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COM 505

GLOBAL HEALTH AND ROLE OF NON-GOVERNMENT HEALTH ORGANISATIONS

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Course code: COM 505

Course title: Global Health and Role of Non-Government Health Organisations

Course credit load: 1 Unit

Series 1: Origins and Development of International Health up to the Second World War

- **Part 1.1: Early Origins of International Health Cooperation**
  - Sub Part 1.1.1: Early quarantine practices and the international spread of disease
  - Sub Part 1.1.2: The International Sanitary Conferences of the nineteenth century
  - Sub Part 1.1.3: The first International Sanitary Convention
- **Part 1.2: Early International Health Organisations**
  - Sub Part 1.2.1: The International Office of Public Hygiene
  - Sub Part 1.2.2: The Health Organisation of the League of Nations
  - Sub Part 1.2.3: The Pan American Sanitary Bureau
- **Part 1.3: International Health in the Interwar Period and the Second World War**
  - Sub Part 1.3.1: International health cooperation between the two world wars
  - Sub Part 1.3.2: Impact of the Second World War on international health
  - Sub Part 1.3.3: The path toward a new permanent international health organisation

Introduction

Long before the modern **World Health Organization** existed, nations were already grappling with a shared problem, how to protect their populations from diseases arriving by ship and by trade route from other parts of the world, without unnecessarily disrupting the commerce upon which their economies depended. Picture a nineteenth century port city, where quarantine officials from several rival nations meet uneasily to negotiate a shared set of rules for inspecting incoming vessels suspected of carrying cholera. Understanding how such early, often reluctant, cooperation gradually evolved into formal international health institutions is essential background for

everything that follows in this course, and it is this history that forms the subject of this opening Series.

The aim of this Series is to equip you with a clear understanding of the origins and development of international health cooperation, from its earliest beginnings through the early international organisations of the twentieth century, up to the outbreak of the Second World War.

This Series begins with the **early origins of international health cooperation**, before turning to the **early international health organisations** that emerged in the early twentieth century. It concludes with **international health in the interwar period and the Second World War**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 1.1:** describe the early origins of international health cooperation, including quarantine practice and the International Sanitary Conferences
- **SLO 1.2:** describe the first International Sanitary Convention and its significance
- **SLO 1.3:** describe the establishment and functions of the International Office of Public Hygiene
- **SLO 1.4:** describe the establishment and functions of the Health Organisation of the League of Nations and the Pan American Sanitary Bureau
- **SLO 1.5:** describe international health cooperation during the interwar period, and
- **SLO 1.6:** describe the impact of the Second World War on international health and the path toward a new permanent international health organisation.

1.1 Early Origins of International Health Cooperation

1.1.1 early quarantine practices and the international spread of disease

Protecting ports from disease arriving by sea

The earliest recognisable form of international health protection was **quarantine**, the practice of detaining ships, passengers, or goods suspected of carrying disease for a defined period before permitting entry into a port, first developed by Mediterranean **port cities** in response to recurring outbreaks of **plague** during the medieval period, and gradually adopted more widely as international trade and travel expanded.

As maritime **trade** intensified during the eighteenth and nineteenth centuries, so too did the frequency with which diseases such as **cholera**, **yellow fever**, and plague spread between countries via shipping routes, and it became increasingly apparent that quarantine measures applied unilaterally, and inconsistently, by individual nations were poorly suited to a problem that was, by its very nature, **international** rather than purely domestic.

Fill in the blank: Quarantine, the earliest recognisable form of international health protection, was first developed by Mediterranean port cities in response to outbreaks of _____.

1.1.2 the international sanitary conferences of the nineteenth century

In recognition of the inherently international nature of epidemic disease, European nations began convening a series of **International Sanitary Conferences**, beginning in **1851** in Paris, bringing together representatives of multiple countries to discuss shared quarantine standards and measures against diseases such as cholera and plague, marking one of the earliest sustained attempts at formal **multilateral** cooperation on a health matter.

These early conferences proved slow and difficult, often taking years, or even decades, to reach meaningful **agreement**, reflecting persistent tension between the public health goal of disease control and the economic interest of participating nations in minimising **disruption** to trade and shipping, a tension that would continue to shape international health cooperation for many decades to come.

Fill in the blank: The International Sanitary Conferences, an early attempt at multilateral cooperation on health, began in 1851 in _____.

1.1.3 the first International Sanitary Convention

After decades of negotiation across successive International Sanitary Conferences, the first binding **International Sanitary Convention** was eventually adopted in **1892**, initially addressing cholera specifically, representing the first genuine international legal **agreement** on a matter of public health, and establishing an important precedent for the more comprehensive international health regulations examined in a later Series of this course.

Further conventions addressing additional diseases and broader sanitary matters followed in subsequent years, gradually expanding the scope of formal international health law, and this body of early conventions provided the essential legal and institutional foundation upon which the more permanent international health **organisations** examined in the next Part of this Series were eventually built.

Fill in the blank: The first binding International Sanitary Convention was adopted in 1892, initially addressing _____.

Figure 1.1: Officials inspecting a ship's cargo hold at a historical port quarantine station.

Pilot questions 1.1

1. Define quarantine and describe its earliest historical origins. (Linked to SLO 1.1)
2. Explain why unilateral national quarantine measures were poorly suited to controlling epidemic disease. (Linked to SLO 1.1)
3. Identify the year and location of the first International Sanitary Conference. (Linked to SLO 1.1)
4. Explain why the early International Sanitary Conferences were slow to reach agreement. (Linked to SLO 1.1)
5. Identify the year of the first binding International Sanitary Convention and the disease it addressed. (Linked to SLO 1.2)

1.2 Early International Health Organisations

1.2.1 the international office of public hygiene

An early permanent secretariat for international health

The **International Office of Public Hygiene**, commonly known by its French acronym **OIHP**, was established in **1907** in Paris, representing the first **permanent** international body dedicated to

public health, tasked principally with monitoring the international spread of specified epidemic diseases and supporting the implementation of the International Sanitary Conventions discussed in the previous Part of this Series.

Although limited in scope compared with later international health organisations, the OIHP represented an important institutional advance, since it provided a standing **secretariat** capable of ongoing epidemiological monitoring and coordination between International Sanitary Conferences, rather than relying solely on periodic, occasional international meetings to address emerging health threats.

Fill in the blank: The International Office of Public Hygiene, commonly known by its French acronym OIHP, was established in 1907 in _____.

1.2.2 the health organisation of the league of nations

Following the establishment of the **League of Nations** after the First World War, a dedicated **Health Organisation** was created as one of the League's technical bodies, with a considerably broader mandate than the earlier OIHP, encompassing not only epidemic disease control but also wider public health matters, including standardisation of biological products and international exchange of public health **expertise**.

The Health Organisation of the League of Nations made significant contributions to international health during the interwar period, including early work on epidemiological **intelligence** gathering and standardisation efforts, and, despite the League of Nations' broader political limitations, is generally regarded as an important direct institutional **predecessor** to the World Health Organization examined in the next Series of this course.

Fill in the blank: The Health Organisation of the League of Nations is generally regarded as an important direct institutional _____ to the World Health Organization.

1.2.3 the pan american sanitary bureau

The **Pan American Sanitary Bureau**, established in **1902**, predates even the OIHP and represents the **oldest** continuously operating international health organisation in the world, created to coordinate public health cooperation among countries of the **Americas**, reflecting particular regional concerns about diseases such as yellow fever affecting trade and travel within the region.

The Pan American Sanitary Bureau's early establishment and sustained operation demonstrated that effective **regional** international health cooperation was achievable even before comparable global institutions had been fully developed, and the Bureau itself continued to operate successfully well beyond the period covered in this Series, eventually becoming the regional office

for the Americas within the World Health Organization system discussed in a later Series of this course.

Fill in the blank: The Pan American Sanitary Bureau, established in 1902, represents the oldest continuously operating international health _____ in the world.

Figure 1.2: Delegates seated around a conference table during an early twentieth century international health meeting.

Pilot questions 1.2

1. Identify the year and location of establishment of the International Office of Public Hygiene. (Linked to SLO 1.3)
2. Describe the principal tasks of the International Office of Public Hygiene. (Linked to SLO 1.3)
3. Describe the mandate of the Health Organisation of the League of Nations. (Linked to SLO 1.4)
4. Explain why the Health Organisation of the League of Nations is considered a predecessor to the WHO. (Linked to SLO 1.4)
5. Identify the year of establishment and regional scope of the Pan American Sanitary Bureau. (Linked to SLO 1.4)

1.3 International Health in the Interwar Period and the Second World War

1.3.1 international health cooperation between the two world wars

Expanding cooperation amid political fragility

The **interwar period**, spanning roughly the two decades between the First and Second World Wars, saw meaningful expansion of international health activity, with the **Health Organisation** of the League of Nations, discussed in the previous Part of this Series, undertaking increasingly ambitious work, including coordinated responses to specific epidemic threats and growing international exchange of epidemiological **data**.

Nonetheless, international health cooperation during this period remained constrained by the same broader **political** fragility that affected the League of Nations more generally, with several major powers either never joining or later withdrawing from the League, limiting the practical reach and authority of its Health Organisation despite its genuine technical achievements.

Fill in the blank: The interwar period spans roughly the two decades between the First and Second _____.

1.3.2 impact of the second world war on international health

The outbreak of the **Second World War** in 1939 severely disrupted the international health cooperation that had gradually developed over the preceding decades, as normal diplomatic and institutional activity across much of the world was overtaken by military conflict, and the League of Nations, along with its Health Organisation, effectively ceased meaningful **operation** during the war years.

At the same time, the war itself generated an enormous **humanitarian** health burden, including displaced populations, disrupted health services, and heightened risk of epidemic disease across affected regions, reinforcing, by stark practical demonstration, the continuing and urgent need for effective international health cooperation once the conflict eventually came to an end.

Fill in the blank: The League of Nations and its Health Organisation effectively ceased meaningful operation during the _____ years.

1.3.3 the path toward a new permanent international health organisation

As the Second World War drew to a close, the newly forming **United Nations** began considering how international health cooperation should be organised going forward, drawing directly on the institutional experience, and recognised limitations, of the earlier OIHP and the League of Nations Health Organisation, both discussed earlier in this Series.

This process would ultimately lead to the establishment of a new, unified, and considerably more ambitious **international health organisation**, replacing the fragmented earlier arrangements with a single permanent body possessing a genuinely global mandate, a development examined in full detail as the central subject of the next Series of this course.

Fill in the blank: The process of establishing a new, unified international health organisation drew directly on the institutional experience of the OIHP and the League of Nations _____.

Figure 1.3: A humanitarian relief worker distributing supplies to displaced families in the aftermath of war.

Pilot questions 1.3

1. Describe the expansion of international health cooperation during the interwar period. (Linked to SLO 1.5)
2. Explain why the League of Nations Health Organisation's practical reach remained limited despite genuine achievements. (Linked to SLO 1.5)
3. Describe the impact of the Second World War on existing international health institutions. (Linked to SLO 1.6)
4. Explain how the Second World War itself reinforced the need for international health cooperation. (Linked to SLO 1.6)
5. Describe how earlier institutional experience shaped the path toward a new international health organisation. (Linked to SLO 1.6)

Series Summary

This opening Series traced the **origins and development of international health** cooperation from its earliest beginnings through to the eve of the establishment of the World Health Organization, beginning with the **early origins** of international health cooperation in medieval port quarantine practice, the nineteenth century International Sanitary Conferences, and the first binding International Sanitary Convention of 1892, before examining the **early international health organisations** that followed, the International Office of Public Hygiene, the Health Organisation of the League of Nations, and the Pan American Sanitary Bureau, each contributing distinct institutional experience to the international health system that would eventually follow.

We then examined **international health in the interwar period and the Second World War**, the meaningful but politically constrained expansion of cooperation between the wars, the severe disruption caused by the Second World War itself, and the path this disruption ultimately opened toward a new, unified international health organisation. Having worked through this Series, you should now possess the essential historical foundation needed to understand the establishment and structure of the World Health Organization, examined in the next Series of this course.

