" Global Health Governance Constitution, which would be initiated by a World Health Governance Forum ("Forum") convened by the World Health Organization (WHO). The content of the new constitution would result from the contributions of the various public health actors. A "Board of Editors," consisting of officials from the WHO and other stakeholders, would then review contributions and produce a non-binding instrument or modus vivendi. *This instrument would be subject to continuous review, with "special temporary revisions" and "opinions" produced on a rolling-basis by the Board of Editors based on open-source contributions and comments submitted by stakeholders. Every year, the Forum would reconvene to comprehensively review the terms of the* modus vivendi. *The "living, breathing" Global Health Governance constitution would complement the existing governance arrangements and offer a structure for current and future action in the field of public health.*

The attainment by all peoples of the highest possible level of health represents a truly noble aim, and it is to this objective that the World Health Organization (WHO) devotes its energy, time and resources. Eradicating disease, advising on health effects, providing life-saving medicines, facilitating access to life-sustaining services, caring for the sick and wounded, creating an environment where people can live good, vibrant, and productive lives—these are the things that bring out the best in humanity. With them, we are able to live *larger* and do *more*.

As the indispensable actor in the field of public health, the WHO contributes to the attainment of this objective in myriad ways. Its universal membership makes it the preeminent venue for intergovernmental relations on issues of health. Its response teams deploy to contain outbreaks of infectious disease and attend to the victims of disaster. Its disease-specific programs take action to eradicate life-threatening illnesses such as HIV/AIDS, tuberculosis, and malaria. Its advocacy and education programs confront chronic disease at all stages of development. Its uniform prescription drug rules ensure consistent access to pharmaceuticals by assigning a single, international name to each chemical compound. Its food safety and medical quality standards protect individuals from ingesting harmful or noxious substances. Its pollution-monitoring mechanisms keep tabs on the natural environment and provide information on corresponding health impacts. Under its Constitution, the organization is charged with no less than twenty-two, clearly articulated functions[1] falling into two broad categories—the direction and coordination of international health work, and technical cooperation with member-states on issues of mutual interest. In this role the organization works tirelessly to deliver health to all humankind.[2]

Despite these praiseworthy aims and ambitions, the complexities of today's institutional health environment pose unique challenges to the WHO's operations. When the organization was formed in 1948, the political structures supporting the institutions of public health could rightly be called *international*. Nation-states served

as the primary units for policy implementation, and national health ministries coordinated with the leaders of the WHO on public health initiatives. Interactions were "relatively simple, with a small cast of actors and [clear] lines of responsibility,"[3] and the WHO was well designed to carry out its missions and mandates. The organization's success in helping to rid the world of polio, smallpox, and onchocerciasis, for example, serve as testimonials to the symbiotic fit between its internal organization and its external operational setting.

Since the end of the Cold War and the emergence of the HIV/AIDS pandemic, however, the structures of public health have changed. The issue has transformed from one of *international* to *global* concern. Nation-states no longer represent the sole, or even the preeminent actors. Alongside national health ministries and international organizations, a number of new entities now exert considerable influence. These include non-governmental and civil society organizations (NGOs and CSOs), such as *Medecins Sans Frontieres*, Partners in Health and Save the Children; public-private partnerships (PPPs) and global funds, such as the U.S. President's Emergency Plan for HIV/AIDs Relief (PEPFAR), the Global Fund to fight AIDS, Tuberculosis, and Malaria, and the International Finance Facility for Immunization; corporations, including large, multinational pharmaceutical companies like GlaxoSmithKline, Merck, and Pfizer, food manufacturers, including Kraft, Nestlé, and Arthur Daniels Midland, tobacco companies, such as Philip Morris, and firms from the extraction and synthetic industries, such as ExxonMobil, DuPont and Sumitomo; philanthropic foundations, such as the Bill and Melinda Gates Foundation, the William J. Clinton Global Initiative, and the Bloomberg Philanthropies.

