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Summary

The purpose of this paper is to investigate the extent to which the change of leadership in the WHO in 1998 has increased the problem solving capacity of the organization and thereby provided the basis for increasing the effectiveness of the WHO. Effectiveness is discussed primarily in relation to the *output* produced by the organization, that is which initiatives, programs and decisions have been taken by the new regime. Ideally we would have focussed on the outcome and impact produced by the WHO. However, these measuring rods have been discarded for methodological reasons. Leadership is discussed in relation to an internal and an external dimension. Internally we study primarily the ability of the new regime to unify the previously fragmented regime both in relation to the Headquarter as well as in relation to the Regional Offices. Externally we study the 'reaching out strategy, cooperation with other relevant international agencies and the related issues of external fund raising and high level agenda setting. The new regime has been highly successful externally and the role played by the new Director-General, Dr. Gro Harlem Brundtland has been crucial for this performance. It is important to note, however, that the WHO has worked *jointly* with other agencies along this dimension. Internally the picture is more mixed, especially regarding the situation at the Headquarters in Geneva. Still, overall the WHO stands forth to day as a more vital and visible organization than it did in 1998, and leadership has played an important part in this development. However, it is important to note that the role of leadership is limited by severe structural constraints within the UN family. 'Good' leadership is therefore no 'miracle cure' to lacking effectiveness within the UN system, but it may play a small but important part.

Lysaker, November 2002

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[1] Stig Schjølset provided very useful assistance and collected and systematized material for this study until he left for the Ministry of the Environment in June 2000.

Contents

1 Introduction

The multilateral institutions have been criticized for lacking effectiveness and the call for UN reform has been high on the agenda over the last decade. The present UN General Secretary has made this one of his top priority issues. There may be a number of reasons for lacking effectiveness and weak leadership may be one (Kapur, 2000). One of the multilateral organizations under heavy fire during most of the 1990 for lacking effectiveness and weak leadership was the World Health Organization (WHO). The *Economist* (9 May, 1998) wrote just before Dr. Brundtland took position as new Director-General:

> The WHO is about to be given a much-needed kick in the backside. If the job had been advertised, the prospectus would have read something like this: The client is a fifty year old multilateral concern that was once the global leader in its sector. Recently, however, it has lost its direction.

Good leadership is a necessary, but not sufficient condition to enhance the effectiveness of an international organization. Against this backdrop, the goal of this paper is to discuss the effect of the new leadership of the WHO established during the summer of 1998 when Dr. Gro Harlem Brundtland was elected as the new Director-General. Considering her reputation, experience and professional background, it was believed that few would be in a better position to reform the WHO. This makes it an ideal case to study the possibilities and limitations for reform that exist through changing the leadership of UN agencies.

As shall be elaborated further below, expectations should not be too high as to what can be achieved through leadership alone. Second, the new leadership has not yet finished its first five-year term – so the timeframe is too short to pass any conclusive judgements.[2] Third, it is not self-evident that findings from this UN organization can be generalized to other parts of the UN family. Still, we believe this case study will shed some light on the significance of leadership in international organizations generally, as well as add some insight on whether leadership change is a way to enhance the effectiveness and reputation of the multilateral institutions.

With this caveat, the paper is organized in the following way. First we give a brief outline of some theoretical and methodological considerations regarding the assessment of the effectiveness of international organizations. We then turn to the concept of leadership before giving a brief outline of the history of the WHO and the organizational set up. Next we discuss some of the changes that have been brought about in the WHO as a result of the new leadership, before we evaluate the effect of the new regime along various dimensions.

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[2] We cover the period from the inauguration of the new team and roughly into the summer of 2002. The interviews for this study, however, crucial for the conclusions drawn, were conducted between February 2000 and May 2001, with some follow up later on.

2 The Effectiveness of International Organizations

A first challenge is to find out how to measure the success or failure of an organization, to assign a score to the *dependent* variable. As a point of departure we rely on the conceptual framework developed in relation to the study of the effectiveness of international regimes.[3] The key question we want to answer is whether or not an organization is able to solve the problems that caused its establishment. One way to approach this question is to start by looking at the *goal* of the organization. Unfortunately this is often so broad or ambitious, that little guidance is provided. Consider for example that the goal of the WHO is 'the attainment by all peoples of the highest levels of health'. One does not need to be an expert on global health problems to know that the health situation for a large portion of the world's population is rather poor. On the other hand, there are other indicators showing that the health of the world population is improving. In the early 1950s the average life expectancy was about 46 years; in 1996 almost 65 years, an increase of more than 40%. The WHO has probably contributed significantly to this development through disease prevention and control, establishing standards and norms for health products and through assistance to national governments. Still, it would be just as misleading to give the WHO the main credit for this development as it would be misleading to give it the blame for the many remaining heath problems of the world.

The main methodological problem with this approach is the fact that we are rarely able to trace the causal links from the organization to the problem(s) at hand, as a number of other causal agents are bound to play a role. This is highly relevant for the WHO, as health is the responsibility of the national governments in any given country, and the WHO only has an advisory role. Broader technological and economic developments also make a difference for the development of health. Finally, there are multitudes of other international organizations working with, or having an impact on health issues. More recently there are few major programs initiated and run by the WHO alone.[4] To single out the role of the WHO would not only be virtually impossible, but perhaps not very meaningful either. In short, although the *impact* of the organization on the problem at hand is really what we would like to know, it is very difficult to measure in practice.

An alternative and somewhat less methodologically demanding indicator is to study the relevant organization as a causal agent in changing the behavior (*outcome*) of relevant target groups. If we can substantiate that the behavior of target groups is moving in the 'right' direction because of the organization, we would say that it was quite effective. This indicator can be used through careful process tracing, but the challenge of causality looms large here as well. While this approach is relevant to the WHO in instances where behavior of target groups

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[3] For the most recent major contribution, see Miles et al., 2001.

[4] This was a different story some decades ago. One example would be the Malaria Eradication Program, launched in 1955. The best known example of a successful program is the eradication of small pox. (Peabody, 1995:736).

matter, like smoking and HIV/AIDS, in other cases it is less relevant, for example in connection with large vaccination programs.

A third indicator of effectiveness deals with the *output* (decisions, programs) produced by an organization. This indicator is the least demanding to apply in methodological terms, but it has the least to say about whether or not the organization is truly effective. An important distinction is between internal procedural decisions relating to for example reorganization and substantive decisions relating to the adoption of new programs. Let us illustrate the relation between the three indicators in relation to the tobacco problem. First a *decision* needs to be made to fight the use of tobacco and to establish relevant programs to achieve this (output); usually a necessary, but not sufficient condition in order to *reduce* (outcome) the use of tobacco – a step on the long way to *eliminate* (impact) the problem. In this paper we will deal mostly with this last indicator; that is various procedures, programs and decisions adopted by the new regime in order to provide the basis for increased effectiveness. The main reason is that it would take more resources than we have at our disposal to use the other indicators, due to the considerable methodological challenges outlined above.

Next, how do we *explain* the effectiveness of an organization and what role does leadership have in the overall question of explaining the success or fiasco of an organization?

3 The Significance of Leadership

What is the significance of leadership in a broader explanatory perspective of explaining 'success' or 'failure'? Two different explanatory perspectives have been suggested (Miles et.al, 2001) One is the *nature of the problem* perspective; the more difficult the problem, the harder it will be to solve. In itself this is a trivial observation, but it is often forgotten when comparing achievements of organizations. In general, global health issues represent very *malign* problems, not the least because the most severe health problems are deeply embedded in the problems of poverty. That is, the problems facing the WHO and related agencies are complex long-term issues and expectations for swift positive changes should not be too great. Although this perspective provides an important realistic benchmark when assessing the effectiveness of the WHO, the alternative *problem solving* perspective is more directly relevant. That is, problems can be attacked with different institutional and political skills and energy, and leadership has been identified as one component in this way of explaining institutional effectiveness. Within this perspective it is important to bear in mind differences in institutional strength between organizations. Organizations with broad goals, universal membership and which are de facto consensus-based will normally stand less of a chance to be effective compared to smaller regional organizations composed of wealthy countries. On one end of such a continuum would be the EU; on the other end are UN bodies like the WHO. Consider also that leadership is only one component in explaining performance.[5] Therefore a change of leadership can hardly be expected to be a 'miracle cure' in WHO or any other similar organizations. This does not indicate that its significance is trivial, but any evaluation should be in the context of real world constraints and not some kind of lofty ideals. The tendency on the part of some analysts to compare actual (modest) achievements with wildly ambitious goals and thereafter conclude that organizations are ineffective, does not add much new insight. One has to control for the problem at hand as well as for institutional limitations.

We see leadership as one mechanism to enhance the problem solving capacity of the WHO, but how do we define leadership; what are the various mechanisms for exerting it; and what indicators of leadership are suitable in our context? Finally a brief account will be given of the sources used to decide whether and how leadership has been exerted.

According to the *Blackwell Encyclopedia of Political Science,* leadership may be defined as

> the power of one or a few individuals to induce a group to adopt a particular line of policy.