Glossary of Terms

- **Quarantine:** detaining ships, passengers, or goods suspected of carrying disease before permitting entry.
- **International Sanitary Conference:** a nineteenth century multilateral meeting on shared quarantine and health standards.
- **International Sanitary Convention:** a binding international agreement on public health matters, first adopted in 1892.
- **OIHP:** the International Office of Public Hygiene, established in 1907 in Paris.
- **League of Nations:** the international organisation established after the First World War, precursor to the United Nations.
- **Health Organisation of the League of Nations:** the League of Nations' technical body responsible for international health matters.
- **Pan American Sanitary Bureau:** the oldest continuously operating international health organisation, established in 1902.
- **Interwar period:** the roughly two decades between the First and Second World Wars.
- **Multilateral cooperation:** cooperation involving more than two countries acting together.
- **Epidemiological intelligence:** systematically gathered information on the occurrence and spread of disease.
- **United Nations:** the international organisation established after the Second World War.

- **Institutional predecessor:** an earlier organisation whose experience and structure informed a later organisation.

Concept Check Questions [Series 1]

Objective questions

1. Quarantine was first developed by Mediterranean port cities in response to outbreaks of _____.
2. The International Sanitary Conferences began in 1851 in _____.
3. The first binding International Sanitary Convention, adopted in 1892, initially addressed _____.
4. The International Office of Public Hygiene, or OIHP, was established in 1907 in _____.
5. The Pan American Sanitary Bureau, established in 1902, is the oldest continuously operating international health _____.

Short-answer questions

6. Explain why unilateral national quarantine measures were poorly suited to controlling epidemic disease.
7. Describe the principal tasks of the International Office of Public Hygiene.
8. Explain why the Health Organisation of the League of Nations is considered a predecessor to the WHO.
9. Describe the impact of the Second World War on existing international health institutions.
10. Describe how earlier institutional experience shaped the path toward a new international health organisation.

Long-answer questions

11. Discuss the early origins of international health cooperation, including quarantine and the International Sanitary Conferences. (Linked to SLO 1.1, SLO 1.2)
12. Discuss the establishment and functions of the International Office of Public Hygiene. (Linked to SLO 1.3)
13. Discuss the establishment and functions of the Health Organisation of the League of Nations and the Pan American Sanitary Bureau. (Linked to SLO 1.4)
14. Discuss international health cooperation during the interwar period. (Linked to SLO 1.5)
15. Discuss the impact of the Second World War on international health and the path toward a new permanent international health organisation. (Linked to SLO 1.6)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Plague.
2. Paris.
3. Cholera.
4. Paris.
5. Organisation.

Short-answer questions

6. Epidemic disease is inherently international in nature, so inconsistent unilateral measures could not effectively address it.
7. Monitoring the international spread of specified epidemic diseases and supporting implementation of the International Sanitary Conventions.
8. It provided direct institutional experience and technical groundwork that informed the WHO's later establishment.
9. It severely disrupted operations, and the League of Nations and its Health Organisation effectively ceased meaningful activity.
10. The new United Nations drew directly on the experience and recognised limitations of the OIHP and League of Nations Health Organisation.

Long-answer questions

11. **Basic response:** Quarantine, the earliest form of international health protection, originated in medieval Mediterranean port cities, and grew into formal International Sanitary Conferences beginning in 1851 as trade intensified.

Value-added response: These conferences were slow to reach agreement, reflecting tension between disease control and trade interests, but eventually produced the first binding International Sanitary Convention in 1892, addressing cholera and establishing an important precedent for international health law.

12. **Basic response:** The International Office of Public Hygiene, established in 1907 in Paris, was the first permanent international body dedicated to public health, monitoring epidemic disease spread and supporting the Sanitary Conventions.

Value-added response: Though limited in scope, it provided a standing secretariat for ongoing coordination between conferences, an important institutional advance over purely periodic international meetings.

13. **Basic response:** The Health Organisation of the League of Nations, established after the First World War, had a broader mandate than the OIHP, while the Pan American Sanitary Bureau, established in 1902, remains the oldest continuously operating international health organisation.

Value-added response: The Health Organisation is regarded as a direct institutional predecessor to the WHO, while the Bureau demonstrated that effective regional cooperation was achievable even before comparable global institutions existed, later becoming the WHO's regional office for the Americas.

14. **Basic response:** The interwar period saw meaningful expansion of international health activity through the League of Nations Health Organisation, including epidemiological data exchange and coordinated epidemic response.

Value-added response: This cooperation remained constrained by the same political fragility affecting the League of Nations more broadly, with major powers never joining or later withdrawing, limiting the Health Organisation's practical reach despite genuine technical achievements.

15. **Basic response:** The Second World War severely disrupted existing international health cooperation, effectively halting League of Nations Health Organisation activity, while simultaneously generating an enormous humanitarian health burden.

Value-added response: This disruption reinforced the urgent need for effective international health cooperation, and the newly forming United Nations drew directly on the institutional experience of the OIHP and League of Nations Health Organisation in shaping a new, unified international health organisation.

Answers to Pilot Questions [Series 1]

Part 1.1

1. Detaining ships, passengers, or goods suspected of carrying disease; it originated in medieval Mediterranean port cities responding to plague.
2. Because epidemic disease spreads across borders, so uncoordinated national measures could not effectively address a fundamentally international problem.
3. 1851, in Paris.
4. Because of persistent tension between the goal of disease control and nations' economic interest in minimising disruption to trade.
5. 1892; it initially addressed cholera.

Part 1.2

1. 1907, in Paris.
2. Monitoring the international spread of specified epidemic diseases and supporting implementation of the Sanitary Conventions.
3. It encompassed epidemic disease control plus broader public health matters, including standardisation of biological products.
4. Because it provided direct institutional experience and technical groundwork that informed the WHO's later establishment.
5. 1902; it coordinated public health cooperation among countries of the Americas.

Part 1.3

1. The League of Nations Health Organisation undertook increasingly ambitious work, including epidemic response and epidemiological data exchange.
2. Because several major powers never joined or later withdrew from the League, limiting the Health Organisation's practical authority.
3. It severely disrupted existing cooperation, and the League of Nations and its Health Organisation effectively ceased meaningful operation.
4. The war generated a large humanitarian health burden, demonstrating the continuing and urgent need for effective international health cooperation.
5. The new United Nations drew directly on the recognised experience and limitations of the OIHP and League of Nations Health Organisation.

References and Attributions [Series 1]

- World Health Organization (2008). The First Ten Years of the World Health Organization. WHO Press.
- Howard-Jones, N. (1975). The Scientific Background of the International Sanitary Conferences, 1851-1938. WHO Press.
- Fee, E., Cueto, M., & Brown, T. M. (2016). WHO at 70: Origins and current issues. American Journal of Public Health.
- Pan American Health Organization (2002). Pan American Sanitary Bureau: a century of history.

Figures, Plates, Tables, and Boxes

- Figure 1.1: Officials inspecting a ship's cargo hold at a historical port quarantine station. AI-generated using the prompt: "A single clean, realistic historical illustration of port officials inspecting cargo aboard a docked sailing ship at a quarantine station, period-appropriate

setting, muted natural lighting, no text overlays, no multiple panels, accurate and respectful depiction, no graphic detail."

- Figure 1.2: Delegates seated around a conference table during an early twentieth century international health meeting. AI-generated using the prompt: "A single clean, realistic historical illustration of delegates seated around a formal wooden conference table in an early twentieth century meeting room, period-appropriate attire, muted natural lighting, no text overlays, no multiple panels, accurate and respectful depiction, no graphic detail."
- Figure 1.3: A humanitarian relief worker distributing supplies to displaced families in the aftermath of war. AI-generated using the prompt: "A single clean, realistic historical illustration of a relief worker distributing supplies to displaced families at an outdoor gathering point, period-appropriate setting, muted natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic detail."

Course code: COM 505

Course title: Global Health and Role of Non-Government Health Organisations

Course credit load: 1 Unit

Series 2: The World Health Organisation: Establishment, Objectives, Structure, and Functions

- **Part 2.1: Establishment and Objectives of the World Health Organisation**
  - Sub Part 2.1.1: Establishment of the World Health Organisation
  - Sub Part 2.1.2: The WHO constitution and definition of health
  - Sub Part 2.1.3: Objectives of the World Health Organisation
- **Part 2.2: Organisational Structure of the World Health Organisation**
  - Sub Part 2.2.1: The World Health Assembly
  - Sub Part 2.2.2: The Executive Board
  - Sub Part 2.2.3: The Secretariat and regional offices
- **Part 2.3: Functions of the World Health Organisation**
  - Sub Part 2.3.1: Normative and standard-setting functions
  - Sub Part 2.3.2: Technical support and capacity building functions
  - Sub Part 2.3.3: Health emergency response functions

Introduction

In the last Series, we traced the **origins and development of international health** cooperation from medieval quarantine practice through the fragmented, war-interrupted institutions of the early twentieth century. We now turn to the organisation that emerged from that long history to become the world's leading authority on international health, the **World Health Organization**, commonly known as the **WHO**. Picture delegates from newly independent and long-established nations alike, gathered together in the aftermath of a devastating world war, drafting a founding document bold enough to declare health itself, not merely the absence of disease, as a fundamental human right.

Understanding how this ambitious vision was translated into a working global organisation, with a defined structure and specific functions, is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of the establishment and objectives of the WHO, its organisational structure, and its principal functions.

This Series begins with the **establishment and objectives** of the World Health Organization, before turning to its **organisational structure**. It concludes with the WHO's principal **functions**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 2.1:** describe the establishment of the World Health Organization and the significance of its constitution
- **SLO 2.2:** state the WHO's definition of health and describe the objectives of the organisation
- **SLO 2.3:** describe the composition and role of the World Health Assembly and the Executive Board
- **SLO 2.4:** describe the role of the Secretariat and the WHO's regional office structure
- **SLO 2.5:** describe the normative, standard-setting, and technical support functions of the WHO, and
- **SLO 2.6:** describe the WHO's health emergency response functions.

2.1 Establishment and Objectives of the World Health Organisation

2.1.1 establishment of the world health organisation

A new, unified organisation with a genuinely global mandate

The **World Health Organization** was formally established on **7 April 1948**, a date now commemorated annually as **World Health Day**, when its founding **constitution** entered into force following ratification by a sufficient number of member states, bringing together, for the first time, a single unified organisation with a genuinely **global** health mandate, replacing the fragmented earlier arrangements discussed in the previous Series of this course.

The WHO was established as a **specialised agency** of the newly formed **United Nations**, discussed in the previous Series, reflecting a deliberate decision to embed international health

cooperation within the broader postwar international system rather than maintaining it as an entirely separate, standalone institution, a structural choice that continues to shape the WHO's relationships with other international bodies to this day.

Fill in the blank: The World Health Organization was formally established on 7 April 1948, a date now commemorated annually as World Health _____.

2.1.2 the who constitution and definition of health

The WHO **constitution** opens with a famously ambitious **definition of health**, describing it as a state of complete **physical**, **mental**, and **social** well-being, and not merely the absence of disease or infirmity, a definition that deliberately moved beyond a narrow, purely biomedical understanding of health toward a considerably broader, more holistic conception.

The constitution further declares the enjoyment of the highest attainable standard of health to be one of the fundamental **rights** of every human being, without distinction of race, religion, political belief, economic, or social condition, establishing an explicitly **rights-based** foundation for the organisation's subsequent work that distinguishes it from a purely technical or scientific body.

Fill in the blank: The WHO constitution defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or _____.

2.1.3 objectives of the world health organisation

The WHO constitution states that the organisation's overarching **objective** is the attainment by all peoples of the **highest possible level of health**, a deliberately broad and inclusive aim intended to guide the full range of the organisation's subsequent activities, examined in the functions discussed later in this Series, rather than confining its mandate to any single narrow area of health work.

In pursuit of this overarching objective, the WHO undertakes a wide range of more specific activities, including directing and coordinating international **health work**, assisting governments in strengthening their own **health services**, and promoting cooperation among scientific and professional groups contributing to the advancement of health, laying the foundation for the specific structural and functional arrangements examined in the remainder of this Series.