Despite the proliferation of actors and initiatives, current programs are failing to solve many of the world's global health problems. For instance, numerous global health initiatives have either missed or are missing their targets, including the WHO's "3 by 5" HIV/AIDS initiative and the United Nations (UN) Millennium Development Goals (MDGs). To live up to its lofty aspirations in this crowded, complex, and decentered global health environment, the WHO has had to recognize the necessity of adjusting its *modus operandi*. Recent reform proposals have focused, for instance, on the WHO's role in global health governance (GHG), and in particular on formulating new strategies for facilitating engagement and coherence between and among the various actors. If the WHO is to continue as the vanguard of global public health, it must figure out ways to incentivize the various global public health actors to participate in a cohesive and comprehensive governance system. The WHO can and should orchestrate a process that enables the many different actors to effectively contribute to the health of all peoples, but this will take continuous effort and well thought-out strategies.

In addressing these new demands and challenges, the WHO faces the imperative of reforming how it operates and how it is structured. Many changes are needed and the process must begin immediately. But in recreating itself, the organization should also remain faithful to its core values and objectives. The politicians, diplomats, medical professionals, development experts, business leaders and other members of civil society who came together to create the WHO did so on the belief that they were constructing a new landmark in international cooperation for public health. As Walter Sharp, who served as a staff official to the International Health Conference of 1946, where the WHO was founded, and as an Administrative Consultant to the Interim Commission of the WHO, wrote of the WHO Constitution in 1947:

> The new *Magna Carta* of health, if it receives sustained and generous support from the major countries of the world, and if it succeeds in escaping the curse of bureaucratic timidity, should afford a powerful impetus for progress in man's unceasing struggle against disease, stunted growth, and social maladjustment.[4]

The WHO must recall Sharp's decades old challenge. By acting forcefully in the face of uncertainty and by pushing aside the bureaucratic malaise, the WHO can breathe new life into its operations and reassert itself as the world's leader in global public health.

GLOBAL HEALTH GOVERNANCE

At present the global public health system is defined by a plethora of new actors and processes, greater political recognition, an influx of funding, and an ever broadening set of health challenges. Moreover, the clear lines of responsibility from the era of international public health no longer exist. The new complex, globalized system creates a need for new forms of organization, new rules, new norms, and new expectations. In short, the global public health system needs GHG. The challenge for the WHO has been how, and in what ways, it could take a leadership role in creating system-wide coherence.

A lack of a clear structure is a conspicuous feature of the global health system. The roles played by nation-states, UN organizations, international organizations, NGOs, CSOs, PPPs, and the various funds for instance, are not neatly delineated. Each serves multiple functions: as sources of funding, as originators of initiatives, and as implementers, monitors, and evaluators. Competition among actors and priorities creates additional problems.[5] Funding and initiatives often totally bypass the governments, introducing complications into the national planning and regulatory processes.[6] Some have described the system as "open source anarchy" given the wide array of actors and processes that contribute to the formation of global health policies and agendas.[7]

These dynamics pose particular grand challenges to GHG and the functions of the WHO. These include: the lack of global health leadership; the need to harness creativity, energy and resources for global health; the need for collaboration and coordination of multiple players; the neglect of basic survival needs and health systems strengthening; the lack of funding and priority setting; and the need for accountability, transparency, monitoring and enforcement.[8] It should be noted that each of these challenges is interconnected, and must be viewed within the larger background structure of the global health system as a whole. Therefore, a systemic, multidimensional approach is necessary to adequately and appropriately address each issue.[9]

The WHO leadership and the organization's member-states have been cognizant of the shifting dynamics of the global health system, as well as the operational imperative demanding an active role for the organization in GHG. At the sixty-fourth meeting of the World Health Assembly (WHA), a number of reforms were proposed on the issue of GHG. Specifically, the Director-General identified the objective of "greater coherence in global health," with the WHO serving as the central actor in a process to enable "the many different actors to play an active and effective role in contributing to the health of all peoples."[10]

In a follow-up to the Assembly report, the Director-General submitted a report to the Executive Board titled "*WHO Reforms for a Healthy Future*"[11] in which she further detailed her reform agenda. On the issue of GHG and the WHO's role, she asserted that "the key challenge [is] to determine how WHO can engage with wider range of players without undermining its intergovernmental nature or opening itself to influence by those with vested interests."[12] To respond to this challenge, she suggested that any reform proposals be considered in light of the following principles:[13]

> Retention of the intergovernmental nature of WHO's decision-making;
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> The development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;
>
> Neither increasing engagement nor promoting coherence are ends in themselves: any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity;
>
> Building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes.