According to the *Dictionary of Policy Analysis,* leadership is what

> enables an individual to shape the collective pattern of behavior of a group in a direction determined by his or hers own values.[6]

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[5] The institutional structure of the organizations and the distribution of power among the actors have been identified as other indicators. Miles et al. (2002).

[6] These definitions are borrowed from Malnes, 1992:7.

These definitions confine leadership to *individuals* and the *relational* aspect between leaders and followers is stressed. They are different in the sense that one relates leadership to power, the other to values. This difference has implications for the various types or mechanisms of leadership that are commonly used in the study of international relations. The following general mechanisms have been identified: *power- based* leadership, *instrumental* leadership and *intellectual* leadership (Underdal, 1991, Young 1991). Considering that we are contemplating the leadership of an international organization, instrumental and intellectual leadership seems most relevant. However, power-based leadership may *indirectly* be relevant through alliances between the WHO Secretariat and powerful states. Intellectual leadership may be an important way of introducing new concepts and approaches and thereby contribute to institutional growth. An instrumental leader seeks to find the means to achieve common goals and convince others about the substantive merits of the specific diagnosis he offers or the cure he prescribes (Underdal, 1991). It is a function of an actor's position, skill and energy. These leadership mechanisms have been defined in relation to international politics, and particularly international negotiations. What additional insight can we get from the discussion of leadership from other arenas?

Studies of leadership in business and management theory are of limited use in our context.[7] A classic on leadership, Selznick (1957), is more relevant in discussing 'institutional leadership' in large-scale organizations. His categories can be regarded as a specification of the broader category of instrumental leadership mentioned above. Space does not allow us to pursue all types of institutional leadership identified (Selznick, 1957:62). First he points to the importance of the leader's ability to *define the institutional mission and role*, as set by internal and external demands. Next, Selznick points to the *institutional embodiment of purpose.* The task of leadership is not only to make policy but also to build it into the organization's social structure. That is, leadership goes beyond narrow efficiency when it sets the basic mission of the organization and when it creates a social organism capable of fulfilling that mission. The attainment of efficiency, in the sense of transforming a basically inefficient organization into one that runs according to modern standards, may itself be a leadership goal. But the task as he defines it is a creative one, a matter of reshaping fundamental perspectives and relationships. When the goals of the organization are clear-cut, and when most choices can be made on the basis of known and objective technical criteria, the engineer rather than the leader is called for.[8] Considering the type of organization that WHO is, it is clearly a true leader that is called for, not the administrator. Where does this leave us in terms of more specific indicators of leadership? [9]

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[7] Much of the literature gives practical advice to the good leader – 'think creative', 'work in team', 'create enthusiasm', 'delegate responsibility', etc.

[8] See also Bass and Aviolo, 1994.

[9] In an interview the DG claimed that the standard setting role of the WHO was its most important function, Naim, 2002.

Almost thirty years ago it was claimed that the following three factors were crucial for WHO's performance: 'the quality of the DG, the attitude of the leading states, and the quality of the organizational elite' (Jacobsen, 1973). These factors are still probably valid, and although we do not use exactly the same indicators, we attempt to shed light on them. Two sets of indicators are used: WHO in its *external* relations and WHO *internally.*[10] The internal dimension deals with whether or not the new leadership has been able to give the organization a common institutional mission and role, to make the WHO one unified organization, both at the headquarters in Geneva as well as in relation to the six regional offices. This has been a declared goal of the new regime. This twofold internal indicator is hard to measure precisely. We have added a 'harder' indicator: the level of funding, as it has been an important goal for the new leadership to improve the funding of the organization, as a means to improve its effectiveness. This brings us over to the external dimension, as the WHO has an internal (UN) budget as well as extra budgetary funding. What is the 'score' of the new regime here? Another explicit goal of the new team has been more extensive co-operation with other relevant international organizations through its '*reaching out strategy*', as a means to attack health problems more effectively and with greater institutional energy. This strategy relates to other members of the UN family and non-governmental organizations as well as private companies. Finally, has the new team been able to bring health issues higher on the international agenda, since this assumedly also is a prerequisite for greater effectiveness. In line with Jacobsen (1973), the 'score', especially on the external indicators, is likely to depend on relations to key actors like the US and the EU, and this will be touched upon.

How do we 'measure' the extent of leadership along our dimensions?[11] In addition to traditional primary and secondary written sources, we have relied quite heavily on interviews. We have emphasized getting the viewpoints of key officials in various positions and with differing interests in relation to the new leadership team. At the headquarters in Geneva we have made interviews at the senior policy level as well as at the cluster director level. Some of them also served under previous DG's and should be in a good position to evaluate the present team in a comparative perspective. Very valuable information has also been obtained from the Communication Advisor to the present DG, who follows the day-to-day business closely. Key officials previously associated with the new team have also been interviewed. As a point of departure, these persons can be expected to speak more freely than those presently in position. We have also spoken with representatives of three of the six Regional Offices as well as one representative of the country offices and representatives of some key partners to the WHO. However, considering the complexity of the questions we aspire to answer, this is a

[10] In her inaugural speech to the WHO staff 21 July 1998, the new DG split the goals and challenges into one internal and one external dimension. The external dimension deals roughly with the 'reaching out' strategy, while the internal dimension deals with pulling WHO together, creating a flatter structure, more transparency and less bureaucracy. We have chosen slightly different, but somewhat easier measurable indicators.

[11] As Young (1991) has observed, leadership may well be exerted without achieving the goals aimed for. However, we have chosen to concentrate primarily on attempting to establish causal links between leadership and output.

small and not necessarily representative sample of respondents. Other indicators and other respondents may have given a somewhat different result. Still, although no firm conclusions can be drawn, we expect to illuminate the questions asked and believe the overall trend portrayed to be valid.

In sum our point of departure is that leadership is one possible mechanism to enhance the problem solving capacity of the WHO and thereby its effectiveness. More specifically, our assumption is that if the new team has contributed to a more unified organization, improved its economy, cooperated more with relevant actors and contributed to get health higher on the political agenda, this may contribute to enhancing the effectiveness of the WHO. As leadership is only one indicator deciding the success or failure of an organization, and since the WHO is a consensus driven, large and complex organization, expectations as to the effect of leadership should be modest. Finally, the difficulty in establishing causality looms large in any discussion of the effect of leadership.

4 History, Organizational Structure and the Role of the Director General

4.1 A Brief History of the WHO

The initial proposal for a World Health Organization was forwarded by Brazil and China at the United Nations Conference on International Organization in 1945. A year later, at an International Health Conference in New York where all the 51 members of the United Nations were present, the WHO constitution was signed. This constitution came into force on 7 April 1948, when the required 26 ratifications were achieved. The 7th of April is now marked as the World Health Day each year.

The main objective of the WHO, as it was defined in the constitution is 'the attainment by all peoples of the highest possible levels of health'.[12] Neither this general objective nor the more specific functions assigned to the organization, caused much controversy among the member states. Achieving consensus over the organizational structure proved more difficult, especially the question of the status of the regional organizations. Before the establishment of the WHO, a number of regional health organizations already existed – most notably the Pan American Sanitary Organization. Although there was general agreement that existing regional organizations should be brought in line with the WHO, there was considerable controversy concerning the degree of their autonomy (Jacobsen 1973:177).

After prolonged deliberations, a rather vaguely formulated compromise was reached: the regional organizations were to be 'integral' parts of the WHO, and existing organizations like the Pan American Sanitary Organization 'shall in due course be integrated in the organization'. These formulations made it possible to reach an agreement on the constitution, and further discussions could be carried out within the various institutions of the WHO. By the end of 1951 regional organizations were established in six geographical areas.[13] The organizational shaping of the WHO was then completed, and only minor adjustments have taken place at later stages (Siddiqi 1995:68). As we shall explain later, however, the relationship between the regions and the headquarters in Geneva has not always been smooth.

The ambition of universal membership has made it crucial for the WHO to deal with any problems over membership in a flexible and pragmatic manner.[14] This goal was strongly

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[12] The WHO constitution defines health 'not merely the absence of disease' but as a 'state of complete physical, mental and social well-being' (WHO Constitution, World Health Organization, Geneva).

[13] The six regions are the Eastern Mediterranean Region, the Western Pacific Region, the Southeast Asia Region, the European Region, the African Region and the American Region.