Fill in the blank: The WHO constitution states that the organisation's overarching objective is the attainment by all peoples of the highest possible level of _____.

Figure 2.1: Delegates signing a founding document at a formal ceremony table.

Pilot questions 2.1

6. Identify the date the WHO was formally established and the associated annual observance. (Linked to SLO 2.1)
7. Explain the WHO's relationship to the United Nations. (Linked to SLO 2.1)
8. State the WHO's constitutional definition of health. (Linked to SLO 2.2)
9. Explain the significance of the WHO's rights-based declaration on health. (Linked to SLO 2.2)
10. State the WHO's overarching constitutional objective. (Linked to SLO 2.2)

2.2 Organisational Structure of the World Health Organisation

2.2.1 the world health assembly

The WHO's supreme decision-making body

The **World Health Assembly**, or **WHA**, is the supreme **decision-making** body of the WHO, composed of delegations from all **member states**, and meets annually, generally in **Geneva**, Switzerland, to determine the organisation's overall **policies**, approve its programme budget, and elect the Director-General for a defined term.

Each member state is generally entitled to a single **vote** within the Assembly regardless of its size or financial contribution, reflecting the WHO's foundational principle of **sovereign equality** among member states in matters of global health governance, a structural feature that shapes the character of debate and decision-making within the organisation.

Fill in the blank: The World Health Assembly, the WHO's supreme decision-making body, meets annually, generally in _____, Switzerland.

2.2.2 the executive board

The **Executive Board** is composed of individuals technically qualified in the field of health, designated by a defined number of member states elected to serve on the Board for a fixed term, and is responsible for giving effect to the decisions and policies of the **World Health Assembly**, discussed in the previous sub-Part, meeting more frequently than the Assembly itself to provide ongoing operational oversight.

Among its principal responsibilities, the Executive Board prepares the **agenda** for forthcoming World Health Assembly sessions and submits **advice** and proposals to the Assembly for consideration, functioning as an essential intermediate governance layer between the broad annual policy-setting role of the Assembly and the day-to-day operational work of the Secretariat, discussed in the next sub-Part.

Fill in the blank: The Executive Board prepares the agenda for forthcoming World Health Assembly sessions and submits advice and proposals to the _____.

2.2.3 the secretariat and regional offices

The **Secretariat**, headed by the **Director-General**, comprises the WHO's international technical and administrative staff, based principally at the organisation's **headquarters** in Geneva, and is responsible for implementing the policies and programmes approved by the World Health Assembly and overseen by the Executive Board, discussed earlier in this Part.

The WHO additionally operates through **six regional offices**, each serving a defined group of member states, including the **African Regional Office**, based in Brazzaville, and others covering the Americas, Europe, South-East Asia, the Eastern Mediterranean, and the Western Pacific, allowing the organisation to adapt its global work to the specific health priorities and circumstances of each region.

Fill in the blank: The WHO operates through six regional offices, including the African Regional Office based in _____.

Table 2.2: Comparing the World Health Assembly and the Executive Board.

Feature	World Health Assembly	Executive Board
Composition	Delegations from all member states	Technically qualified individuals from elected member states
Meeting frequency	Annually	More frequently than the Assembly
Principal role	Supreme policy-making and budget approval	Prepares agenda and advises the Assembly

Pilot questions 2.2

6. Describe the composition and principal responsibilities of the World Health Assembly. (Linked to SLO 2.3)
7. Explain the principle of sovereign equality as it applies to voting in the World Health Assembly. (Linked to SLO 2.3)
8. Describe the composition and role of the Executive Board. (Linked to SLO 2.3)
9. Describe the role of the Secretariat and the position of the Director-General. (Linked to SLO 2.4)
10. List two of the WHO's six regional offices and their geographical scope. (Linked to SLO 2.4)

2.3 Functions of the World Health Organisation

2.3.1 normative and standard-setting functions

Setting shared global standards for health

One of the WHO's core functions is its **normative** role, developing and promoting internationally agreed **standards**, guidelines, and classifications in the field of health, including, for example, the **International Classification of Diseases**, used worldwide to standardise recording of causes of illness and death, and essential medicines lists guiding national medicine procurement and prescribing practice.

The WHO also possesses a limited but significant **treaty-making** power under its constitution, most notably exercised in the adoption of the **International Health Regulations**, examined in detail in the next Series of this course, and the **WHO Framework Convention on Tobacco Control**, illustrating how the organisation's normative function extends beyond voluntary guidance into legally binding international **instruments** in certain circumstances.

Fill in the blank: The WHO's normative role includes developing internationally agreed standards such as the International Classification of _____.

2.3.2 technical support and capacity building functions

The WHO provides substantial **technical support** to member states, particularly low and middle-income countries, including expert **advice** on health policy and programme design, direct support for **strengthening health systems**, and assistance with training of health workforce, reflecting one of the organisation's original constitutional objectives of assisting governments in strengthening their own health services.

This technical support function extends to promoting and conducting **research** in the field of health, disseminating scientific and technical **information**, and fostering activities in the field of mental health, particularly those affecting the harmony of human relations, illustrating the considerable breadth of areas encompassed by the WHO's broad capacity building mandate.

Fill in the blank: The WHO's technical support function includes assistance with training of health _____.

2.3.3 health emergency response functions

The WHO plays a central coordinating role during international **health emergencies**, including declaring a **public health emergency of international concern**, discussed further in the next Series of this course, mobilising international technical expertise and resources in support of affected countries, and providing authoritative, evidence-based **guidance** to member states and the wider public during rapidly evolving health crises.

This emergency response function has been exercised in response to numerous major outbreaks and pandemics over the WHO's history, and, given the increasing frequency and scale of such events in recent decades, **strengthening** the organisation's emergency response capacity has become an increasingly prominent priority within the broader discussion of WHO reform, a theme examined further in the next Series of this course.

Fill in the blank: The WHO's emergency response function includes declaring a public health emergency of international _____.

Figure 2.3: WHO technical staff reviewing global health data on a wall-mounted display in an operations room.

Pilot questions 2.3

6. Describe the WHO's normative function, with an example. (Linked to SLO 2.5)
7. Explain the significance of the WHO's limited treaty-making power. (Linked to SLO 2.5)
8. Describe two aspects of the WHO's technical support function to member states. (Linked to SLO 2.5)
9. Describe the WHO's role during an international health emergency. (Linked to SLO 2.6)
10. Explain why strengthening WHO emergency response capacity has become an increasingly prominent priority. (Linked to SLO 2.6)

Series Summary

This Series examined the **World Health Organization**, beginning with its **establishment** on 7 April 1948 as a specialised agency of the United Nations, its constitution's famously broad definition of health as complete physical, mental, and social well-being, and its overarching constitutional objective of the attainment by all peoples of the highest possible level of health, before turning to its **organisational structure**, the policy-making World Health Assembly, the intermediate

governance role of the Executive Board, and the implementing work of the Secretariat and its six regional offices.

We concluded with the WHO's principal **functions**, its normative and standard-setting role, its technical support and capacity building work with member states, and its central coordinating role during international health emergencies. Having worked through this Series, you should now possess a clear understanding of how the WHO is established, organised, and what it does, in preparation for the discussion of its challenges and the International Health Regulations in the next Series of this course.

Glossary of Terms

- **World Health Organization:** the United Nations specialised agency for international health, established in 1948.
- **World Health Day:** the annual observance on 7 April marking the WHO's establishment.
- **Specialised agency:** an autonomous organisation working with the United Nations under a formal agreement.
- **World Health Assembly:** the WHO's supreme decision-making body, composed of delegations from all member states.
- **Sovereign equality:** the principle that each member state holds equal standing, generally reflected in one vote per state.
- **Executive Board:** the WHO governance body that prepares the Assembly's agenda and advises on policy.
- **Secretariat:** the WHO's international technical and administrative staff, headed by the Director-General.
- **Director-General:** the chief technical and administrative officer of the WHO.
- **Regional office:** one of six WHO offices coordinating the organisation's work within a defined group of member states.
- **Normative function:** the WHO's role in developing and promoting internationally agreed health standards.
- **International Classification of Diseases:** a WHO standard used worldwide to record causes of illness and death.
- **Public health emergency of international concern:** the WHO's formal declaration of a serious international health risk.

Concept Check Questions [Series 2]

Objective questions

6. The World Health Organization was formally established on 7 April 1948, a date now commemorated as World Health _____.
7. The WHO constitution defines health as complete physical, mental, and social well-being, and not merely the absence of disease or _____.
8. The World Health Assembly meets annually, generally in _____, Switzerland.
9. The WHO operates through six regional offices, including the African Regional Office based in _____.
10. The WHO's normative role includes developing standards such as the International Classification of _____.

Short-answer questions

11. Explain the WHO's relationship to the United Nations.
12. Describe the composition and principal responsibilities of the World Health Assembly.
13. Describe the composition and role of the Executive Board.
14. Describe the role of the Secretariat and the position of the Director-General.
15. Describe the WHO's role during an international health emergency.

Long-answer questions

16. Discuss the establishment of the WHO and the significance of its constitution. (Linked to SLO 2.1, SLO 2.2)
17. Discuss the composition and roles of the World Health Assembly and the Executive Board. (Linked to SLO 2.3)
18. Discuss the role of the Secretariat and the WHO's regional office structure. (Linked to SLO 2.4)
19. Discuss the WHO's normative and technical support functions. (Linked to SLO 2.5)
20. Discuss the WHO's health emergency response functions. (Linked to SLO 2.6)

Answers to Concept Check Questions [Series 2]

Objective questions

16. Day.
17. Infirmity.
18. Geneva.
19. Brazzaville.
20. Diseases.

Short-answer questions

21. The WHO was established as a specialised agency of the United Nations, embedding international health within the broader postwar system.
22. It is composed of delegations from all member states, meeting annually to determine policy, approve the budget, and elect the Director-General.
23. The Executive Board comprises technically qualified individuals from elected member states, preparing the Assembly's agenda and giving effect to its decisions.
24. The Secretariat, headed by the Director-General, implements approved policies and programmes and comprises the WHO's international staff.
25. The WHO coordinates response, may declare a public health emergency of international concern, mobilises expertise and resources, and provides guidance.

Long-answer questions

26. **Basic response:** The WHO was established on 7 April 1948 as a UN specialised agency, with its constitution defining health broadly as complete physical, mental, and social well-being.

Value-added response: The constitution declares health a fundamental human right and sets the organisation's overarching objective as the attainment by all peoples of the highest possible level of health, establishing an explicitly rights-based foundation for its work.

27. **Basic response:** The World Health Assembly, composed of delegations from all member states, is the WHO's supreme policy-making body, meeting annually under a principle of sovereign equality, while the Executive Board, composed of technically qualified individuals, provides more frequent operational oversight.

Value-added response: The Executive Board prepares the Assembly's agenda and advises on policy, functioning as an essential intermediate governance layer between the Assembly's broad annual role and the Secretariat's day-to-day operational work.

28. **Basic response:** The Secretariat, headed by the Director-General and based principally in Geneva, implements the policies approved by the Assembly and overseen by the Executive Board.

Value-added response: The WHO's six regional offices, including the African Regional Office in Brazzaville, allow the organisation to adapt its global work to the specific health priorities and circumstances of each world region.

29. **Basic response:** The WHO's normative function includes developing standards such as the International Classification of Diseases and exercising limited treaty-making power, as seen in the International Health Regulations and the Framework Convention on Tobacco Control.

Value-added response: Its technical support function includes policy advice, health system strengthening, workforce training, and research, reflecting the organisation's original constitutional objective of assisting governments in strengthening their own health services.

30. **Basic response:** The WHO plays a central coordinating role during international health emergencies, including declaring a public health emergency of international concern and mobilising technical expertise and resources.

Value-added response: Given the increasing frequency and scale of major outbreaks and pandemics in recent decades, strengthening this emergency response capacity has become an increasingly prominent priority within broader discussions of WHO reform.

Answers to Pilot Questions [Series 2]

Part 2.1

6. 7 April 1948; commemorated annually as World Health Day.
7. The WHO is a specialised agency of the United Nations.
8. A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.
9. It establishes health as a fundamental human right, without distinction of race, religion, political belief, or economic or social condition.
10. The attainment by all peoples of the highest possible level of health.