In light of these principles, the Director-General made the following proposals to enlarge the WHO's role with respect to GHG:[14]

> **Widen engagement**. In particular this would occur through formal *multi-stakeholder forums* on key issues in global health that would bring together civil society, governments, and the private sector; *separate consultations with different groups of stakeholders*, such as informal working groups made up of stakeholders and WHO representatives that would address specific issues under consideration by member-states; or, finally, consultations through *face-to-face meetings or web-based forums*, in which the role of stakeholders would be restricted to commenting on specific aspects of an issue on which they have particular expertise.[15]
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> **Strengthen coordination**. This would occur in two separate contexts: *strengthening coordination within the UN system* and *strengthening coordination with coalitions and alliances*.[16]
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> **Work in partnerships**. In particular, to increase the membership for WHO representatives in various formal arrangements.[17]
>
> **Develop a framework to guide stakeholder action**. Such a framework could be based either on agreed targets and indicators, or it could be modeled on a "code" or "charter" that sets out rights and responsibilities.[18]

Since the Director-General made her GHG-related proposals in late 2011, the Executive Board has agreed to the principles elucidated in her reports.[19] At the January 2012 meeting of the Board, the Secretariat made two additional proposals for action, which are currently under the consideration of the Board and the WHA:[20]

> To review and update the principles governing WHO's relations with NGOs;[21]
>
> To develop comprehensive policy frameworks to guide interaction with the private, for-profit sector as well as not-for-profit philanthropic organizations.[22]

Summarizing the reform project to-date, it is expected that the GHG-related proposals may eventually result in the establishment of regular consultation with a wide range of partners in global health; the creation of multi-stakeholder working groups and interactive engagements, including a possible *World Health Forum*, convened and/or led by WHO to ensure that all voices are heard; the clarification of roles and responsibilities, with the aims of sharpening the division of labor, avoiding fragmentation, eliminating duplication of effort, and contributing to better health outcomes; and development of a charter or framework for GHG.[23]

A practical impediment to the WHO's effectiveness in driving the development of GHG has been the organization's general lack of supranational powers. Under its Constitution, the WHO has no enforcement capacity. Rather, its functions are to *direct*, *assist*, *report*, *propose,* and *coordinate* issues of international public health.[24] As a result, it usually depends on the cooperation of the member-states and the exercise of *soft power* to implement its proposals and programs.

In an effort to control the outbreak of dangerous pandemics, which is where issues of GHG are often most salient, and in an attempt to assert a greater role with regard to national health initiatives and the provision of health security, the WHO substantially expanded its formal supranational powers in 2005 through the adoption of new International Health Regulations (IHRs).[25] The new IHRs, which went into effect in 2007, were spurred in part by the UN Secretary-General's assertion of the international human right to health in his March 2005 report *In Larger Freedom: Towards Development, Security and Human Rights for All.*[26] Building on this momentum, the IHRs engage both state and non-state actors, address numerous public health threats, and draw together objectives found in multiple international legal regimes, including infectious disease control, human rights, trade, environmental protection, and security, and configure them in a way that has "no precedent in international law on public health."[27] Of particular note, the 2005 IHRs give the WHO the authority to declare the existence of "public health emergencies of international concern"[28] and issue non-binding temporary recommendations to states concerning how they should respond to such emergencies.[29] This moved the IHRs from a limited number of infectious diseases to the broader realm of public health emergencies, and vested substantial supranational power in the WHO Director-General.

The power to declare a public health emergency marked a departure from the previous version of the IHRs, which were first adopted by the WHA in 1969. Under the old IHRs, the refusal of a state to provide information or to cooperate with the WHO

essentially blocked the organization from taking effective actions to address the public health threat. The 2005 IHRs eliminate the ability of a state to veto WHO action on public health emergencies of international concern. States are required to notify the WHO of events that may constitute public health emergencies of international concern[30] but the power to declare such an emergency rests with the Director-General.[31] Importantly, the WHO may also make use of information from non-governmental sources in making its determination about whether a public health emergency exists.[32] This allows the organization to substantially expand its surveillance effectiveness. Once a determination has been made, the Director-General must issue temporary recommendations to states on the appropriate responses and health measures that must be taken.[33]