[14] One example is the American entry into the WHO. The US required that it should be able to withdraw from the WHO on a year's notice, a reservation that was significant in light of the absence from the WHO constitution of any provision for terminating membership. Nevertheless, at the WHA in 1948 the US was admitted as a full member of the organization. To some extent, this reflected the importance attributed to US participation, both politically and financially. In addition, the pragmatic attitude of the WHA was probably a

emphasized by the organization's 'founding fathers' and also written into the WHO Constitution in 1948. Some fifty years later, it is safe to conclude that this aspiration has been achieved. From the 26 members in April 1948, the number increased rapidly to 74 in 1950, twelve more than the United Nations proper. The difference between the WHO and the UN memberships continued to increase during the following years, and in 1954 the WHO had 81 members – nineteen more than the UN. This year marks the greatest difference in size between the two, but WHO remained the larger of the two also in the following decades. When the organization celebrated its 25th anniversary in 1973, the WHO had 138 member states, and when it turned 50 in 1998, 191 countries had joined the organization The dramatic increase in membership in the WHO, as well as in the UN system in general, reflects the increasing number of states in the world. Thus WHO is, of course, now a much more complex organization, consisting of states with highly different needs and interests. Considering the organizational structure with six regional offices as well as a number of country offices, it has been claimed that the WHO is one of the most complex UN organizations

The WHO was designed according to the functionalist ideas which were very influential in the early post-war years. In short, functionalism is based on the belief that politics can be segregated from the technical or apolitical work of an organization like the WHO.[15] As the early problems related to the decentralized structure of the organization had seemingly been solved, the medical experts felt that the organization could embark on the more important and apolitical technical issues (Ibid.124). Overall, the development in the WHO has been an example of a UN agency that – at least in most areas – has avoided politicization of its work and organization.

Nevertheless, the development has been characterized by the formation of different alliances or blocs within the organization – regional as well as political. As we shall see below, the WHO as other international organizations also mirrors the political controversies in the outside world, not the least in questions dealing with membership.

The first example arose already a year after the organization came into being. In 1949 the Soviet Union surprisingly announced that it no longer considered itself a member of the WHO. A 'domino effect' and a long series of withdrawals from socialist countries followed. The Soviet and its allies claimed that the reason was the discriminative attitude from the other member states, and that the organization had not responded to their actual needs. In a broader context, withdrawal of the socialist states from the WHO was a part of international developments and the Soviet perception of the UN agencies as 'enemy tools in the Cold War' (Dallin 1962:64). The official WHO reaction was very subdued: a World Health Assembly (WHA) resolution urged the 'inactive members' (the constitution did not provide for withdrawal) to reconsider their decisions and resume active participation. This was also what

consequence of the dominance of medical doctors who preferred practical solutions to any strictly legal considerations (Siddiqi 1995:104).

[15] See for instance David Mitrany (1971) for an interesting presentation of the functionalist approach to international organization.

happened. After Stalin's death in 1953 the Soviet foreign policy became less hostile to the UN system, and Soviet participation in international organizations expanded markedly in the post-Stalin era. In 1955 the Soviet resumed its membership, and the rest of the socialist did the same in the following years (Siddiqi 1995:108).

While the socialist countries were 'boycotting' the WHO, the organization was almost totally dominated by the Western countries. This dominance was further strengthened by the exclusion of the People's Republic of China in 1952 when it was decided that Taiwan should represent China. This situation continued for over twenty years. However, as the Western dominance in the organization gradually became diluted, partly by the re-entry of the socialist countries, and partly by a growing number of developing countries, the WHA's attitude to this issue changed as well. In 1971 the situation was thus reversed, and the government of the People's Republic became China's only legitimate representative in the WHO.

The action against China is one of very few examples of the 'politics of exclusion' in the WHO. Another well-known case is the suspension of South Africa in 1964, just after the South African government declared apartheid to be its official policy. The WHA referred to this as a 'special circumstance of failure to adhere to the humanitarian principles governing the World Health Organization', and decided to deprive the Apartheid State of its voting privileges in the organization. South Africa thus withdrew from the WHO, and became an inactive member until 1994 when it again was restored to full membership rights.

The most troublesome and politicized membership issue in recent years has clearly been the Palestinian State's application for membership. In 1988 the PLO declared the formation of a Palestinian State in the occupied West Bank and Gaza. When the PLO applied for WHO membership a year later, ninety-eight countries had already recognized the self-proclaimed state. The application was, however, met with strong reactions, in particular by the US who threatened to withdraw US funds from the organization. The WHO's Director-General, Hiroshi Nakajima, also stated that it was 'most inappropriate' for the PLO to put WHO programs in jeopardy by making the organization its first target in a drive to win international recognition of its proclamation of statehood (Siddiqi 1995:115). After a highly politicized and high-tempered debate in the WHA the whole issue was deferred. As a concession to PLO and its allies, a detailed study of its request for leadership was to be conducted – a study which was issued against strong objections from Israel and the US. Ten years later, the Palestinian State is still not a WHO member.

Still, in comparative UN terms, the WHO has avoided the paralyzing polarization characterizing many UN bodies, although as we have seen time and energy have at times been used more on political than on health issues. Let us turn then to the organizational set up of the WHO.

4.2 Organizational Structure[16]

As envisaged in the constitution, the central organs of the WHO are the World Health Assembly, the Executive Board, and the Director General and his or her Secretariat. Delegates representing all member of the WHO compose the Assembly. It meets annually and makes decisions on 'important questions' by a two-thirds majority and on other matters by simple majority. Each member state has one vote. As with the General Assembly, the egalitarian structure of the Assembly in the WHO makes it a favorite organ of weak states, because it gives them influence over decisions that they lack in other forums (Siddiqi 1995:83). The Assembly also appoints out the 32 members of the Executive Board, or more correctly: the Assembly chooses 32 countries, which thereafter are responsible for designating the Board Members.

The Executive Board is composed of 32 technically qualified individuals, elected for a three-year period. They meet at least twice a year, with the main meeting usually in January. They oversee the operation of the WHO, effect the Assembly decisions and nominate the Director General (DG). According to the WHO constitution, the Board exercises its powers 'on behalf of the whole Health Assembly'. Nevertheless, as almost all Board members are governmental officials, they normally reflect the viewpoints of their governments (Siddiqi 1995:82). This is said to be particularly true for the developing countries. The distribution of formal power between the Assembly and the Board is skewed somewhat in favor of the former. Most formal decisions have to be made by the Assembly, and the Assembly alone can approve the budget. In many ways the mandate of the Board is to act as a steering committee for the assembly. The Board oversees the operation of WHO, sets policy and nominates the DG. The WHA is then empowered to formally elect the DG. The control over the nomination process makes the Board the decisive body in this sense (Peabody 1995:733).

The Secretariat is headed by the Director General, who is appointed by the Assembly on nomination by the Executive Board. The DG appoints all professional staff, although this responsibility is often delegated, and proposes the budget – giving authority that provides enormous discretion over the course of international health activity (Peabody 1995:733). The DG functions as an initiator, controller, and 'vetoer' as far as programmatic decisions are concerned, but the Assembly and the Board set the direction and much of the content of the organization's work, and the DG is bound by their resolutions. Still, the role of the DG in the WHO is among the strongest and most autonomous of any of the UN special agencies.

As of 31 December 2000, the WHO had a total of 3486 staff members on fixed-term appointments. In addition, 8547 short-term contracts were granted during the same year. The number of staff members holding long-term appointments has decreased by more than 600 since the mid 1990s and continues to decrease. The total regular budget is US $ 842 654 million, and has been unaltered for a long time as a result of the financial crisis of the UN. As

[16] Some of the organizational innovations introduced by the new regime are dealt with later on.

we shall see, this causes considerable problems for the organization, and the strong increase in the extraordinary budget has not improved the situation for the regular staff.

The WHO's *decentralized structure* is unique for a specialized UN agency, and this is important for understanding WHO leadership and policy formulation in its internal milieu. In short, the headquarters in Geneva formulates policy, sets the budget and charts the overall direction. The six regional offices then supervise and coordinate program implementation. The Regional Offices through their program implementation, however, formulate a significant amount of policy. The regional directors are elected by their constituent countries rather than appointed by the DG, and they can hire and fire staff within their regions. The regional directors are also responsible for appointing country representatives – the front liners. The country representatives are responsible for overseeing the implementation of national programs, and they report directly to their regional directors. All in all, the regional directors have important institutional roles within the WHO, and they clearly limit the centralized control of the organization (BMJ, 1 August 98).

4.3 The Director Generals

The organizational structure of the WHO makes the DG more important than in most international organizations. The fact that they have tended to stay in position for a very long period of time makes them – for better or worse – particularly important for the effectiveness of the organization. In fact, in it's more than 50-year history, the WHO has only had four DGs before Dr. Brundtland took over. The first of them, Dr. Brock Chisholm from Canada, played an important role in defining the mandate and position of the DG. It was during his five years in office that the decentralized organizational structure was established. In this process Dr. Chrisholm worked firmly and successfully to avoid a complete fragmentation of the organization. The second DG, Dr. Marcolino G. Candau from Brazil, is probably the most influential one in the organization history. He was first elected in 1953 and then re-elected three times. During his 20 years in office the organization experienced rapid growth, and Dr. Candau initiated several reforms to preserve the cohesion of the organization (Jacobsen 1973:199). The third DG, Halfdan Mahler from Denmark, stayed in position for ten years and was considered to be a good and respected leader. According to most observers, the fourth General Director, Hiroshi Nakajima, who also served for ten years, broke the tendency towards essentially good leadership in the WHO.