Part 2.2

6. Delegations from all member states; it determines overall policy, approves the budget, and elects the Director-General.
7. Each member state is generally entitled to a single vote regardless of size or financial contribution.
8. Technically qualified individuals from elected member states; it prepares the Assembly's agenda and gives effect to its decisions.
9. The Secretariat, headed by the Director-General, implements approved policies and programmes.
10. The African Regional Office (Brazzaville) and the Regional Office for the Americas, among others.

Part 2.3

6. Developing internationally agreed standards, such as the International Classification of Diseases.
7. It allows the WHO to adopt legally binding instruments, such as the International Health Regulations, beyond voluntary guidance.
8. Providing expert policy advice and supporting health system strengthening and workforce training.
9. Coordinating response, potentially declaring a public health emergency of international concern, and providing guidance.
10. Because of the increasing frequency and scale of major outbreaks and pandemics in recent decades.

References and Attributions [Series 2]

- World Health Organization (1948). Constitution of the World Health Organization.
- World Health Organization (2008). The First Ten Years of the World Health Organization. WHO Press.
- World Health Organization. WHO governance: World Health Assembly and Executive Board (overview).
- World Health Organization. WHO regional offices (overview).

Figures, Plates, Tables, and Boxes

- Figure 2.1: Delegates signing a founding document at a formal ceremony table. AI-generated using the prompt: "A single clean, realistic historical illustration of delegates signing a formal document at a ceremonial table, period-appropriate attire, muted formal lighting, no text overlays, no multiple panels, accurate and respectful depiction, no graphic detail."
- Table 2.2: Comparing the World Health Assembly and the Executive Board. AI-generated using the prompt: "Create a clean reference table titled Comparing the World Health Assembly and the Executive Board, listing feature, World Health Assembly, and Executive Board. Simple clinical reference table style with outside border."
- Figure 2.3: WHO technical staff reviewing global health data on a wall-mounted display in an operations room. AI-generated using the prompt: "A single clean, realistic illustration of technical staff reviewing data on a wall-mounted screen in a calm professional operations

room, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

Course code: COM 505

Course title: Global Health and Role of Non-Government Health Organisations

Course credit load: 1 Unit

Series 3: Challenges Facing the World Health Organisation and International Health Regulations

- **Part 3.1: Challenges Facing the World Health Organisation**
  - Sub Part 3.1.1: Financial and funding challenges
  - Sub Part 3.1.2: Political and governance challenges
  - Sub Part 3.1.3: Operational and capacity challenges
- **Part 3.2: The International Health Regulations: Purpose and Framework**
  - Sub Part 3.2.1: Background and purpose of the International Health Regulations
  - Sub Part 3.2.2: Core capacities required under the International Health Regulations
  - Sub Part 3.2.3: The concept of a public health emergency of international concern
- **Part 3.3: Implementation of the International Health Regulations**
  - Sub Part 3.3.1: Obligations of states parties under the International Health Regulations
  - Sub Part 3.3.2: Role of the WHO in International Health Regulations implementation
  - Sub Part 3.3.3: Challenges in implementing the International Health Regulations

Introduction

In the last Series, we examined the **establishment, objectives, structure, and functions** of the World Health Organization. No organisation of the WHO's scale and ambition operates without significant difficulty, however, and we now turn to the **challenges** the organisation faces, alongside one of its most important legal instruments, the **International Health Regulations**. Picture the WHO's Director-General weighing whether to declare a public health emergency of international concern, aware that the decision carries major diplomatic, economic, and public health consequences, while simultaneously managing a budget substantially dependent on voluntary

contributions from a small number of donors. Understanding both the organisation's practical constraints and the legal framework within which it operates is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of the challenges facing the WHO, and to explain the purpose, framework, and implementation of the International Health Regulations.

This Series begins with the **challenges facing the World Health Organisation**, before turning to the **purpose and framework** of the International Health Regulations. It concludes with their **implementation**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 3.1:** describe the financial and funding challenges facing the WHO
- **SLO 3.2:** describe the political, governance, operational, and capacity challenges facing the WHO
- **SLO 3.3:** explain the background, purpose, and core capacities of the International Health Regulations
- **SLO 3.4:** define a public health emergency of international concern
- **SLO 3.5:** describe the obligations of states parties and the role of the WHO under the International Health Regulations, and
- **SLO 3.6:** describe the challenges in implementing the International Health Regulations.

3.1 Challenges Facing the World Health Organisation

3.1.1 financial and funding challenges

An ambitious mandate constrained by an uncertain budget

A significant proportion of the WHO's overall **budget** is derived from **voluntary contributions**, provided at the discretion of individual member states and other donors, rather than from **assessed contributions**, the mandatory dues member states are required to pay according to an agreed formula, meaning a considerable share of the organisation's funding is neither predictable nor guaranteed from one budget cycle to the next.

This heavy reliance on voluntary funding means individual donors can exert disproportionate **influence** over which specific programmes and priorities receive adequate resources, since voluntary contributions are often **earmarked** for particular purposes chosen by the donor, potentially at the expense of the organisation's own independently determined priorities, a persistent tension in ongoing discussions of WHO **financing reform**.

Fill in the blank: A significant proportion of the WHO's budget derives from voluntary contributions rather than mandatory assessed _____.

3.1.2 political and governance challenges

As an intergovernmental organisation composed of sovereign member states, the WHO's decision-making inevitably reflects underlying **political** dynamics among its members, meaning achieving **consensus** on contested issues can prove difficult, and the organisation's independence and authority can, at times, be constrained by the differing, and occasionally competing, interests of powerful member states.

The WHO also faces ongoing governance questions regarding its own internal **accountability** and **transparency**, and its relationship with other international bodies working in overlapping areas of global health, requiring continuous effort to maintain effective coordination and avoid unnecessary duplication of work across the increasingly crowded global health governance landscape.

Fill in the blank: As an intergovernmental organisation, the WHO's decision-making inevitably reflects underlying political dynamics among its member _____.

3.1.3 operational and capacity challenges

The WHO faces significant **operational** challenges in translating its global normative and technical guidance into effective action at **country level**, particularly in settings with weak underlying health systems, since the organisation itself generally provides technical support and coordination rather than directly delivering health services, meaning ultimate implementation always depends substantially on national **capacity** and commitment.

Workforce and logistical **capacity constraints** within the organisation itself, particularly during major simultaneous health emergencies affecting multiple regions, can further strain the WHO's ability to respond effectively everywhere it is needed at once, reinforcing the importance of the strengthened emergency response capacity discussed as an ongoing priority in the previous Series of this course.

Fill in the blank: The WHO faces significant operational challenges in translating its global guidance into effective action at _____ level.

Figure 3.1: A WHO official presenting a budget chart during a formal meeting.

Pilot questions 3.1

11. Distinguish assessed contributions from voluntary contributions in the WHO's funding. (Linked to SLO 3.1)
12. Explain why heavy reliance on voluntary, earmarked funding presents a challenge for the WHO. (Linked to SLO 3.1)
13. Explain why achieving consensus among member states can be politically difficult for the WHO. (Linked to SLO 3.2)
14. Describe a governance challenge relating to WHO accountability or its relationship with other bodies. (Linked to SLO 3.2)
15. Explain why country-level implementation of WHO guidance depends substantially on national capacity. (Linked to SLO 3.2)

3.2 The International Health Regulations: Purpose and Framework

3.2.1 background and purpose of the international health regulations

A binding legal instrument for cross-border health threats

The **International Health Regulations**, or **IHR**, are a legally binding international instrument adopted by member states of the WHO under the treaty-making authority discussed in the previous Series of this course, tracing their conceptual origins to the earlier International Sanitary Conventions discussed in an even earlier Series, though substantially revised and expanded, most notably in **2005**, to address a far broader range of public health risks than their historical predecessors.

The stated purpose of the IHR is to prevent, protect against, control, and provide a public health response to the international spread of disease, in ways that are commensurate with and restricted to **public health risks**, while avoiding unnecessary interference with international **traffic** and **trade**, directly echoing the historical tension between disease control and commercial disruption discussed in an earlier Series of this course.

Fill in the blank: The International Health Regulations were substantially revised and expanded, most notably in the year _____.

3.2.2 core capacities required under the international health regulations

The IHR require states parties to develop and maintain defined minimum **core capacities**, including effective national **surveillance** and reporting systems, capacity for prompt **laboratory** diagnosis, and the ability to mount a coordinated **response** to detected public health events, at both national and, critically, designated international points of entry such as ports, airports, and ground crossings.

These core capacity requirements reflect a recognition that effective global health security depends fundamentally on the strength of individual national systems, since a public health threat can only be detected and reported promptly if the country where it first emerges possesses adequate surveillance and **laboratory** capacity, reinforcing the surveillance principles discussed in an earlier related course.

Fill in the blank: The IHR require states parties to develop core capacities including effective national surveillance and reporting systems, and capacity for prompt _____ diagnosis.

3.2.3 the concept of a public health emergency of international concern

A **public health emergency of international concern**, or **PHEIC**, is a formal declaration made by the **Director-General** of the WHO, following advice from an independent **Emergency Committee**, when an event is determined to constitute a serious, unusual, or unexpected public health risk

requiring a coordinated **international** response, representing the highest level of alert available under the International Health Regulations.

A PHEIC declaration serves both to mobilise **international resources** and attention toward the affected countries and to encourage coordinated, evidence-based measures rather than uncoordinated, potentially excessive unilateral actions by individual countries, and, once declared, the WHO Director-General may issue **temporary recommendations** to member states regarding appropriate health measures in response to the specific event.

Fill in the blank: A public health emergency of international concern is a formal declaration made by the Director-General following advice from an independent Emergency _____.

Figure 3.2: A public health officer scanning a traveller's temperature at an international airport arrivals point.

Pilot questions 3.2

11. Describe the background and stated purpose of the International Health Regulations. (Linked to SLO 3.3)

12. Explain how the IHR balance public health protection against interference with trade and traffic. (Linked to SLO 3.3)
13. List two core capacities states parties are required to develop under the IHR. (Linked to SLO 3.3)
14. Define a public health emergency of international concern and identify who declares one. (Linked to SLO 3.4)
15. Explain the purpose of a PHEIC declaration. (Linked to SLO 3.4)

3.3 Implementation of the International Health Regulations

3.3.1 obligations of states parties under the international health regulations

Shared legal duties binding all member states

States parties to the IHR are obligated to develop and maintain the **core capacities** discussed in the previous Part of this Series, and to notify the WHO, generally within **24 hours**, of events that may constitute a public health emergency of international concern, using a defined decision instrument to guide this assessment, reflecting the emphasis on **timeliness** central to effective disease surveillance discussed in an earlier related course.

States parties additionally commit to designating a **National IHR Focal Point**, a national centre accessible at all times for urgent communication with the WHO, and to responding to requests for verification of reported events, together forming a shared, legally grounded system of mutual **obligation** intended to ensure no country need face a significant cross-border health threat entirely alone.

Fill in the blank: States parties to the IHR are generally required to notify the WHO within _____ hours of events that may constitute a public health emergency of international concern.

3.3.2 role of the who in international health regulations implementation

The WHO plays a central role in supporting IHR implementation, including providing **technical assistance** to help states parties develop the required core capacities, discussed earlier in this Series, and **assessing** and verifying reported events to determine whether they may constitute a public health emergency of international concern, drawing on the advice of the independent Emergency Committee discussed earlier in this Series.

The WHO additionally maintains ongoing global **surveillance** for events with potential international significance, including information received from sources beyond formal government notification,

and coordinates the wider international **response** once a significant event has been identified, functioning throughout as the central coordinating hub of the entire IHR system.

Fill in the blank: The WHO plays a central role in assessing and verifying reported events to determine whether they may constitute a public health emergency of international _____.

3.3.3 challenges in implementing the international health regulations

Implementation of the IHR faces significant practical challenges, including substantial **variation** in national core capacity across member states, particularly in low-resource settings, meaning the theoretical obligations set out in the Regulations are not always matched by the practical **capacity** necessary to fulfil them, echoing the operational challenges facing the WHO more broadly discussed earlier in this Series.