Despite the increase in its formal supranational power under the new IHRs, the WHO has struggled to implement the regulations effectively. For instance, with regard to WHO's response to the H1N1 ("swine flu") pandemic in 2009, which was widely viewed by critics as overblown, panicked and disproportionate, an independent review committee convened by the Director-General noted that "the influenza pandemic exposed vulnerabilities in global, national and local public-health capacities, limitations of scientific knowledge, difficulties in decision-making under conditions of uncertainty, complexities in international cooperation, and challenges in communication among experts, policy-makers and the public."[34] Based on a thorough analysis, the committee also made three summary conclusions about the functioning of the 2005 IHRs:[35]

- The IHRs helped make the world better prepared to cope with public health emergencies, but the core national and local capacities called for in the IHRs are not yet fully operational and are not now on a path to timely implementation worldwide.

- WHO performed well in many ways during the pandemic, but confronted systemic difficulties and demonstrated some shortcomings, including with regard to the absence of a consistent, measurable and understandable depiction of severity of the pandemic; the failure to form an impartial and effective Emergency Committee (in accordance with Article 48 and Article 49 of the IHRs); and the failure to disseminate accurate technical information and guidance.[36] Despite these failings, the review committee found no evidence of malfeasance.

- The world is ill prepared to respond to a severe influenza pandemic or to any similarly global, sustained, and threatening public-health emergency. Beyond implementation of core public-health capacities called for in the IHRs, global preparedness can be advanced through research, reliance on a multi-sectoral approach, strengthened health-care delivery systems, economic development in low and middle-income countries, and improved health status.

Given these conclusions, it is clear that while the 2005 IHRs may represent a significant improvement upon the pre-existing regime, more time and sustained effort is needed to realize the benefits of the WHO's newfound supranational authority.

A LIVING, BREATHING GLOBAL HEALTH GOVERNANCE CONSTITUTION

The WHO must act to bring greater coherence to GHG. Throughout the world, global health professionals recognize that the proliferation of new actors represents a systematic challenge. This imperative is explicit in the Director-General's proposals, which advocate for wider engagement, strengthened coordination, stronger partnerships, and a framework convention on GHG. This latter item is the most important. By creating a meta-institution of governance, the WHO can bring order to the chaotic environment. This will enable it to engage, coordinate and partner with other actors in a cohesive, non-random fashion. However, the organization must not be dogmatic. Such a meta-institution must provide order to the system without sacrificing the positive aspects of pluralism, flexibility, and fragmentation. A rigid form of constitutionalism, for instance, might have both positive and negative consequences. In order to be effective, the new GHG project must be attuned both to the deficiencies and the advantages of the current global health system.

Existing proposals, including those put forth by the Director-General in her reports attempt to strike a balance between coherence and flexibility. For instance, the Director-General has advocated for increased engagement but has sought to retain intergovernmental control over the process. Other "theories of the whole" reject this dichotomy and advocate for a more inclusive, diffuse governance process. *Shared health governance* for instance, envisions an ethical commitment to health on the part of GHG actors. This theory focuses on principles of justice as the rules of the order. Because no global health *government* exists to enforce these shared ethical commitments, the theory requires a "global health constitution." This constitution need not be written, but instead sets out a "meta-level system of regulation (by self and others) through ethical commitments."[37] Importantly, such a constitution would neither replace nor compete with the WHO Constitution. Rather, the two would be complementary.[38]

Another way to reset the health governance environment is through the formulation of *global health law*. While it does not yet exist, this body of rules would "[encompass] the legal norms, processes, and institutions needed to create the conditions for people throughout the world to attain the highest possible level of physical and mental health."[39] It seeks to facilitate health-promoting behavior among the key actors that significantly influence the public's health, including international organizations, governments, businesses, foundations, the media, and civil society. In an ideal environment, the mechanisms of global health law would "stimulate investment in research and development, mobilize resources, set priorities, coordinate activities, monitor progress, create incentives, and enforce standards."[40]

Attention should also be paid to the metaphors that are being used to visualize the GHG system. The usual vernacular focuses on "structures" and "mechanisms," which brings to mind the "architecture" of GHG. Perhaps a better way to think about GHG is through a "source code"[41] metaphor, where each actor shapes the governance environment through his or her contributions and inputs, similar to open-source computer software. The resulting "code" would contain the "normative policy reasons why global health is important to protect and promote."[42] States, intergovernmental organizations, and private actors would then "apply the source code in diverse political,

economic, and epidemiological contexts, producing different global health 'software programs' designed to address particular problems."[43]