One observer has noted that 'It is hard to think of any single person in the UN constellation who has done more harm to the effectiveness and the reputation of the world organization' (Robbins, 1999:30). In fact, dissatisfaction with his work on the part of most key members resulted in procedural changes regarding the position of DG. Previously there had been no limitation on number of terms the DG could serve, but during Nakajima's second term a new procedure was introduced to prevent this. Although he was a weak leader, this does not mean that 'all was bad' under Dr Nakajima's reign. The overall performance of a large organization with some four thousand employees does not hinge on just one individual.

Summing up, the WHO is a truly global, inclusive organization with larger membership than the UN General Assembly. Although politicization has not been avoided throughout its history, overall it seems to have succeeded reasonably well in staying with its initial mission: assisting in improving global health, illustrated by some of the examples given above. The organizational set up is fairly traditional, but the position of the DG is stronger than in most UN bodies – with the Regional Offices as a limiting factor. The important role of the DGs has been strengthened by the fact that they have tended to stay in position for a long time.

5 Dr. Brundtland in Office: Reforms, Accomplishments and Challenges

According to one observer, the new DG is:

> Norway's own 'iron lady', an energetic blend of doctor, manager, politician and international activist (BMJ, 1998:317:302).

In more neutral and factual terms, the 5th General Director of the WHO is Norwegian, educated as a medical doctor in Norway and at Harvard, USA. She entered Norwegian politics in the mid-1970s, first as a Minister of Environment for the Labor Party Government. In 1983 she was appointed Chairman of the UN Commission on Sustainable Development and was the principal author of 'Our Common Future' released in 1987, also known as the Brundtland Report, the most important environmental document of the 1980s. She has been considered a very strong-headed person, and she was initially more popular on the international scene than domestically. When she retired from Norwegian politics in the mid-1990s, however, she had been Prime Minister for more than a decade and was almost considered above party politics. It was widely believed that one of the reasons she quit politics was that she wanted some major position in an international organization. When the WHO leadership window opened, she was actively backed by the Norwegian government, both in terms of economic resources as well as in terms of lobbying. In contrast to the other candidates she was a complete outsider in relation to the WHO.

Soon after her nomination by WHO's Executive Board in January 1998, Dr. Brundtland commissioned a five-person transition team to co-ordinate analyses of WHO's activities, structure, and processes. The transition team was headed by Jonas Støre[17], was based in Geneva and was financed by the Norwegian government Thus, the new DG was well prepared, and on her inauguration day she 'swept away' the existing secretariat and announced her own carefully chosen cabinet. As one observer concluded a few months later 'the speed of the appointments has taken the organization by surprise' (BMJ 1 August 1998). The timeframe for the internal restructuring was three months, from 1 August until 1 November 1998. To assist in the more long-term restructuring, a WHO Renewal Fund with a three-year framework (1998-2001) with a resource ceiling of $10 million was set up.[18]

5.1 Internal Organizational Changes and External Initiatives

Maybe the most important new change introduced *internally* was the establishment of a new cabinet structure. All of the existing 50 programs were merged into 35 departments, which were grouped into nine different clusters. The head of each cluster composes the cabinet. Including the DG, the first cabinet had ten members: six of them women seven were 'WHO

[17] Mr. Støre had been her right hand as leader of the PM's office in Norway.

[18] The Rockefeller Foundation, the Norwegian government and 12 other states donated money to the fund. (Dove, 1998:992).

outsiders', and all of the WHO's six regions are represented, with an even split between north and south That is, only two of the 'cabinet members were previously affiliated with the WHO. The old structure with the Cold War tradition where the top WHO echelon of Assistant Directors General represented the Security Council member states was abolished (Dove 1998). The previous Assistant Director Generals were given temporary positions as Special Advisors, with the understanding that their contracts would not be renewed.

Moreover, a new system of Management Support Unit was set up to move the management support closer to the Executive Directors. Several initiatives to upgrade the professional cadre at WHO were also taken.[19] The (internal) memo 'Fourteen points for working together' was circulated to all staff shortly after her inauguration, where the need for an 'open, participatory process' was underlined (BMJ 1 August 1998). A more active use of the staff rotation system was also introduced with the aim of creating a more dynamic and flexible organization. Moreover, the first official act of the new DG was to introduce new financial disclosure rules requiring all senior staff to submit forms detailing financial interests, patents, and positions held in the private sector, hoping to avoid unfortunate incidents which have been troubling the organization in the recent past (Dove 1998:992). However, it was said to be a part of 'a general ethics initiative at the UN' and not a response to specific incidents.[20]

Specific measures have also been introduced to give meaning to the 'One WHO' initiative through a process of internal reorganization at Headquarters as well as in relation to the Regional and country offices. The 10 Executive Directors now meet on a weekly basis, and the cabinet is organized more as a traditional state government. All Executive Directors will thus 'own the policies that emerge from the cabinet', as one Executive Director expressed it (Robbins 1999:36). Moreover, the importance of improving co-operation between the various programs has been stressed, and most of the new initiatives under the new leadership have been of a crosscutting character (WHO 10 May, 1999: 19). The Regional Directors now have regular meetings with the Director-General, and the aim is to harmonize the agendas and programs of the regions and the headquarters. For the first time in the WHO history, country representatives from all member states were brought together in Geneva. During the weeklong meeting in February 1999 the representatives discussed how the organization could be streamlined and what the main priorities of the WHO should be. A similar meeting has been arranged later, indicating that this was not only a 'one time stunt', but the introduction of a new and important procedural change. The more open and inclusive budgetary process towards the Regional Offices is a means to secure better co-ordination This approach has continued and expanded over time, and in the making of the present budget (2002-3) the Regional Offices were fully included for the first time. Goals have also been specified in the present budget, making it easier to measure goal achievements further down the road (WHO, EB108/2 22 May 2001). The new DG has indicated that the process of integration should not stop at the regional level as she has emphasized that 'The real untapped resources of this

[19] For an elaboration, see Robins, 1997:37-38.

[20] A total of 21 top staff members were affected.

Organization are not located in Geneva or in the regional offices. They are in countries'.[21] Later on this has been followed up in practice through the country focus initiative. More emphasis was also attributed to research and knowledge, where corporate decision making should be more informed and evidence-based. One practical follow-up of this was the health systems approach.

Externally, the new team early on launched new high-profile programs in partnership with other relevant international organizations such as: Roll Back Malaria (RBM), Stop Tuberculosis (ST) and the Tobacco Free Initiative (TFI). Later in her period, Dr Brundtland has, within the framework of various partnerships, launched a number of other high-profile initiatives and programs. Some of these are: the Commission on Macroeconomics and Health, new funding mechanisms such as the Vaccine Fund, the TB Fund and the Global Fund to fight Aids, Tuberculosis and Malaria as well as the Global Alliance for Vaccines and Immunization (GAVI). Initiatives have also been taken towards entering into a dialogue with the pharmaceutical companies. All these initiatives will be dealt with in greater detail later on.

5.2 The Internal Dimension: Towards 'One WHO'?

Do these changes and initiatives means that the organization is moving closer to the declared goal of a more unified organization? First a few remarks regarding the challenge of following Dr Nakijama. His lack of leadership was strongly criticized, especially externally. This clearly had negative effects also internally due to lack of external support, a faltering image and lack of energy and drive in the organization. However, a number of 'kings' and 'knights' both at the headquarters (HQ) and at the Regional Offices had taken advantage of the situation by strengthening personal positions and particular turfs. Initiatives to introduce changes and reduce privileges were bound to be opposed by such actors – who had been left in peace during the previous regime. Add the fact that the WHO has been described by long-standing top WHO officials as an incredibly complex and an extremely bureaucratic organization, even by UN standards. This illustrates that the internal challenge facing the new team was formidable. What are the perceptions and opinions on the internal dimension regarding what has been done and accomplished?

The New Team and the Regional Offices

According to key sources at the HQ, the strategy of the new regime was to accomplish a clear structural change early on rather than a long-drawn gradual process that could create a lot of insecurity. That it would take a long time to adjust and work out the consequences was clear from the outset. When it came to the Regional Offices, however, the question was what could be accomplished within the limited power a DG has over the regions.

Based on our sources, overall the Regional Offices overall maintain that the new regime has had a positive effect both for the organization as such as well as for them.

[21] Statement by the Director-General to the Fifty-second World Health Assembly, WHO, A52/3, 18 May 1999, 5.

Especially two points are noted. First, they are much better integrated and take an active part in the decision making processes. The significance of the new, more transparent and inclusive budgetary process is emphasized. Secondly, they stress the benefits accrued from the vastly improved image of WHO following as a direct result of the new leadership in general and the new DG in particular. Closer interaction with HQ and more frequent meetings outside Geneva, as well as increased accessibility and visibility of the new DG was also mentioned by some of our respondents.