Further challenges include occasional reluctance among states to promptly **report** events, out of concern for potential economic or reputational consequences, such as travel or trade restrictions, despite the IHR's explicit aim of avoiding unnecessary interference with **trade** and traffic, illustrating that the same underlying tension between disease control and economic interest that shaped the earliest International Sanitary Conventions, discussed in an earlier Series of this course, continues to influence international health cooperation today.

Fill in the blank: States may show reluctance to promptly report events under the IHR out of concern for potential economic or reputational _____.

Table 3.3: Comparing IHR obligations of states parties and the role of the WHO.

Feature	States parties	World Health Organization
Core obligation	Develop core capacities; notify events within 24 hours	Assess and verify reported events
Key contact point	National IHR Focal Point	WHO Secretariat and Emergency Committee
Main output	Timely event notification	PHEIC declaration and temporary recommendations

Pilot questions 3.3

11. Describe the notification obligation of states parties under the IHR. (Linked to SLO 3.5)
12. Define the National IHR Focal Point and its purpose. (Linked to SLO 3.5)
13. Describe the WHO's role in assessing and verifying reported events under the IHR. (Linked to SLO 3.5)

14. Explain why substantial variation in national core capacity presents a challenge to IHR implementation. (Linked to SLO 3.6)
15. Explain why some states may be reluctant to promptly report events under the IHR. (Linked to SLO 3.6)

Series Summary

This Series examined the **challenges facing the World Health Organisation**, beginning with its **financial and funding** challenges, particularly its heavy reliance on voluntary, often earmarked contributions, before turning to its **political and governance** challenges, and its **operational and capacity** challenges in translating global guidance into effective country-level action, before moving to the **International Health Regulations**, their background and purpose, their required core capacities, and the concept of a public health emergency of international concern.

We concluded with the **implementation** of the International Health Regulations, the obligations of states parties, the WHO's central coordinating role, and the practical challenges, including variable national capacity and occasional reluctance to report, that continue to affect their real-world operation. Having worked through this Series, you should now possess a critical, balanced understanding of the WHO's practical constraints alongside its most important legal instrument, in preparation for the discussion of the TDR Programme in the next Series of this course.

Glossary of Terms

- **Assessed contribution:** the mandatory dues member states pay to the WHO according to an agreed formula.
- **Voluntary contribution:** funding provided to the WHO at the discretion of individual donors, often earmarked.
- **International Health Regulations:** a legally binding WHO instrument governing the international response to public health risks.
- **Core capacity:** the minimum national surveillance, laboratory, and response capability required under the IHR.
- **PHEIC:** public health emergency of international concern, the WHO's highest level of alert under the IHR.

- **Emergency Committee:** an independent WHO advisory body that recommends whether to declare a PHEIC.
- **Temporary recommendation:** time-limited health measure advice issued by the WHO Director-General during a PHEIC.
- **National IHR Focal Point:** a national centre accessible at all times for urgent communication with the WHO under the IHR.
- **Point of entry:** a designated port, airport, or ground crossing subject to IHR public health capacity requirements.
- **Notification:** the formal reporting of a potential public health event to the WHO under the IHR.
- **Global health security:** collective activities to minimise the danger and impact of acute public health events across borders.
- **Earmarked funding:** voluntary contributions designated by a donor for a specific purpose or programme.

Concept Check Questions [Series 3]

Objective questions

11. A significant proportion of the WHO's budget derives from voluntary contributions rather than mandatory assessed _____.
12. The International Health Regulations were substantially revised and expanded, most notably in the year _____.
13. A public health emergency of international concern is declared by the Director-General following advice from an independent _____ Committee.
14. States parties to the IHR are generally required to notify the WHO within _____ hours of a potential PHEIC.
15. States may show reluctance to report events under the IHR out of concern for economic or reputational _____.

Short-answer questions

16. Explain why heavy reliance on voluntary, earmarked funding presents a challenge for the WHO.
17. Explain how the IHR balance public health protection against interference with trade and traffic.
18. Define a public health emergency of international concern and identify who declares one.
19. Define the National IHR Focal Point and its purpose.
20. Explain why substantial variation in national core capacity presents a challenge to IHR implementation.

Long-answer questions

21. Discuss the financial and funding challenges facing the WHO. (Linked to SLO 3.1)
22. Discuss the political, governance, operational, and capacity challenges facing the WHO. (Linked to SLO 3.2)
23. Discuss the background, purpose, and core capacities of the International Health Regulations. (Linked to SLO 3.3, SLO 3.4)
24. Discuss the obligations of states parties and the role of the WHO under the International Health Regulations. (Linked to SLO 3.5)
25. Discuss the challenges in implementing the International Health Regulations. (Linked to SLO 3.6)

Answers to Concept Check Questions [Series 3]

Objective questions

31. Contributions.
32. 2005.
33. Emergency.
34. 24.
35. Consequences.

Short-answer questions

36. Voluntary contributions are unpredictable and often earmarked by donors, potentially skewing priorities away from the organisation's own determinations.
37. The IHR aim to protect against public health risks while avoiding unnecessary interference with international trade and traffic.
38. A serious, unusual, or unexpected public health risk requiring coordinated international response, declared by the WHO Director-General.
39. A national centre accessible at all times for urgent communication with the WHO under the IHR.
40. Because theoretical obligations are not always matched by practical capacity, particularly in low-resource settings.

Long-answer questions

41. **Basic response:** A significant share of the WHO's budget comes from voluntary rather than assessed contributions, meaning funding is often unpredictable and earmarked by donors for specific purposes.

Value-added response: This heavy reliance on voluntary funding allows individual donors disproportionate influence over which programmes receive resources, a persistent tension in ongoing discussions of WHO financing reform.

42. **Basic response:** As an intergovernmental body, the WHO's decision-making reflects underlying political dynamics among member states, making consensus on contested issues difficult, alongside ongoing questions of internal accountability and coordination with other bodies.

Value-added response: Operationally, the WHO depends substantially on national capacity and commitment for country-level implementation, and workforce and logistical constraints can strain its ability to respond to simultaneous emergencies across multiple regions.

43. **Basic response:** The IHR, a legally binding instrument tracing its origins to the earlier International Sanitary Conventions and substantially revised in 2005, aim to protect against international disease spread while avoiding unnecessary interference with trade and traffic.

Value-added response: States parties must develop core capacities in surveillance, laboratory diagnosis, and response, both nationally and at designated points of entry, recognising that global health security depends fundamentally on the strength of individual national systems.

44. **Basic response:** States parties must develop core capacities and notify the WHO within 24 hours of potential PHEIC events, using a National IHR Focal Point for urgent communication, while the WHO assesses and verifies reported events and coordinates the international response.

Value-added response: Once a PHEIC is declared, the WHO Director-General may issue temporary recommendations to member states, mobilising international resources and encouraging coordinated, evidence-based measures over uncoordinated unilateral action.

45. **Basic response:** Implementation of the IHR faces substantial variation in national core capacity, particularly in low-resource settings, meaning obligations are not always matched by practical capability.

Value-added response: States may also show reluctance to promptly report events out of concern for economic or reputational consequences such as trade restrictions, reflecting the same underlying tension between disease control and commercial interest present since the earliest International Sanitary Conventions.

Answers to Pilot Questions [Series 3]

Part 3.1

11. Assessed contributions are mandatory dues under an agreed formula; voluntary contributions are provided at donor discretion.
12. Because voluntary funding is unpredictable and often earmarked, potentially skewing priorities away from the organisation's own determinations.
13. Because the WHO's sovereign member states may hold differing, sometimes competing, interests on contested issues.
14. Ongoing questions around internal accountability, transparency, and coordination with other international bodies.
15. Because the WHO provides technical support and coordination rather than directly delivering health services in countries.

Part 3.2

11. To prevent, protect against, control, and respond to the international spread of disease, tracing origins to the earlier Sanitary Conventions.
12. The IHR restrict measures to public health risks while explicitly aiming to avoid unnecessary interference with trade and traffic.
13. Effective national surveillance and reporting systems, and capacity for prompt laboratory diagnosis.
14. A serious international public health risk declared by the WHO Director-General, following Emergency Committee advice.
15. It mobilises international resources and attention and encourages coordinated, evidence-based response over unilateral action.

Part 3.3

11. States parties must notify the WHO, generally within 24 hours, of events that may constitute a PHEIC.
12. A national centre accessible at all times for urgent communication with the WHO under the IHR.
13. The WHO assesses and verifies reported events, drawing on advice from the independent Emergency Committee.
14. Because obligations set out in the Regulations are not always matched by practical capacity in low-resource settings.
15. Because of concern for potential economic or reputational consequences, such as travel or trade restrictions.

References and Attributions [Series 3]

- World Health Organization (2005, amended). International Health Regulations (3rd ed.).
- World Health Organization. WHO programme budget and financing (overview).
- World Health Organization. IHR core capacities and states parties obligations (overview).
- World Health Organization. Public health emergencies of international concern (overview).

Figures, Plates, Tables, and Boxes

- Figure 3.1: A WHO official presenting a budget chart during a formal meeting. AI-generated using the prompt: "A single clean, realistic illustration of an official presenting a chart on a screen to seated delegates in a formal meeting room, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
- Figure 3.2: A public health officer scanning a traveller's temperature at an international airport arrivals point. AI-generated using the prompt: "A single clean, realistic illustration of a public health officer scanning a traveller's temperature at an airport arrivals area, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic detail."
- Table 3.3: Comparing IHR obligations of states parties and the role of the WHO. AI-generated using the prompt: "Create a clean reference table titled IHR Obligations: States Parties and WHO, listing feature, states parties, and World Health Organization. Simple clinical reference table style with outside border."

Course code: COM 505

Course title: Global Health and Role of Non-Government Health Organisations

Course credit load: 1 Unit

Series 4: The TDR Programme: Establishment, Objectives, and Operations

- **Part 4.1: Establishment and Background of the TDR Programme**
  - Sub Part 4.1.1: Background and rationale for establishing TDR
  - Sub Part 4.1.2: Establishment and co-sponsorship of TDR
  - Sub Part 4.1.3: Governance structure of TDR
- **Part 4.2: Objectives of the TDR Programme**
  - Sub Part 4.2.1: Research objectives of TDR
  - Sub Part 4.2.2: Capacity strengthening objectives of TDR
  - Sub Part 4.2.3: Diseases targeted by TDR
- **Part 4.3: Operations of the TDR Programme**
  - Sub Part 4.3.1: Research funding and grant-making operations
  - Sub Part 4.3.2: Research capacity strengthening operations
  - Sub Part 4.3.3: Achievements and ongoing operations of TDR

Introduction

In the last Series, we examined the **challenges** facing the World Health Organization and the **International Health Regulations**. We now turn to a specific WHO co-sponsored programme with a distinctive and important mandate, the **Special Programme for Research and Training in Tropical Diseases**, commonly known by its abbreviation **TDR**. Picture a small team of scientists in a research institute in a low-income country, receiving both a modest research grant and, just as importantly, sustained mentorship and training that will allow them to lead their own research programme for years to come. Understanding how such a dedicated programme was established, what it aims to achieve, and how it actually operates is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of the establishment, objectives, and operations of the TDR Programme.

This Series begins with the **establishment and background** of TDR, before turning to its **objectives**. It concludes with an examination of its practical **operations**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 4.1:** describe the background, rationale, and establishment of the TDR Programme
- **SLO 4.2:** describe the governance and co-sponsorship structure of TDR
- **SLO 4.3:** describe the research and capacity strengthening objectives of TDR
- **SLO 4.4:** list the diseases targeted by TDR
- **SLO 4.5:** describe the research funding and capacity strengthening operations of TDR, and
- **SLO 4.6:** describe the achievements and ongoing operations of TDR.

4.1 Establishment and Background of the TDR Programme

4.1.1 background and rationale for establishing tdr

Addressing chronic under-investment in diseases of poverty

By the early **1970s**, it had become increasingly apparent that diseases disproportionately affecting **poor** populations in tropical, low-income countries received substantially less global research investment than their true public health burden warranted, since ordinary **commercial** research incentives are generally weak for diseases affecting populations with limited ability to pay for resulting new products.