Each of these "theories of the whole" represents an attempt to solve the fundamental problems GHG. Given the nature of the global health system, the revitalized GHG framework must enfranchise both private and public sector actors. Formal inclusivity, however, is not enough. The GHG structure must also be flexible enough to react to changing conditions on the ground. This requires an institution of governance that is dynamic and subject to continuous revision. Finally, the governance arrangement must create incentives for voluntary participation. Non-governmental actors must believe that they are better off cooperating in the GHG system. Operationalizing these three strategic imperatives yields the following novel proposal—call it *The Living, Breathing GHG Constitution.*

Leveraging the WHO's existing institutional advantages, including its power to convene, its significant reservoirs of technical and scientific expertise, and its normative strength, the *Living, Breathing GHG Constitution* will result from a series of sequential steps.

> STEP 1: The WHO convenes a multi-stakeholder *World Health Governance Forum* (Forum) that is "open to all GHG stakeholders" with the goal of deciding on a framework convention applicable to GHG.
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> STEP 2: The stakeholders "open-source" the framework convention for a set amount of time (*e.g.* 6 months) filling it in with specifics; these suggestions are submitted to a "board of editors," which could be a subcommittee of the Forum[44] or a working group convened by the WHO Secretariat. The important element is that the board of editors is representative and renowned, and that it includes WHO staff members, civil society, and private sector representatives, and intergovernmental officials.
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> STEP 3: The editors review the open-source contributions and produce a "global health constitution." While *non-binding,* this instrument serves as the guiding set of meta-rules (the *modus vivendi*) for one calendar year, at which point it is reopened for comments. Mechanisms might also be developed for "special temporary revisions" that are proposed by the editors. Finally, editors might be available to offer selected "opinions" on GHG questions that will be published on a publically available website.
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> STEP 4: The process repeats itself every year, with one month (*e.g.* January) set aside for commentary, revision and the convention of a Forum, followed by the production of a revised global health constitution.

The attributes to this proposal are numerous. At the outset, it avoids many of the problems of prior governance proposals because it does not attempt to formalize relationships between private and public actors. Rather, the goal is *inclusion* of these various actors in a collaborative process, and the *institutionalization* of the relationships that already exist. For instance, WHO officials and Gates Foundation representatives

already collaborate on a variety of projects, but many of these interactions take place on an *ad hoc* basis. By creating an umbrella *modus vivendi* both the WHO and the Gates Foundation will be able to ground their interactions in a normative, pluralistic, and operationally realistic order. Rather than reacting to different dynamics within the global health system, or recreating relationships in response to emergencies, the new GHG constitution will frame the responses to issues ahead of time, offering a preset structure within which the different actors can pursue their projects. In effect this will serve as a supplement to existing institutions, such as the IHRs, which have been slow to respond to exogenous shocks to the system.

The non-binding nature of the project is also one of its strengths. It will only work if actors believe in its merits and possibilities. By sticking to the structure of a *modus vivendi*, as opposed to a formal intergovernmental agreement, the *Living, Breathing GHG Constitution* cuts down on transaction costs and emphasizes effectiveness. Rather than replacing the WHO Constitution, the resulting arrangement will fill the interstices in the existing order.

The proposal will also lead to the centralization and progressive development of GHG expertise. By bringing together individuals whose sole mission is the development of a cohesive GHG system, the editorial board will serve as a nexus for the formation of a new epistemic community of health governance experts. This community will provide advice, interpretations, and information on the vast uncertainties of the GHG system.