The regional Offices, however, are concerned that streamlining should not be pursued too far. It has been pointed out that although the decentralized structure of the WHO may create problems of co-ordination, it may have advantages over other more centralized institutions regarding problem solving 'on the ground', the most important function of any multilateral institution. Regional Offices and even more so country offices have first hand knowledge of the most pressing health problems. Thus, streamlining should not be a goal in itself, but a means towards increased goal attainment. In line with this thinking, some of the Regional Offices emphasize that in their respective regions *they* are seen as representing the WHO, *not* the HQ in Geneva, and major health programs are initiated and run independently by the Regional Offices. Therefore, any evaluation of the WHO should include the role of the Regional Offices and too much emphasis should not be placed on the HQ.[22] On the other hand, the Regional Offices rely heavily on HQ, not the least regarding technical assistance and expertise. Five of the six Regional Offices receive 100% of their financing from Geneva. Thus, as one key observer sums it up, 'there is bound to be a love-hate relationship on part of the Regional Offices towards HQ'.

There has also been some tension over attempts on the part of the HQ to get more control over the Regional Offices and the country offices as a part of the aim towards 'One WHO', such as the Country Focus Initiative, which has led to the Country Cooperation Strategies. This has been the DG's main tool to improve work in the countries – in collaboration with the Regional Offices, but maintaining a HQ control over the speed and direction of the process. The internal rotation system has also been used towards this end. By asking the Regional Directors to find vacant regional or country positions for professionals in Geneva, the Director-General has indirectly become involved in regional personnel decisions. This was the first time that HQ has been involved in staff decisions at the regional level (Robbins 1999:36).

There are differences between the Regional Offices in terms of experiences with the new regime – depending upon their position and geographic location. The Pan American Health Organization (PAHO) stands out as a particular case, primarily because it only receives some 20% of its financing from Geneva, making it much more independent than the other Regional Offices, and thereby much less affected by the new leadership. As one key observer quite bluntly said, PAHO will live, and live well without the WHO. This is strengthened by the fact that PAHO is said to be a very well run unit. A potential bone of

[22] Although this point may be well taken, time and resources have not allowed for a broader focus.

contention between PAHO and HQ may have been the fact that the present Director of PAHO was one of the three candidates from the Regional Offices to the present position of Director General, and he was considered the best qualified candidate among them. In PAHO the general benefit of the improved image and high profile is underlined. Still, there have been controversies between some PAHO countries and the new team in various governing bodies over the past few years, assumedly with tacit or explicit support from PAHO. Whether these differences follow from the more independent role of PAHO or whether they have their roots elsewhere, we do not know.

The benefits of an improved external image were very strongly underlined by the European branch of WHO, maintaining that already from day one of the new regime this could be noted. This has been manifested not the least in a vast improvement in the relation between this regional branch and the European Union. During the previous regime the EU wanted no contact with the WHO due to poor performance and negative image. Now there is regular contact and extensive cooperation between the two in a number of areas such as the fight against communicable diseases, tobacco and other health threats (WHO Press release 6 June 2002).

Increased energy and a sense of mission for the European branch, however, is also linked to factors unrelated to the new leadership. While this branch was about to lose its purpose due to general good health in Europe, this changed dramatically with the break up of the old regimes in Eastern Europe and the creation of a number of new states where serious health problems flourish. As a result of this, the region now receives a higher proportion of funds from the HQ – but this process was initiated before the new regime was in place.

In the less developed Eastern Mediterranean Region it was pointed out that WHO was about to lose influence in the region and new international health organizations were about to take their role. This had now changed, not the least due to the new regime, but also because important groundwork had also been done by the Regional Office and the country offices. One manifestation was that the WHO once more was in charge as main coordinator of the large number of donors in the region. The comparative advantages of the WHO was stressed, its unique technical expertise, long time perspective and not the least the close co-operation with the relevant governments to 'help them help themselves'. Many of the international organizations that were present often had a short time horizon, emphasized 'high visibility projects' and suddenly disappeared leaving little lasting effect behind. In short, in their view, a stronger WHO had considerable benefits for this developing region. The new high profile external partnership based on initiatives like RBM and ST were also welcomed in this developing region. It was deemed particularly positive that they were embedded in the broader health systems approach and were not just 'easy targets' to provide nice statistics.

In short, although there are bound to be some tensions between Geneva and the Regional Offices due to the structural factors like the decentralized structure of WHO and the limited power of the DG over the regions, considerable improvements appear to have been made towards the goal of 'One WHO' along this dimension.

Relations at Headquarter

It is more difficult to judge the ability of the new leadership team to strengthen and unify the WHO at the HQ in Geneva, as opinions vary strongly. The general impression is, however, that there are still problems at the HQ in Geneva. Again, the question is whether the problems are of a more structural nature, that is, if they can be mended through effective leadership or not.

To the outside observer the many new initiatives seemed promising in terms of simplifying, streamlining, bringing in more fresh blood, reducing old privileges and getting rid of organizational structures dating back to the cold war. Moreover, a 'correct' political as well as gender balance in the newly established cabinet was established. This was exactly what was expected from a new dynamic leader with considerable experience in international governance and with no previous strings attached to the 'old' WHO. External reactions to the 'new' WHO have generally been very positive. Not surprisingly, internal reactions have been more mixed.

Overall there is hardly any doubt that the internal reforms have had a positive effect and been well received. Still, few dispute that there are problems at the HQ in Geneva. To a large extent these are probably problems that any organization of this type will struggle with – especially given its recent history accounted for above. The leadership has been criticized for taking too long to conduct a staff survey to learn the true nature of the problems. When a survey was undertaken, no conclusive picture appeared, but it confirmed that there were some problems at HQ.[23] According to information we have obtained, the main problem appears to be a 'malign' combination of cultural mix and strained economic resources. More specifically, the Executive Directors do not share a common platform due to differences of background and values. Given the fact that a certain political balance is called for, this is a structural problem hard to overcome. In order to obtain the 'right' political and gender balance, crucial in the UN system, you cannot always recruit the people you want. As this is combined with heavy reliance on extra budgetary funds, this creates competition and fragmentation within the organization. The uncertainty and limitation of regular funding also cause much grief among the staff, such as contract duration, difficulties regarding long-term planning, unpredictability and bureaucracy. As we shall see below, the DG has been very successful in increasing extra budgetary funds, but faced an uphill battle regarding the regular budget.

In addition, the many changes made will inevitably cause strain on the organization. For example, the call for more staff rotation at all levels of the organization was a way to revitalize the organization, but it had high personal costs for many. To mention but one example of the magnitude of the organizational change at HQ; hundreds of people were physically relocated to fit into the new cluster structure. Understandably, there was some initial worry in the corridors as to what the outcome of this process would be. Still, the first half year or so was generally considered a 'honeymoon period' – most staff were inclined to

[23] We have not had access to the staff survey.

give the new regime a chance with it ambitious plans. The process was also smoothened, as a separate position was established to oversee the process and individual follow ups and personal conversations were held with some 1500 staff members over a three month period.

Not all observers, however, were equally impressed with the quality and depth of the reforms. One of them notes that an important motive for the reform was to gain control of the organization. If this is correct, this is in itself not surprising, as so many of the new team were outsiders to the WHO. This illustrates the potential problems of bringing in many new people. However, if motivation for change was also to increase the goal attainment of the WHO, this is a legitimate strategy. Some observers also maintain that it was important for the new regime to create an impression that a lot was going on, but that changes made were not really that deep- seated. To some extent this fits well with the observations made by architects of the new regime. Regrets were expressed that changes made had not been profound enough.

Another problem pointed out by some is lacking accessibility on the part of the DG, and this has been negative for the morale of the organization. Initially she seemed very accessible, illustrated by her presence in the WHO cafeteria. This was perceived by many as a deliberate strategy by the new team towards more openness and inclusiveness. Representatives of the regime regret this initial 'cafeteria-policy' as it proved impossible to live up to, given the extremely busy schedule of Dr Brundtland. The DG has acknowledged the fact that she needs to spend more time in Geneva (WHO 8 January, 2001:4). Representatives of the regime claim, however, that on matters of importance and when there are internal discussions, full access is granted, regardless of rank, but 'you don't get access to her by being a friend or schmoosing with her in the corridors'. It is claimed that some of the complaints are not a result of lacking access, but dissatisfaction due to a lack of influence on the organization's policy.

Some maintain that unfortunate changes in the team have weakened its internal policy clout as 'half the original leadership team has now left', and this is seen as a manifestation of internal problems. It is a fact that some have left because they have been offered other high-level positions, and others may have left due to internal strife. Whatever the reason, some claim this has weakened the organization and tended to isolate the DG more from the rest of the staff, as some of the key policy persons representing the 'glue' of the organization, have left. New members have very high technical quality, contributing to strengthening the external dimension, but weakening the WHO internally.[24]

Although increased transparency has been a key slogan of the new leadership, it is said that this is not always the case. In connection with the rather controversial World Health Report 2000, where countries were ranked in terms of 'health performance', it is claimed that the internal debate was suppressed. Key sources in WHO, on the other hand, claim that as the report was so controversial, if it was going to be published, the process had to be governed and controlled. A counter argument is that it would be better to have an open debate to

[24] In contrast, some maintain that too much emphasis is placed on strategic policy aspects while its technical functions are not getting enough attention.

improve it, avoiding the controversy and risk of disrepute afterwards.[25] Be this as it may, it appears that this have been somewhat of an exception compared to the normal decision-making procedures, conducted in a far more transparent way.