This recognised gap in research attention created the underlying **rationale** for a dedicated, coordinated global programme specifically focused on **tropical diseases** of major importance to low and middle-income countries, capable of directing research resources and international scientific collaboration toward diseases that market forces alone were unlikely to adequately address.

Fill in the blank: Ordinary commercial research incentives are generally weak for diseases affecting populations with limited ability to pay for resulting new _____.

4.1.2 establishment and co-sponsorship of tdr

The **Special Programme for Research and Training in Tropical Diseases** was established in **1975**, co-sponsored by several international agencies working together, including the **World Health Organization**, the **United Nations Children's Fund**, the **United Nations Development Programme**, and the **World Bank**, reflecting a deliberate, coordinated multi-agency approach rather than a programme housed within a single organisation alone.

This multi-agency co-sponsorship structure was intended to draw on the distinct complementary strengths of each participating organisation, combining the WHO's technical health **expertise**, the development finance and administrative capacity of agencies such as the World Bank, and the broader development mandate of **UNDP** and **UNICEF**, in support of a shared programme with a genuinely global research and development mission.

Fill in the blank: The Special Programme for Research and Training in Tropical Diseases was established in the year _____.

4.1.3 governance structure of tdr

TDR is governed by a **Joint Coordinating Board**, representing the co-sponsoring agencies, contributing donor countries, and, importantly, representatives of disease-endemic countries themselves, reflecting a deliberate governance principle that countries most directly affected by the diseases TDR addresses should have a meaningful voice in setting the programme's overall strategic direction.

Day-to-day management of TDR is undertaken by a dedicated **Secretariat**, hosted at WHO headquarters in Geneva, which implements the strategic priorities set by the Joint Coordinating Board, and TDR additionally draws on the advice of a **Scientific and Technical Advisory Committee**, providing independent scientific input into the programme's research priorities and funding decisions.

Fill in the blank: TDR is governed by a Joint Coordinating Board, representing co-sponsoring agencies, donor countries, and disease-endemic _____.

Figure 4.1: Board members seated around a table during a formal programme governance meeting.

Pilot questions 4.1

16. Explain the rationale for establishing a dedicated global tropical disease research programme. (Linked to SLO 4.1)
17. Identify the year TDR was established. (Linked to SLO 4.1)
18. List two of TDR's co-sponsoring agencies. (Linked to SLO 4.1)
19. Describe the composition and role of the Joint Coordinating Board. (Linked to SLO 4.2)
20. Describe the role of TDR's Secretariat and its Scientific and Technical Advisory Committee. (Linked to SLO 4.2)

4.2 Objectives of the TDR Programme

4.2.1 research objectives of tdr

Generating new knowledge and tools against tropical diseases

A central objective of TDR is to support high quality **research** leading to new or improved **diagnostics**, **drugs**, and **vector control** tools for tropical diseases disproportionately affecting poor populations, funding research across the full pathway from basic scientific discovery through to practical, field-applicable **implementation** research.

TDR places particular emphasis on **implementation research**, examining not only whether a new tool works under ideal conditions but also how it can be effectively delivered and used within real-world health systems in disease-endemic countries, reflecting a deliberate recognition that scientific discovery alone is insufficient without practical attention to how new tools will actually reach the populations who need them.

Fill in the blank: TDR places particular emphasis on implementation research, examining how a new tool can be effectively delivered within real-world health _____.

4.2.2 capacity strengthening objectives of tdr

Alongside its research objectives, TDR places substantial emphasis on **capacity strengthening**, supporting the development of sustainable research capability within disease-endemic countries themselves, including **training** of individual scientists and institutional support helping research institutions in affected countries build durable capacity to conduct their own high quality tropical disease research over the long term.

This capacity strengthening objective reflects a deliberate strategic choice to move beyond simply funding research conducted by external researchers on behalf of affected countries, toward genuinely building **local** scientific leadership and institutional capability within the countries most affected by tropical diseases, a principle intended to ensure the benefits of TDR's investment persist well beyond any single funded research project.

Fill in the blank: TDR's capacity strengthening objective aims to build durable research capability within disease-endemic countries, moving beyond funding research by _____ researchers alone.

4.2.3 diseases targeted by tdr

Diseases historically targeted by TDR fall within the broader category of **neglected tropical diseases**, including **malaria**, **onchocerciasis**, **schistosomiasis**, **lymphatic filariasis**, **leprosy**, and **trypanosomiasis**, or sleeping sickness, each selected on the basis of substantial disease burden combined with historically limited research investment relative to that burden.

TDR's specific disease priorities have evolved somewhat over time in response to changing global disease burden and emerging research opportunities, but the programme's underlying selection **criteria**, disproportionate impact on poor populations and persistent research **neglect** relative to disease burden, have remained broadly consistent since the programme's establishment, discussed earlier in this Series.

Fill in the blank: TDR's underlying selection criteria include disproportionate impact on poor populations and persistent research neglect relative to disease _____.

Table 4.2: Comparing the research and capacity strengthening objectives of TDR.

Feature	Research objective	Capacity strengthening objective
Main focus	New diagnostics, drugs, and vector control tools	Sustainable local scientific capability
Key emphasis	Implementation research in real-world settings	Training and institutional support
Intended long-term outcome	New or improved tools reaching affected populations	Durable, locally led research leadership

Pilot questions 4.2

16. Describe TDR's research objective, including the concept of implementation research. (Linked to SLO 4.3)
17. Explain the rationale behind TDR's capacity strengthening objective. (Linked to SLO 4.3)
18. List three diseases historically targeted by TDR. (Linked to SLO 4.4)
19. Describe TDR's underlying criteria for selecting priority diseases. (Linked to SLO 4.4)
20. Explain why TDR emphasises building local, rather than only external, research leadership. (Linked to SLO 4.3)

4.3 Operations of the TDR Programme

4.3.1 research funding and grant-making operations

Directing resources toward priority tropical disease research

TDR operates principally through a competitive **grant-making** process, providing research funding to scientists and institutions, with particular priority given to researchers based in disease-endemic **countries**, in line with the capacity strengthening objective discussed earlier in this Series, and with funding decisions guided by independent scientific review coordinated through the Scientific and Technical Advisory Committee discussed earlier in this Series.

TDR's grant-making operations span the full research **pathway**, from smaller grants supporting early career researchers and pilot studies through to larger awards supporting more advanced clinical or implementation research, reflecting a deliberate strategy of nurturing research talent and promising research questions across their full development trajectory rather than funding only already well established researchers or fully mature research questions.

Fill in the blank: TDR operates principally through a competitive grant-making process, with particular priority given to researchers based in disease-endemic _____.

4.3.2 research capacity strengthening operations

In practical operation, TDR's capacity strengthening work includes structured **training** programmes and **fellowships** supporting individual researchers, mentorship arrangements pairing early career scientists with more experienced researchers, and direct institutional support helping research institutions in disease-endemic countries develop durable **infrastructure** and administrative capability.

TDR additionally supports the development of **research networks** connecting scientists and institutions across different disease-endemic countries, facilitating shared learning, collaborative research, and, importantly, ongoing peer support extending well beyond the duration of any single individual funded grant or training placement.

Fill in the blank: TDR supports the development of research networks connecting scientists and institutions across different disease-endemic _____.

4.3.3 achievements and ongoing operations of tdr

Since its establishment, discussed earlier in this Series, TDR has contributed to the development of several important tools now used in tropical disease control, including improved **diagnostics** and treatment regimens for diseases such as onchocerciasis and schistosomiasis, discussed in an earlier related course, and has supported the training of a substantial number of researchers now working within disease-endemic countries themselves.

TDR continues to operate today, adapting its priorities to evolving global tropical disease **burden** and research opportunities while maintaining its core dual mission of research and capacity strengthening discussed throughout this Series, and remains a distinctive example of coordinated multi-agency investment in diseases that ordinary commercial research incentives, discussed earlier in this Series, would otherwise be unlikely to adequately address.

Fill in the blank: TDR continues to operate today, adapting its priorities to evolving global tropical disease burden and research _____.

Figure 4.3: A senior researcher mentoring a younger scientist at a laboratory bench.

Pilot questions 4.3

16. Describe TDR's grant-making process and its priority for disease-endemic country researchers. (Linked to SLO 4.5)
17. Explain why TDR funds research across the full pathway from early career to advanced research. (Linked to SLO 4.5)
18. Describe two components of TDR's practical capacity strengthening operations. (Linked to SLO 4.5)
19. Describe one achievement attributable to TDR since its establishment. (Linked to SLO 4.6)
20. Explain why TDR is described as a distinctive example of coordinated multi-agency investment. (Linked to SLO 4.6)

Series Summary

This Series examined the **TDR Programme**, beginning with its **establishment and background**, the recognised gap in research investment for diseases affecting poor populations that motivated its founding in 1975, its multi-agency co-sponsorship structure, and its Joint Coordinating Board and Secretariat governance arrangements, before turning to its **objectives**, its research objective

spanning basic science through implementation research, its capacity strengthening objective aimed at building durable local scientific leadership, and the specific neglected tropical diseases it has historically targeted.

We concluded with TDR's practical **operations**, its competitive grant-making process prioritising disease-endemic country researchers, its training, mentorship, and institutional capacity strengthening activities, and its notable achievements and continuing operation today. Having worked through this Series, you should now possess a clear understanding of how TDR was established, what it aims to achieve, and how it operates in practice, in preparation for the discussion of other governmental and non-governmental organisations in international health in the final Series of this course.

Glossary of Terms

- **TDR:** the Special Programme for Research and Training in Tropical Diseases, established in 1975.
- **Co-sponsorship:** joint governance and funding of a programme by multiple partner agencies.
- **Joint Coordinating Board:** TDR's governing body, representing co-sponsors, donors, and disease-endemic countries.
- **Secretariat:** the staff body responsible for day-to-day management and implementation of a programme.
- **Scientific and Technical Advisory Committee:** an independent body providing scientific advice on TDR's research priorities.
- **Implementation research:** research examining how a tool can be effectively delivered and used within real-world health systems.
- **Capacity strengthening:** building sustainable local research capability within disease-endemic countries.
- **Neglected tropical disease:** a disease disproportionately affecting poor populations and historically under-resourced in research.
- **Grant-making:** the process of providing competitive research funding to selected scientists and institutions.
- **Research network:** a connected group of scientists and institutions collaborating and sharing learning.
- **Disease-endemic country:** a country where a particular disease is consistently present within the population.
- **Fellowship:** structured funded support enabling an individual researcher's training or research development.

Concept Check Questions [Series 4]

Objective questions

16. Ordinary commercial research incentives are generally weak for diseases affecting populations with limited ability to pay for resulting new _____.
17. The Special Programme for Research and Training in Tropical Diseases was established in the year _____.
18. TDR is governed by a Joint Coordinating Board, representing co-sponsoring agencies, donors, and disease-endemic _____.
19. TDR's underlying selection criteria include disproportionate impact on poor populations and persistent research neglect relative to disease _____.
20. TDR operates principally through a competitive grant-making process, with priority given to researchers based in disease-endemic _____.

Short-answer questions

21. Explain the rationale for establishing a dedicated global tropical disease research programme.
22. List two of TDR's co-sponsoring agencies.
23. Describe TDR's research objective, including the concept of implementation research.
24. Explain the rationale behind TDR's capacity strengthening objective.
25. Describe one achievement attributable to TDR since its establishment.

Long-answer questions

26. Discuss the background, rationale, and establishment of the TDR Programme, including its governance. (Linked to SLO 4.1, SLO 4.2)
27. Discuss the research and capacity strengthening objectives of TDR. (Linked to SLO 4.3)
28. Discuss the diseases targeted by TDR and its selection criteria. (Linked to SLO 4.4)
29. Discuss TDR's research funding and capacity strengthening operations. (Linked to SLO 4.5)
30. Discuss the achievements and ongoing operations of TDR. (Linked to SLO 4.6)

Answers to Concept Check Questions [Series 4]

Objective questions

46. Products.
47. 1975.
48. Countries.
49. Burden.

50. Countries.

Short-answer questions

51. Diseases affecting poor populations received substantially less research investment than their burden warranted, since commercial incentives are weak for such diseases.
52. The World Health Organization and the World Bank, among others.
53. TDR funds research from basic science to implementation research, examining how tools can be effectively delivered within real-world health systems.
54. It aims to build durable local scientific leadership so that research benefits persist beyond any single funded project.
55. Improved diagnostics and treatment regimens for diseases such as onchocerciasis and schistosomiasis.