Finally, the proposal is eminently flexible. It has within it mechanisms that can be used to constantly update and revise its provisions. The annual Forum, the "special temporary revisions" and the request for "opinions" can all be conscripted to drive the *Living, Breathing GHG Constitution* in whatever direction the global health community wishes it to go. Refreshing Walter Sharp's challenge from six decades ago, if this new constitutional project receives sustained and generous support from the major global health actors of the world, and if it succeeds in escaping the curse of bureaucratic timidity, then it should afford a powerful new impetus for sustained progress in humankind's unceasing struggle against disease, stunted growth, and social maladjustment.[45]

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[1] *See* Constitution of the World Health Organization, art. 2.
[2] *See* Constitution of the World Health Organization, *Preamble*.
[3] Nora Ng and Jennifer Prah Ruger, *Global Health Governance at a Crossroads*, 3(2) GLOBAL HEALTH GOVERNANCE 1, 2 (Spring 2011).
[4] *See* Walter Sharp, *The New World Health Organization*, 41 AM. J. INT'L L. 509, 530 (1947).
[5] *See* Ng and Ruger, *supra* note 3, at 2-3.
[6] *Id.*
[7] *See* David Fidler, *Architecture amidst Anarchy: Global Health's Quest for Governance*, 1(1) GLOBAL HEALTH GOVERNANCE 1, 2 (Spring 2007) [hereinafter *Architecture amidst Anarchy*].
[8] These challenges are discussed and analyzed in Lawrence Gostin and Emily Mok, *Grand Challenges in Global Health Governance*, 90 BRITISH MEDICAL BULLETIN 7 (2009).

[9] *Id.* at 9.
[10] World Health Organization, World Health Assembly, Report of the Director-General, *The Future Financing for WHO*, A64/4 (May 5, 2011) [hereinafter *The Future of Financing for the WHO*].
[11] World Health Organization, Executive Board, Report of the Director-General, *WHO Reforms for a Healthy Future*, EBSS/2/2 (Oct. 15, 2011) [hereinafter *WHO Reforms for a Healthy Future*].
[12] *Id.* at 87.
[13] *Id.*
[14] *Id.* at 88-97. These proposals are also succinctly summarized in the Director-General's remarks to the Executive Board on the issue of GHG-inspired reforms. *See* World Health Organization, Executive Board, *Governance: Introductory Remarks by the Director-General*, EBSS/2/INF.DOC./11 (Nov. 2, 2011).
[15] *See WHO Reforms for a Healthy Future*, *supra* note 13, at 88-91. Such consultations could be open to all or limited to particular stakeholders. These types of engagements are sometimes called the "PIP model" after the WHO Pandemic Influenza Preparedness (PIP) program, which brought together member-states, industry representatives, other key stakeholders and the WHO to implement a global, member-state developed approach to pandemic influenza preparedness and response. The PIP program became operational on May 24, 2011.
[16] *See id.* at 92-95. With regard to *strengthening coordination within the UN system*, the Director-General suggested that the first priority is to ensure that the issue of health is actively supported and well-represented in the UN General Assembly and other intergovernmental *fora*. In addition, she suggested that the WHO should focus on high-level coordination through the Chief Executives Board for Coordination, the High-Level Committee on Programmes (HLCP), and the High-Level Committee on Management (HLCM). Finally, she advocated for increased support by WHO to UN Country Teams. In the context of *strengthening coordination with coalitions and alliances*, the Director-General recognized the importance of coordinating with the various non-UN health actors, including funds, development banks, foundations, CSO, NGOs and private entities. Her proposals included forging new alliances from existing mechanisms at both the global level, including through the Inter-Agency Standing Committee health cluster and the Fourth High-Level Forum on Aid Effectiveness and at the local level, including through the Health and Harmonization in Africa program and the International Health Partnership.
[17] *See id.* at ¶96. For instance, independent entities might include the WHO as part of their governance bodies. The WHO could then leverage that presence to drive the work of the partner organization in particular directions. Other partnerships that include independent entities might also be hosted by the WHO. The thrust of the proposal is that the WHO can and should play an important role the various partnerships that exist in the global health system. The idea is that the organization's presence in various partnerships, combined with a strategic plan of action, will bring greater coherence to the global health system.
[18] *See id.* at ¶97. In her report, the Director-General suggested that "in the longer term" a framework for guiding the interactions of the different stakeholders could be developed.
[19] *See* World Health Organization, Executive Board, *Special Session on WHO Reform*, EBSS/2/DIV/2 (Nov. 7, 2011) at 2.
[20] World Health Organization, Executive Board, *WHO Reform, Governance: Promoting engagement with other stakeholders and involvement with and oversight of partnerships, Report by the Secretariat*, EB/130/5 Add.4 (Dec. 27, 2011) at 14.
[21] The review will consider widening and improving the modalities for the participation of nongovernmental organizations at regional and global governing body meetings; seeking the views of nongovernmental organizations in the development of new health policies and strategies; and updating practices and criteria for accreditation. *Id.* In relation to the last point, the review will consider ways of differentiating between the different types of NGOs that interact with WHO. *See id.*
[22] The proposed frameworks should, *inter alia*, tackle the issue of institutional conflicts of interest. *See id.*
[23] World Health Organization, *WHO: Reform for a Healthy Future: An Overview* (July 20, 2011).
[24] *See generally* Constitution of the World Health Organization, art. 2.
[25] In accordance with Article 22 of the WHO Constitution, IHRs, which are adopted by the WHA, enter into force for member-states after due process has been given of their adoption, unless a member-state enters a reservation. The presumptively binding nature of the IHRs gives the WHA the power to drive the content of member-states' positive obligations. All 194 current member-states are parties to the 2005 IHRs.