In sum, there is no doubt that leadership has been exerted in attempting to pave a new road for the WHO at the HQ, and there is hardly any doubt that there have been many achievements, but there are still remaining problems. The main reason seems to be an unfortunate mix between a strained economy and differences of values within the leadership team, causing fragmentation in the organization. The goal of 'One-WHO' along this dimension therefore still seems rather distant.

The Battle for Increased Funding

When Dr Brundtland entered office in May 1998, virtually the whole biannual budget of $842 million for the period 1998-99 had been obligated. Thus, the budget for 2000-01 was the first which was prepared and presented by the new team. The regular budget is based on contributions from the WHO member states, and the budget proposed a *zero real growth*. Compared to the budgets under the previous Director-General, which were based on a zero nominal growth – in line with regular UN budget procedures - this was a significant change. Just during the 1990s, the member states' contributions to the WHO had declined by 20% in real terms due to the zero nominal growth budgets. For the 2000-2001 budget, the difference between a zero nominal growth and a zero real growth would amount to more than 30 million dollars. Although this increase was far below what she desired, the DG feared that a proposal for more dramatically increased contributions would divide the member states at a time when unity was needed to renew and revitalize the organization. However, the WHO Executive Board rejected this and suggested the budget should follow the zero nominal growth patterns, and the Assembly confirmed this. This happened in spite of the widespread support expressed by most governments for the reforms instituted by the new WHO leadership.

An important reason why the proposed increase was turned down, was that key donor countries like the US, Japan and Germany feared that if they rewarded WHO with more money, a precedent would be set for the less deserving among the UN agencies. Later on it has been confirmed that it seems impossible for one single UN organization to breach the overall UN pattern of zero nominal growth, meaning that the funds in real terms continue to fall. This has clearly been a major disappointment for Dr. Brundtland and her team.

5.3 The External Dimension: Reaching Out, Agenda Setting and Financing

The new team was very conscious of the need to get a good, high profile start of its term. For example, the initial programs launched (The Tobacco Free Initiative (TFI), Stop Tuberculosis (ST), Roll Back Malaria (RBM) were selected not only because they were important from a

[25] This issue has been hotly debated and work is continuing to improve the methodology. See for example WHO A54/2 30 March 2001:2 and Nygaard, 2001.

health perspective. According to a key source in the process, they were intended to have high 'visibility'. It was important for the new leadership to have something to flag and place WHO on the high level international agenda. The initial programs were also carefully selected to sustain the support of various actors. Tobacco was definitely a 'winner' to secure the support of the US and other Western countries while Roll Back Malaria and Stop Tuberculosis were the 'breadwinners' of the South. The emphasis on the evidence-based approach also struck a positive chord, especially among Western countries.[26] This emphasized a key comparative advantage of the WHO as it underlined the 'neutral' technical, expertise of the WHO – in contrast to the traditional politicization of many UN bodies. There is no doubt that the sum of this policy change had a positive effect externally and contributed to strengthening relations and increasing donations from key member like the US, the EU and the UK as well as from other types of actors. A key source stated that under real world circumstances 'little can be achieved by an organization like the WHO if you are no able to cooperate closely with key members'. There have, however, been critical voices that the DG pays too much attention to being on good footing with the major donor countries, not least the US in relation to the question of cheaper drugs in developing countries (Dagbladet, 13 July, 2002). In any case, the 'score' of the new team seems to be very high in terms of securing support from key WHO members. This provided a necessary basis for the expansive external strategy on the part of the new team, with the explicit goal of breaking the negative isolation of the previous regime. Key elements were more cooperation with relevant actors, getting health issues higher on the political agenda and increased external financing.

Reaching Out and Agenda Setting

'We have created and recreated partnerships – with the UN family, with the Bretton Woods institutions, with the private sector, with non-governmental organizations, with research and with civil society'.[27]

One important reason for the strong emphasis on this approach is the shift made from the traditional approach that favored its own small-scale projects – to one that gives more emphasis to strategic alliances. Another reason is the fact that there are now a multitude of actors on the global 'health market'. The WHO no longer has the exclusive franchise on world health it had during the first years of its existence. Broader strategic co-operation is therefore a necessity, and the approach has existed for some time. What is new is that the WHO puts much more emphasis on this strategy and that the WHO plays a much more significant role in these partnerships than it used to do. This being said, it is extremely important to underline, both from an analytical as well as from a policy point of view, that the WHO *alone* cannot take the credit of what is described below.

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[26] Although this approach has been generally endorsed, there have been strong controversies over specific issues. One case in point regards the optimal target blood pressure when treating hypersensitive patients.

[27] Address by the Director-General to the Fifty-second World Health Assembly. WHO A52/3 18 May 1999:5.

Partnerships have most frequently been with other key health players like the World Bank, UNICEF and UNAIDS, but contact and initiatives have also been taken in relation to international economic institutions like the World Trade Organization (WTO), the International Monetary Fund (IMF) and the OECD. Contact has also been established with a number of other relevant UN organizations like FAO, UNESCO, ILO, the UN Reform Process and follow-up of relevant UN organizations.[28] Since the Fifty Fourth World Health Assembly (2001), WHO has actively participated in the deliberations of the UN General Assembly as well as the forum for Chief Executives of the United Nations system. Close connections have also been established with non- governmental organizations.

In the following we shall run through some of the major new initiatives of potential importance to make the international society deal more effectively with major health problems – and where the WHO has played an important part.

The first session of the Intergovernmental Negotiating Body on the WHO framework convention on tobacco control took place in October 2000 and was attended by almost 150 countries as well as a number of other actors (WHO:A54/13 2 April 2001). This rather novel approach for a health issue was no doubt 'borrowed' from the 'convention approach' common for dealing with international environmental problems, with which Dr. Brundtland is very familiar.[29] The fourth negotiation round was finished in March 2002, and progress seems to have been limited, not the least due to pressure and commercial inducements from the tobacco industry on developing countries, particularly in Africa (New York Times, March 21, 2002).[30]

The WHO played a key role in the establishment and running of the Global Alliance for Vaccines and Immunization GAVI, an international coalition of partners including governments, research institutions, the pharmaceutical industry, WHO, the World Bank and UNICEF. GAVIs partners are collaborating to protect human health through the widespread use of safe vaccines. One of the tools that GAVI uses is the Vaccine Fund. Beyond the initial five-year commitment of US$ 750 million from the Bill & Belinda Gates Foundation, the Vaccine Fund has expanded its resources to almost US$ 1000 million for 2001–2005 with contributions from a number of western countries, including the US, the UK, Canada and Norway. To date, 65 of 74 eligible countries have applied, 54 of which have been have been awarded a total of US$ 820 million for vaccine procurement or direct financial aid over a period of five years. One of the goals of GAVI is that 'By 2005, the world will be certified polio-free' (WHO A55/10, 23 March 2002:2).[31] The key role of the WHO in this process is

[28] For an elaboration, see WHO, A55/34, 22 April 2002.

[29] Legal experts in international environmental law were used to provide input to this work.

[30] Parts of the tobacco industry have used highly untraditional and strong measures to discredit the DG and the WHO in its fight against tobacco; even the pro-whaling attitude of the present DG has been used!

[31] For an account of the substantial results achieved to eradicate polio, see Press Release WHA 54/5 18 May 2001:1. Originally the WHO was aiming to eradicate polio by late 2000, but failed due to lack of funding.

illustrated by the fact that Dr. Brundtland chaired the Board for its two first years.[32] The WHO has also led the Task Force on Country Coordination.

A global fund for AIDS and health was first conceptualized at a meeting of the G-7/8 group of countries in Okinawa, Japan in July 2000. It was given the 'powerful support of the General Secretary of the United Nations and the General Director of the WHO in early 2001' (WHO A55/8 19 April 2002:1). A consensus emerged among major stakeholders in June 2001 that the target of the fund should be AIDS, tuberculosis and malaria.[33] The fund was to be international and a partnership between the public and the private sector, not tied to any country or (UN) institution. In December 2001 a transitional working group fulfilled its term of reference and the Board of the Fund was established comprising of donor countries, developing countries, non-governmental organizations and the private sector. Four ex officio positions, for the World Bank, UNAIDS, the WHO and an additional NGO representative were added as non-voting members. WHO and UNAIDS have been instrumental in selecting and setting up a Technical Review Panel. WHO has worked actively in providing support to the fund as well as assisting countries to prepare proposals for submission. The UN Secretary General, the Director of UNAIDS and the General Director of WHO appear to have been particularly important in this process.[34] The goal was to raise 10 billion US dollars a year, but so far 'only' $ 2,8 billion have been raised. There as been strong criticism from NGOs and others, particularly against the US for modest contributions (Aftenposten, July 11, 2002).[35]

Another high-level initiative has been the Commission on Microeconomics and Health established by the Director-General of WHO to assess the place of health in global economic development. The Chairman was one of the world's leading economists, Jeffery Sachs. This Commission was not a partnership as it was a WHO initiative, but a number of actors outside the WHO participated in its work. 'In summary, the report provides compelling evidence that better health for the world's poor is not only a goal in its own right, but can act as a major catalyst for economic development and poverty reductions' (WHO A55/5 23 April 2002:1). Also, it showed that economic losses from ill health have been underestimated.[36] The report has had an impact internationally, notably at the International Conference on Financing and Development (Monterey, Mexico, March 2002), where the need for increased spending on health was a prominent theme. The report was also central to WHO's contribution to the World Conference on Sustainable Development in Johannesburg, South Africa, in

[32] July 1 2001 she was succeeded by the Executive Director of UNICEF.