Long-answer questions

56. **Basic response:** TDR was established in 1975 to address the recognised gap in research investment for diseases disproportionately affecting poor populations, co-sponsored by agencies including the WHO, UNICEF, UNDP, and the World Bank.

Value-added response: Its Joint Coordinating Board includes representatives of disease-endemic countries themselves, ensuring affected countries have a meaningful voice in strategic direction, while a Secretariat and Scientific and Technical Advisory Committee manage day-to-day operations and scientific review.

57. **Basic response:** TDR's research objective spans basic science through implementation research, examining how new diagnostics, drugs, and vector control tools can be effectively delivered in real-world health systems.

Value-added response: Its capacity strengthening objective aims to build durable local scientific leadership within disease-endemic countries, moving beyond funding external researchers alone toward sustainable, locally led research capability.

58. **Basic response:** TDR has historically targeted neglected tropical diseases including malaria, onchocerciasis, schistosomiasis, lymphatic filariasis, leprosy, and trypanosomiasis.

Value-added response: These diseases were selected on the basis of disproportionate impact on poor populations combined with persistent research neglect relative to their true disease burden, criteria that have remained broadly consistent since TDR's establishment.

59. **Basic response:** TDR operates through competitive grant-making prioritising disease-endemic country researchers, spanning the full research pathway from early career pilot studies to advanced clinical research.

Value-added response: Its capacity strengthening operations include structured training, fellowships, mentorship, institutional support, and research networks connecting scientists across disease-endemic countries.

60. **Basic response:** TDR has contributed to improved diagnostics and treatment regimens for diseases such as onchocerciasis and schistosomiasis, and has supported training a substantial number of researchers now working within disease-endemic countries.

Value-added response: TDR continues to operate today, adapting its priorities to evolving disease burden while maintaining its dual research and capacity strengthening mission, remaining a distinctive example of coordinated multi-agency investment in otherwise under-resourced diseases.

Answers to Pilot Questions [Series 4]

Part 4.1

16. Ordinary commercial research incentives are weak for diseases affecting poor populations, so a dedicated coordinated programme was needed.
17. 1975.
18. The World Health Organization and the World Bank.
19. It represents co-sponsoring agencies, donors, and disease-endemic countries, and sets TDR's overall strategic direction.
20. The Secretariat, based at WHO headquarters, manages day-to-day operations; the Advisory Committee provides independent scientific input.

Part 4.2

16. TDR funds research from basic science through implementation research, examining how tools can be effectively delivered in real-world health systems.
17. It aims to ensure research benefits persist beyond any single project by building durable local scientific leadership.
18. Malaria, onchocerciasis, and schistosomiasis, among others.
19. Disproportionate impact on poor populations and persistent research neglect relative to disease burden.

20. Because sustainable improvement in tropical disease control depends on lasting local capability, not only external research contributions.

Part 4.3

16. TDR provides competitive research grants, with priority given to researchers based in disease-endemic countries.
17. To nurture research talent and promising questions across their full development trajectory, not only already established researchers.
18. Structured training and fellowships, and mentorship pairing early career and experienced researchers.
19. Improved diagnostics and treatment regimens for diseases such as onchocerciasis and schistosomiasis.
20. Because it combines the distinct strengths of several co-sponsoring agencies toward diseases market forces alone would not adequately address.

References and Attributions [Series 4]

- World Health Organization (2024). Special Programme for Research and Training in Tropical Diseases (TDR): overview.
- TDR (2021). TDR strategy and governance report.
- World Health Organization (2008). The First Ten Years of the World Health Organization. WHO Press.
- TDR (2020). Neglected tropical diseases research portfolio overview.

Figures, Plates, Tables, and Boxes

- Figure 4.1: Board members seated around a table during a formal programme governance meeting. AI-generated using the prompt: "A single clean, realistic illustration of board members seated around a formal conference table during a governance meeting, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
- Table 4.2: Comparing the research and capacity strengthening objectives of TDR. AI-generated using the prompt: "Create a clean reference table titled TDR Objectives:

Research and Capacity Strengthening, listing feature, research objective, and capacity strengthening objective. Simple clinical reference table style with outside border."

- Figure 4.3: A senior researcher mentoring a younger scientist at a laboratory bench. AI-generated using the prompt: "A single clean, realistic illustration of a senior researcher mentoring a younger scientist together at a laboratory bench, calm professional setting, soft laboratory lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

Course code: COM 505

Course title: Global Health and Role of Non-Government Health Organisations

Course credit load: 1 Unit

Series 5: Other Governmental and Non-Governmental Organisations in International Health (Port Health Services, UNHCR, and the Red Cross and Red Crescent)

- **Part 5.1: Port Health Services**
    - Sub Part 5.1.1: Role and functions of port health services
    - Sub Part 5.1.2: Port health services and the International Health Regulations
    - Sub Part 5.1.3: Challenges facing port health services
- **Part 5.2: The United Nations High Commissioner for Refugees (UNHCR)**
    - Sub Part 5.2.1: Establishment and mandate of UNHCR
    - Sub Part 5.2.2: UNHCR's role in refugee health
    - Sub Part 5.2.3: UNHCR's operations and challenges
- **Part 5.3: The Red Cross and Red Crescent Movement**
    - Sub Part 5.3.1: Origins and fundamental principles of the Movement
    - Sub Part 5.3.2: Components of the Movement
    - Sub Part 5.3.3: Role of the Movement in international health

Introduction

In the last Series, we examined the **TDR Programme**, a specialised WHO co-sponsored research initiative. We now conclude this course by examining several further organisations, both governmental and non-governmental, that play important roles in international health beyond the WHO itself, **port health services**, the **United Nations High Commissioner for Refugees**, and the **Red Cross and Red Crescent Movement**. Picture a refugee camp health post, staffed jointly by national government health workers, UNHCR public health coordinators, and Red Crescent volunteers, all working alongside one another to serve a displaced population in urgent need. Understanding the distinct but complementary roles played by such organisations completes the picture of the international health landscape addressed throughout this course.

The aim of this Series is to equip you with a clear understanding of the role of port health services, the establishment, mandate, and operations of UNHCR, and the origins, principles, and role of the Red Cross and Red Crescent Movement in international health.

This Series begins with **port health services**, before turning to the **United Nations High Commissioner for Refugees**. It concludes with the **Red Cross and Red Crescent Movement**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 5.1:** describe the role and functions of port health services and their relationship to the International Health Regulations
- **SLO 5.2:** describe the challenges facing port health services
- **SLO 5.3:** describe the establishment, mandate, and role in refugee health of UNHCR
- **SLO 5.4:** describe UNHCR's operations and challenges
- **SLO 5.5:** describe the origins, fundamental principles, and components of the Red Cross and Red Crescent Movement, and
- **SLO 5.6:** describe the role of the Red Cross and Red Crescent Movement in international health.

5.1 Port Health Services

5.1.1 role and functions of port health services

The national frontline for cross-border disease control

Port health services are national government health services responsible for public health functions at designated **points of entry**, including seaports, airports, and, in some countries, major ground crossings, tracing their conceptual origins directly to the historical quarantine practices discussed in an earlier Series of this course, though considerably modernised in their present-day operation.

Core functions of port health services include health **inspection** of arriving vessels, aircraft, and travellers, **vector control** within port environments to prevent the spread of vector-borne disease, discussed in an earlier related course, and coordinated response to travellers found to be unwell, ensuring appropriate assessment, isolation where necessary, and referral for further **treatment**.

Fill in the blank: Port health services are national government health services responsible for public health functions at designated points of _____.

5.1.2 port health services and the international health regulations

Port health services form an essential practical component of national compliance with the **International Health Regulations**, discussed in an earlier Series of this course, since designated points of entry are specifically required to maintain the **core capacities** necessary to detect and respond appropriately to public health events arising among arriving travellers or cargo.

In practice, this means port health services must be capable of applying appropriate public health **measures** to travellers or conveyances, without imposing unnecessary interference with international **traffic**, directly reflecting the balance between disease control and trade facilitation embedded within the IHR framework and discussed at length in an earlier Series of this course.

Fill in the blank: Port health services must apply appropriate public health measures without imposing unnecessary interference with international _____.

5.1.3 challenges facing port health services

Port health services in many countries, including Nigeria, face significant practical challenges, including limited **staffing** and inadequate equipment at some points of entry, particularly at busy or informal border crossings, and the sheer practical difficulty of maintaining thorough inspection capacity given the very high **volume** of travellers and cargo passing through major international ports.

Further challenges include coordinating effectively across multiple government **agencies** with overlapping responsibilities at a given port, such as customs, immigration, and agricultural inspection authorities, and ensuring port health staff maintain current **training** and awareness of evolving international health threats and IHR requirements, echoing the broader operational challenges facing global health institutions discussed in an earlier Series of this course.

Fill in the blank: Port health services face challenges including limited staffing and the difficulty of maintaining thorough inspection capacity given high traveller and cargo _____.

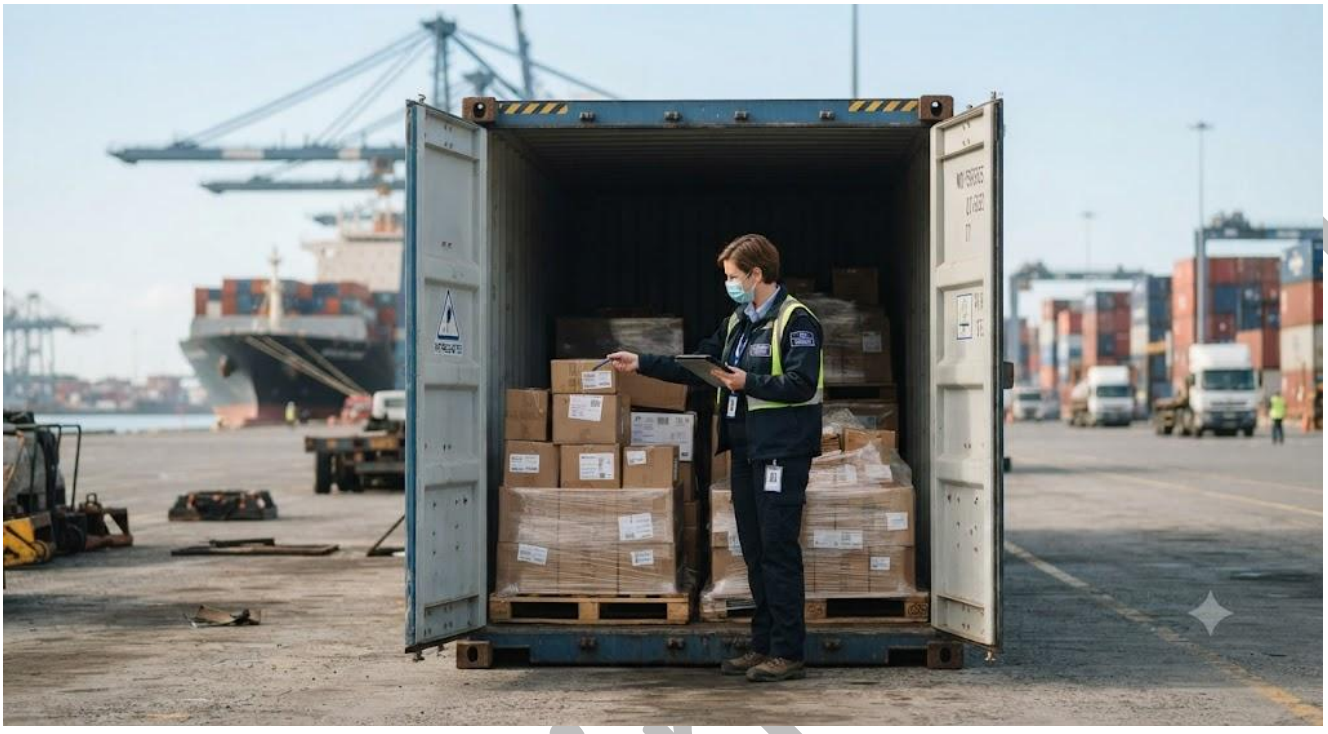

Figure 5.1: A port health officer inspecting a shipping container at a seaport.