[26] United Nations, Report of the Secretary-General, *In Larger Freedom: Towards Development, Security and Human Rights for All*, A/59/2005, (Mar. 21 2005) at 64 [hereinafter *In Larger Freedom*].
[27] David Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4(2) CHINESE J. INT'L L. 325, 326 (2005). Fidler adds that "[t]he manner in which the new IHR involve a range of actors, apply to diverse health threats and incorporate public health, economic, human rights, environmental and security concerns reveals an approach to global governance that echoes constitutional law perhaps more than international law." *Id.* It should be noted that the process of revising the IHRs began all the way back in 1995, when the WHA adopted a resolution calling for the revision and update of the regulations. *See* World Health Organization, World Health Assembly, *Revision and Updating of the International Health Regulations*, A48/7 (May 12, 1995). The Severe Acute Respiratory Syndrome (SARS) outbreak in China in 2003 also served as an important impetus for the project. *See* Gian Luis Burci and Riikka Koskenmäki, *Human Rights Implications of Governance Responses to Public Health Emergencies: The Case of Major Disease Outbreaks*, *in* ANDREW CLAPHAM, et al. (ed.), REALIZING THE RIGHT TO HEALTH (2009) at 346-47.
[28] International Health Regulations (2005) at art. 12. The IHRs define "public health emergencies of international concern" as "an extraordinary event which is determined, as provided in [the IHRs]: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response." *Id.* at art. 1.
[29] *Id.* at art 15.
[30] *Id.* at art 6.
[31] *Id.* at art 12.
[32] *Id.* at art. 9.
[33] *Id.* at art 15. In determining whether a public health emergency exists, the Director-General must first consult with the state in whose territory the event arises. If the Director-General and the state agree that a public health emergency exists, then the Director-General shall seek the view of the "Emergency Committee" established under Article 48 of the IHRs on temporary measures. If the Director-General and the state do not agree within 48 hours, then the Director-General shall make a determination in consultation with the Emergency Committee in accordance with Article 49 of the IHRs. *See id.* at art. 12, 48 and 49.
[34] World Health Organization, World Health Assembly, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009*, A64/10 (May 5, 2011) at 6.
[35] *Id.* at 128.
[36] For a full list of the WHO's failures with respect to the H1N1 pandemic *see id.* at 132-33.
[37] Jennifer Prah Ruger, *Global Health Governance as Shared Health Governance*, J. EPIDEMIOLOGY AND COMM. HEALTH 5 (Dec. 14, 2011).
[38] *See id.* at 5.
[39] Lawrence Gostin and Allyn Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 55 (2008).
[40] *Id.*
[41] *See Architecture amidst Anarchy*, *supra* note 9, at 2.
[42] *Id.* at 15.
[43] *Id.*
[44] This tracks an interesting proposal for a WHA "Committee C" that would address GHG issues for the WHO. The WHA already has two committees (A and B) that address managerial and operational issues for the WHA. *See* Ilona Kickbusch, Wolfgang Hein and Gaudenz Silberschmidt, *Addressing Global Health Governance Challenges through a New Mechanism: The Proposal for a Committee C of the World Health Assembly*, J. OF L. MED. AND ETHICS 550 (Fall 2010).
[45] *See* Sharp, *supra* note 6, at 530.