[33] The WHO played a key role in broadening the mandate to include aspects other than HIV/AIDS, as there are strong inter-linkages between these illnesses. The formal name of the fund is the Global Fund to fight AIDS, Tuberculosis and Malaria.

[34] The close connections between the UN Secretary General and the WHO is underlined by the fact that for the first time in history, the UN Secretary General addressed the World Health Assembly in 2001.

[35] The US has so far contributed $ 500 million, while a small country like Norway has contributed $ 130 million. Aftenposten, July 11, 2002.

[36] The Commission also quantifies gains and losses provided by 'level of health'.

August/September 2002. The cornerstone for applying the Commission's recommendations will be a mechanism that brings together ministers of finance, health and other key players, including civil society. Concrete steps have later been launched 'to start turning theory – on improving health, which spurs economic development – into action'.[37]

While the more traditional partnerships have been uncontroversial, this has not been the case with the closer co-operation between WHO (and others) and private business, particularly the pharmaceutical industry – long seen as an 'arch-enemy' by WHO and other multilateral institutions since its goal was perceived to be *profit,* not health.[38] More UN pragmatism has led to a change of strategy: there is a growing consensus among UN agencies that more can be achieved by co-operation than by condemnation. No doubt, Dr Brundtland has been among the key architects behind this more inclusive pragmatic approach of attempting to make the problem (private business) a part of the solution. Considerable progress has also been noted in this regard through *differentiated pricing* on HIV and the related TB and malaria drugs, and specific programs and goals have been adopted. The process is still in an early phase and it is likely to be a tough and long-term battle.[39] In addition, there has been increased interaction between WHO (and others) and the WTO regarding the TRIPS Agreement and the rules on patents, highly relevant in this regard.[40]

A key goal of this dialogue has been to get cheaper prices on essential drugs for poor countries. However, this issue should be seen in a broad political process where a number of players have taken part and massive media attention, exposure, shaming and general political pressure have been a part of the picture.[41] That is, a number of players of various kinds, including countries like Brazil and South Africa, and non governmental organizations like Doctors without Borders have played different roles, and the WHO is but one among many actors. In this process many have been critical towards what has been seen as a conciliatory role of the WHO towards the pharmaceutical industry (Dagbladet and Aftenposten, 13 July, 2002).[42] Our take on this is that the different actors have played *complementary* roles, and together been decisive for the progress made. It is also important to see the results achieved in light of the broader effort of the WHO in their effort to *distribute* medicine more effectively

[37] Twenty developing countries met with partners from a dozen agencies and foundations in Geneva in June 2002 to discuss effective implementation of the measures suggested by the Commission. (WHO Press Release, WHO/47, 17 June 2002).

[38] There are now regular roundtable discussions between the WHO and these companies, and the WHO maintains that the WHO and the pharmaceuticals have a *common* goal. WHO 11 October, 2001.

[39] WHO, 54 WHO A54/17, 10 April 2001.

[40] WHO, 54 WHO, A55/34, 22 April 2002.

[41] See for example, Aftenposten, 11.04.01, Aftenposten 05.03.01.

[42] The WHO may well have adopted a cooperative approach, but there has also been conflict between the WHO and the pharmaceutical industry. One instance was when the WHO released its first list of manufacturers of safe AIDS which included a large Indian producer. This was regarded as a way to bring down the prices, and the industry lobby was strongly against it. New York Times, March 23, 2002a.

in the context of the broader health system approach. Cheaper medicine is of little use if they do not reach those who need them.

Although there is no doubt that while the 'reaching-out' strategy of the WHO has been very successful, the more active role of the WHO has also created problems of its own, according to some observers. Under the previous regime the WHO was so weak that other organizations moved into its territory. Now it is claimed that the problem is the other way around. In its eagerness to stand forth as an international health leader, the WHO has become somewhat intrusive on the traditional turf of others, has a propensity to take the credit for joint action and is described as rather 'pushy' in getting 'their way'.[43] Although the WHO should be wary of such criticism, it may also be unavoidable for a revitalized large and complex organization with many personalities, typical for the situation with an '800 pound gorilla' in the room.[44]

Over the last decade, the main challenge to the WHO's position has probably come from the World Bank.[45] The Bank's activities have always had an impact on world health, but the reciprocal relationship between economic growth and human health has become increasingly clear. The Bank has gradually become more directly involved in health issues. This involvement was explicitly formalized in 1993, when the Bank devoted its annual World Development Report to health. Currently, the Bank has its own specialized 'Network for Health, Nutrition and Population', and manages a $ 10 billion portfolio of loans specifically for health related projects (*Economist,* 9 May 1998). Compared to the total WHO budget of less than $ 2 billion, the Bank may seem to have the ability to outmuscle the WHO financially, but this is not necessarily correct.[46] However, the Bank has direct access to the finance ministries of countries, an obvious advantage for raising political and financial support for health related projects. Although the WHO officially always has welcomed the Bank's involvement in health issues, the tension between the two institutions was considerable during Dr Nakajima's reign. In some countries the collaboration between them broke down completely, and cooperative projects like UNAIDS were jeopardized in many regions. One of the new leadership's early objectives was to 'put a stop to that kind of nonsense' (*Economist,* 9 May 1998).

During her first year in office, Dr Brundtland had several top-level meetings with the World Bank, and this was a turning point in the relation between the two institutions. Dr. Richard Feachem, the previous director of health, nutrition and population in the World Bank, said about a year after Gro Harlem Brundtland had taken office in the WHO that: 'The WHO

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[43] Sources at Headquarters admit this has been a problem in isolated cases, but claim that this has been rectified.

[44] Similar criticism has been voiced against another much bigger 'gorilla', the World Bank.

[45] Although formally belonging to the UN system, the World Bank is clearly a very independent institution. In fact, the Bank in widely seen as separate from the UN system in general (Bergesen and Lunde, 1999).

[46] It should be noted that the Bank's figure is on lending commitments, about $1,3 billion per year and $ 10 billion in current commitments. As this is loans and credits to countries – in effect these are the countries resources they have secured through sovereign debt.

has just elected the best possible leader that it could elect. Dr Gro Harlem Bruntland is fantastic, and her leadership heralds an era where the WHO can be a truly powerful and influential agency working for the good of humankind around the world and really making a difference. And the bank's commitment must be to support that process right down the line'.

According to a key source in the World Bank, it appears that this positive trend has continued, as a much more in depth and fruitful relationship has been established between the two. With a more expansive WHO, there may occasionally be duplication of work and overlaps, but complimentary and reinforcing efforts are said to be more typical for their relationship, although there is room for 'some contest of ideas'. When this happens, it is said that in the overwhelming majority of cases open discussions at the top level are conducted in an open and frank manner. The senior staff of WHO is very accessible and Dr Brundtland has been very accommodating, according to our sources.

The fact that the WHO has become much more preoccupied with the relationship between economy and health has, however, caused some tension. Traditionally this is an area where the World Bank has comparative advantages, not the WHO, which is seen more as a technical, standard-setting organization. Some dissatisfaction was expressed of the WHO appointment of its own Committee on Macro-Economics and Health (CMH), using some of the same expertise as the World Bank had used in similar work. The World Bank felt that this was the sort of initiative that the two logically should have discussed the merits of, and the possibility of *doing it jointly,* but the WHO saw it otherwise. The Bank was informed of the initiative, but was not invited to either comment on the proposed commission, nor to co-sponsor it. According to sources at the WHO, the Bank deserves credit for putting this issue on the agenda some time ago, but as it was not followed up, someone needed to continue this work. However, this conflict was short-lived. When the CMH got underway, the World Bank has been very central in its work, with a good and close relationship between the two during the work of the Commission.[47]

On the personal level, however, there have been some controversies between scientists of the Bank and the WHO in connection with the 'health system performance approach'. Chris Murray, the architect behind this work in the WHO, as well as many of the people now working with him, used to work in the WB. There are genuine differences of opinions on methods and content between some of these scientists in the two institutions – as well as rivalries of a more personal nature. This, however, does not affect the institutional relations between the WB and WHO. According to a key representative of the Bank, on balance, 'we've never had a better, more robust relationship though there are as in all relationships differences of opinion and emphasis. We are at our best when we work together and potentially our best days of shared purpose and effort are in front of us'.

[47] Eduardo Doryan was the World Bank representative on the Commission, while Chris Lovelace often stood in for him during meetings. His close personal relationship with several WHO staff generally facilitated the exchanges and the relationship.

It has been a part of Dr Brundtland's ambition to raise *health issues on the international agenda.* Considering the increased international attention towards the health issues more recently accounted for above, the following quote is not just the usual UN rhetoric:

> Global public opinion is starting to realize where health belongs. At the core of every community's 'opportunity to secure sustainable economic development for its citizens. At the core of our efforts to combat poverty and foster development for all.[48]

There is no doubt that the WHO has been among a group of key actors in raising health issues higher on the international political agenda. For example, as we have seen, health has been an important issue at the last G-7 and G-8 meetings, while it previously was not an issue in such foras. There is hardly a novel initiative where the footprint of the new DG has not left a significant imprint. Nevertheless, it is important to underline that neither the new DG nor the WHO have been alone in this drive to get health issues higher on the international political agenda. It is a fact, though, that this development started at roughly the same time as the new regime was in place, but it is beyond the scope of this report to trace the precise causal links. Moreover, we do not find it fruitful to speculate on who deserves 'most' credit for this new drive; the UN General Secretary, the Director of UNAIDS, Peter Piot, the DG of the WHO, or others. Neither does it seem fruitful to speculate on the *priorities* made by the new WHO regime; should AIDS/HIV have been higher on the agenda initially, instead of for example tobacco? Some would maintain that.[49] Our point of departure is that *both* are deadly threats to humanity and both should be given high priority, which comes first is not decisive.

Success in Increasing External Funding

In contrast to the lost battle of the DG to increase the regular budget, extrabudgetary funding has been a success, but it has also created certain problems and challenges. Compared to the 1998-1999 budget, the headquarters' share of the total budget was expected to increase by about 16% in the previous biannual budget. This increase was solely provided through extrabudgetary funding. Looking at the regular budget funds, there has indeed been a shift to the country level from both headquarters and regional offices. This implies that a larger share of the direct contributions from the WHO members are redirected to the country level, while the increased activities in the headquarters to a larger extent are financed through extrabudgetary sources.

In contrast to the zero nominal growth in the regular budget, the expected 19% increase in the extra budgetary funding for the 2000-2001 biannual budget seemed quite dramatic. Many sources doubted that this ambitious goal would be reached. The skeptics were proved wrong, as the extrabudgetary funding subsequently increased much more than expected and the two budgets were about to become the same size.

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[48] Address by the Director-General to the Fifty-Third World Health Assembly, WHO, Geneva, 15 May, 2000, A53/3, 1.

[49] It seems likely that the initial strong focus on tobacco was an effective way of getting the US on board.

The significant increase in extrabudgetary funds in 1998/99 was sustained in 2000-2001, with resources reaching US$ 1500 million, almost double the ordinary budget of some $ 842 million.[50] Expenditure for these funds was 141% of the originally budgeted amount, resulting from a significant increase in voluntary contributions. It has been noted, however, that this strong increase in extrabudgetary funds create certain problems of its own: '..the disproportionate effect that the costs of administrating them might have on the regular budget' (WHO A55/38:3 10 May, 2002). This trend necessitated WHO to ensure that the extrabudgetary funds were effectively managed. The success of WHO and others in raising health issues higher on the political agenda, somewhat paradoxically also created other challenges and problems: 'The increased global emphasis on health initiatives was inevitably placing more pressure on WHO's relatively small country offices' (Ibid.).

Considering that the regular WHO is tied to the UN and is thereby a part of the broader issue of UN reforms, the extraordinary budget route becomes a tempting – and in this case very successful – alternative. Still, as one key source pointed out, this may ultimately lead to '*Arthur Anderson Health Co*'– not necessarily quite what the founding fathers had envisioned.[51] The members and the WHO do not have the same control over these contributions, as they may come with strings attached and they pose challenges in terms of job security, priorities, control and the direction of the organization.

The WHO, together with others, has also contributed to an overall increase in economic support to improve global health outside its own budgets through participation in numerous international programs and initiatives described earlier. In short, the expansive strategy along this dimension has been a 'smashing success' – but like most successes it also has a downside.

With all this new international political and economic energy unleashed, can we conclude that the world's population is getting healthier , or has change consisted mainly of 'the usual political talk'? We have explicitly avoided evaluating the specific measurable *results* obtained by the new regime, in part due to a relatively short period under study, but mainly for methodological reasons. Still, it is reason to believe that some progress have been made through the joint efforts of WHO and others. The goal of making a *difference* is at least partly realized, although the pace has been slower than the optimists had believed and there are many bumps on the way ahead. [52]

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[50] For further details, see WHO A55/38 10 May 2002.

[51] What has later happened to Arthur Anderson's strongly re-emphasizes the significance of this point.

[52] For an illustration, see WHO A55/3, 2002:1-17.

6 Brief Concluding Discussion: Leadership Achievements and Challenges[53]

Various types of leadership has been conducted by the new regime. Prominent examples of *intellectual leadership* is the strong emphasis on the links between health, economy and poverty as well as on the health system approach. This has sparked off debates and set the international health agenda. As expected *instrumental leadership* has been most prominent. The very purpose of the new regime has been to *lead* by the way of internal reform and external initiatives through its position, skill and energy (Underdal, 1991). Although important internal changes have been introduced, all of them have not been welcomed by the staff and they have sometimes been reluctant *followers.* It is therefore questionable whether the new regime has been fully able to institutionalize the mission and role of the organization at the Headquarter, as is expectedly by an instrumental leader (Selznik, 1957). However, the new regime has been highly successful in relation to the leading states (Jacobsen, 1973), a prerequisite for successful external activities and for bringing health higher on the international political agenda.

Let us summarize more systematically achievements and problems along the two dimensions. *Internally,* has the new leadership been able to move the organization towards *one WHO*, thereby fulfilling its ambition of a more unified organization? Regarding relations to the Regional Offices, important achievements have been made through the new procedures introduced, especially their integration into key decision-making processes. Of at least equal importance are the benefits accruing to the Regional Offices from the considerably improved external image through increased external support and a stronger position vs. other health agencies. With the limited power the DG has over the regions, however, attempts to streamline and control are bound to cause some friction, but the trend appears to be positive. As noted, the 'score' appears to more negative in relation to realizing the 'One WHO' at the headquarters in Geneva. There is no doubt that major achievements have been made, but there are remaining problems. The main reason seems to be an unfortunate combination of a strained economy and differences of values within the leadership team, causing competition and fragmentation. Given the fact that a certain political balance is called for, crucial in the UN system, this is a structural problem that is hard to change. Attempts have also been made to increase regular UN funding, but in vain. There has also been some complaints in relation to lacking access to the DG, unfortunate changes in the leadership team and lacking transparency, but there is no consensus on these points.

Externally, as noted, the overall conclusion is positive. It is important to note, however, that the WHO has not been *alone* in its strive for more attention and money to health. It has been a joint strategy with some other key partners. The reaching out strategy,

[53] For a rather comprehensive evaluation of what has been achieved and remaining challenges by the DG herself, see Naim, 2002.

agenda setting and external funding have all been mostly success stories. Overall, the evaluation of the WHO in these processes is positive, although, not surprisingly, its newborn ambition to stand forth as a leader and to expand its traditional 'territory' has caused some tension with other partners at times. Its cooperative and pragmatic approach towards the pharmaceutical companies has been criticized by some, but it can also be seen as one element along with more aggressive strategies, in bringing prices down for essential drugs. Extra budgetary funding has skyrocketed, putting the WHO in a much better position to fulfil its mandate of improved global health. Still, the fast pace of this development combined with no increase in regular funding creates problems of its own: The WHO must avoid becoming 'the Arthur Anderson of health'. One important reason for the overall external success has been good relations to key actors like the US and the EU. Overall, we have witnessed a transformation of an organization that was discredited, fragmented and lacking leadership into one that is alive, ambitious and expansive. None of the many officials we have interviewed question this development and there seems to be no doubt that the revitalization of the WHO is causally directly linked to the change in leadership, especially the new General Director, Dr Gro Harlem Brundtland. Her reputation, energy and connections internationally have opened doors and opportunities that are not common for directors of UN agencies. This has been particularly helpful externally in increasing funds, building new and strong partnerships and raising health issues higher on the international political agenda. The sky, however, is not all blue as there are considerable challenges ahead, especially internally. the problem solving capacity of the WHO has increased considerably and thereby provided the basis for increasing its effectiveness.

Finally, to the question of improved leadership as a means to enhance the effectiveness of multilateral institutions. As a point of departure this case study indicates that a lot can be accomplished with better leaders. It may seem that the UN is starting to realize this, as Dr Brundtland is not the only high level political person that has been elected to a key UN agency.[54] It has also been claimed that it is often an advantage for a leader of a multilateral institution to come from a small 'neutral' country (Kapur, 2000:45). Still, the limits of leadership are also clearly demonstrated due to the structural problems facing any leader that wants to reform a UN agency; lacking funds, competing values and fragmentation. These problems can hardly be mended by good leadership alone. If the members want the multilateral institutions to improve future effectiveness, better leadership is just a tiny, albeit important part in a large, complex puzzle.

[54] The high-level German politician Klaus Topfer has fairly recently been elected the new leader of another rather discredited UN agency, UNEP.

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