Pilot questions 5.1

21. Define port health services and describe their core functions. (Linked to SLO 5.1)
22. Explain the historical connection between port health services and early quarantine practice. (Linked to SLO 5.1)
23. Explain how port health services support national compliance with the International Health Regulations. (Linked to SLO 5.1)
24. Describe two challenges facing port health services in a country such as Nigeria. (Linked to SLO 5.2)
25. Explain why coordination across multiple government agencies is important at ports. (Linked to SLO 5.2)

5.2 The United Nations High Commissioner for Refugees (UNHCR)

5.2.1 establishment and mandate of unhcr

Protecting and assisting the world's displaced people

The **United Nations High Commissioner for Refugees**, or **UNHCR**, was established in **1950** by the **United Nations**, discussed in an earlier Series of this course, with a core mandate to lead and

coordinate international action to **protect** refugees and other forcibly displaced persons, and to seek permanent solutions to their situation, whether through voluntary return, local integration, or resettlement in a third country.

Although UNHCR was not originally established as a health-focused organisation, its broader **protection** mandate has always encompassed attention to the health and wellbeing of displaced populations, since ensuring adequate health care forms an essential component of the wider humanitarian protection UNHCR is charged with providing to refugees and other people of concern.

Fill in the blank: UNHCR was established in 1950 with a core mandate to lead and coordinate international action to protect _____.

5.2.2 unhcr's role in refugee health

In practice, UNHCR plays a significant role in **refugee health**, including supporting the provision of **primary health care** services within refugee camps and settlements, often working closely with host government health systems and other partner organisations, coordinating **disease surveillance** among displaced populations, and supporting access to **immunisation** and other essential preventive health services.

Displaced populations frequently face particularly elevated **health risks**, including disrupted access to routine health care during displacement, increased risk of communicable disease transmission in crowded settlement conditions, discussed in relation to epidemic control in an earlier related course, and significant **mental health** burden associated with the trauma and disruption of forced displacement, each requiring coordinated attention within UNHCR's broader health-related work.

Fill in the blank: Displaced populations frequently face increased risk of communicable disease transmission in crowded settlement _____.

5.2.3 unhcr's operations and challenges

UNHCR operates through **field offices** in many countries hosting significant refugee populations, working in close partnership with host governments, other United Nations agencies, and non-governmental organisations, including the Red Cross and Red Crescent Movement examined later in this Series, to coordinate the overall humanitarian **response** to displacement situations.

UNHCR faces significant operational challenges, including chronic **funding shortfalls** relative to the scale of global displacement needs, the sheer logistical difficulty of sustaining services during **protracted** displacement situations lasting many years, and navigating complex political and

security environments within host countries, each requiring sustained diplomatic and operational effort to manage effectively.

Fill in the blank: UNHCR faces significant operational challenges, including chronic funding shortfalls relative to the scale of global displacement _____.

Figure 5.2: A UNHCR health worker examining a child at a mobile clinic in a refugee settlement.

Pilot questions 5.2

21. Identify the year UNHCR was established and describe its core mandate. (Linked to SLO 5.3)
22. Explain why health falls within UNHCR's broader protection mandate. (Linked to SLO 5.3)
23. Describe two aspects of UNHCR's role in refugee health. (Linked to SLO 5.3)
24. List two elevated health risks facing displaced populations. (Linked to SLO 5.4)
25. Describe two operational challenges facing UNHCR. (Linked to SLO 5.4)

5.3 The Red Cross and Red Crescent Movement

5.3.1 origins and fundamental principles of the movement

Humanitarian relief born from the battlefield

The **Red Cross and Red Crescent Movement** traces its origins to **Henry Dunant**, a Swiss businessman whose experience witnessing the suffering of wounded soldiers following the Battle of Solferino in **1859** led directly to the founding of the **International Committee of the Red Cross**, or **ICRC**, in **1863**, one of the oldest continuously operating humanitarian organisations in the world.

The Movement operates according to seven **Fundamental Principles**, including **humanity**, **impartiality**, **neutrality**, and **independence**, principles that together allow the Movement to provide assistance to people affected by conflict and disaster regardless of which party to a conflict they belong to, a distinctive operating stance that has helped sustain the Movement's access and credibility across many decades of changing global conflict.

Fill in the blank: The Red Cross and Red Crescent Movement traces its origins to Henry Dunant's experience at the Battle of _____ in 1859.

5.3.2 components of the movement

The Movement comprises three distinct but closely related components, the **International Committee of the Red Cross**, discussed in the previous sub-Part, which holds a specific mandate under international **humanitarian law** to protect victims of armed conflict, the **International Federation of Red Cross and Red Crescent Societies**, or **IFRC**, coordinating disaster response and development work among national societies, and **National Red Cross or Red Crescent Societies**, operating within individual countries worldwide.

Each **National Society** operates as an auxiliary to its own government's humanitarian services while maintaining its independence and adherence to the Movement's shared Fundamental Principles, discussed in the previous sub-Part, meaning National Societies such as the **Nigerian Red Cross Society** play a distinctive dual role, closely supporting national government humanitarian efforts while remaining part of a genuinely global humanitarian movement.

Fill in the blank: The International Federation of Red Cross and Red Crescent Societies, or IFRC, coordinates disaster response and development work among National _____.

5.3.3 role of the movement in international health

The Red Cross and Red Crescent Movement plays a substantial role in international **health**, including providing emergency **medical care** during conflicts and disasters, supporting **blood transfusion** services in many countries, and delivering community-based first aid **training** and health education, activities that frequently complement the work of governmental health services

and organisations such as UNHCR, discussed earlier in this Series, particularly in humanitarian settings.

The Movement's distinctive Fundamental Principles, discussed earlier in this Part, particularly **neutrality** and **independence**, often allow it to gain humanitarian **access** to populations in active conflict settings that may be difficult for other organisations to reach safely, making the Movement a particularly important health actor precisely in the most challenging humanitarian environments addressed throughout this Series.

Fill in the blank: The Movement's distinctive Fundamental Principles of neutrality and independence often allow it to gain humanitarian access to populations in active conflict _____.

Table 5.3: Comparing UNHCR and the Red Cross and Red Crescent Movement.

Feature	**UNHCR**	**Red Cross and Red Crescent Movement**
Established	1950	1863 (ICRC)
Core mandate	Protection and solutions for refugees and displaced persons	Humanitarian relief guided by the Fundamental Principles
Health-related role	Coordinating refugee health and primary care access	Emergency medical care, blood services, first aid training

Pilot questions 5.3

21. Describe the origins of the Red Cross and Red Crescent Movement. (Linked to SLO 5.5)
22. List four of the Movement's Fundamental Principles. (Linked to SLO 5.5)
23. Describe the three components of the Movement. (Linked to SLO 5.5)
24. Describe two aspects of the Movement's role in international health. (Linked to SLO 5.6)
25. Explain why the Movement's neutrality and independence often grant it access other organisations lack. (Linked to SLO 5.6)

Series Summary

This final Series examined a further set of organisations, both governmental and non-governmental, contributing to international health beyond the WHO, beginning with **port health services**, their historical roots in early quarantine practice, their core inspection and response functions, their essential relationship to national compliance with the International Health Regulations, and the practical challenges they face, before turning to **UNHCR**, its establishment in 1950 and its protection mandate for refugees and displaced persons, its significant role in refugee health, and its operational challenges, including chronic funding shortfalls.

We concluded with the **Red Cross and Red Crescent Movement**, its origins in Henry Dunant's experience at the Battle of Solferino, its Fundamental Principles of humanity, impartiality, neutrality, and independence, its three component parts, and its substantial role in international health, particularly in the most challenging humanitarian settings. Having worked through this Series, and indeed this entire course, you should now possess a comprehensive understanding of the international health landscape, from its historical origins through the establishment and functioning of the WHO to the diverse range of governmental and non-governmental organisations that together sustain global health cooperation today.

Glossary of Terms

- **Port health services:** national government health services responsible for public health functions at points of entry.
- **Point of entry:** a designated port, airport, or ground crossing subject to public health inspection and IHR requirements.
- **UNHCR:** the United Nations High Commissioner for Refugees, established in 1950.
- **Protection mandate:** UNHCR's core responsibility to protect refugees and seek permanent solutions to displacement.
- **Protracted displacement:** a displacement situation lasting many years without a permanent solution.
- **International Committee of the Red Cross (ICRC):** the Movement component protecting victims of armed conflict, founded in 1863.
- **International Federation of Red Cross and Red Crescent Societies (IFRC):** the Movement component coordinating disaster response and development among national societies.
- **National Society:** a country-level Red Cross or Red Crescent organisation acting as an auxiliary to its government.
- **Fundamental Principles:** the seven guiding principles of the Red Cross and Red Crescent Movement, including humanity and neutrality.
- **Neutrality:** a Fundamental Principle requiring the Movement not to take sides in conflicts.
- **Humanitarian access:** the ability of an organisation to reach and assist populations in need, particularly in conflict settings.
- **Auxiliary role:** a National Society's function of supporting, while remaining independent of, its own government's humanitarian services.

Concept Check Questions [Series 5]

Objective questions

21. Port health services are responsible for public health functions at designated points of _____.
22. UNHCR was established in 1950 with a core mandate to protect _____.
23. The Red Cross and Red Crescent Movement traces its origins to Henry Dunant's experience at the Battle of _____.
24. The International Federation of Red Cross and Red Crescent Societies coordinates disaster response among National _____.
25. The Movement's Fundamental Principles of neutrality and independence often grant access to populations in active conflict _____.

Short-answer questions

26. Describe the core functions of port health services.
27. Explain how port health services support national compliance with the International Health Regulations.
28. Describe two aspects of UNHCR's role in refugee health.
29. Describe the three components of the Red Cross and Red Crescent Movement.
30. Describe two aspects of the Movement's role in international health.

Long-answer questions

31. Discuss the role and functions of port health services and their relationship to the International Health Regulations. (Linked to SLO 5.1)
32. Discuss the challenges facing port health services. (Linked to SLO 5.2)
33. Discuss the establishment, mandate, and role in refugee health of UNHCR. (Linked to SLO 5.3, SLO 5.4)
34. Discuss the origins, fundamental principles, and components of the Red Cross and Red Crescent Movement. (Linked to SLO 5.5)
35. Discuss the role of the Red Cross and Red Crescent Movement in international health. (Linked to SLO 5.6)

Answers to Concept Check Questions [Series 5]

Objective questions

61. Entry.
62. Refugees.
63. Solferino.
64. Societies.
65. Settings.

Short-answer questions

66. Health inspection of arriving travellers, vessels, and cargo, vector control, and response to unwell travellers.
67. Designated points of entry must maintain core capacities to detect and respond to public health events under the IHR.
68. Supporting primary health care in refugee camps and coordinating disease surveillance and immunisation among displaced populations.
69. The International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, and National Societies.
70. Providing emergency medical care during conflicts and disasters, and supporting blood transfusion services.

Long-answer questions

71. **Basic response:** Port health services conduct health inspection, vector control, and response to unwell travellers at designated points of entry, tracing their roots to early quarantine practice.

Value-added response: They form an essential practical component of national compliance with the IHR, since designated points of entry must maintain core surveillance and response capacities while avoiding unnecessary interference with international traffic.

72. **Basic response:** Port health services face limited staffing and equipment, particularly at busy or informal crossings, and the practical difficulty of maintaining thorough inspection given high traveller and cargo volume.

Value-added response: Further challenges include coordinating across multiple government agencies with overlapping responsibilities and ensuring staff maintain current training on evolving international health threats and IHR requirements.

73. **Basic response:** UNHCR, established in 1950, holds a core mandate to protect refugees and displaced persons and seek permanent solutions, with health falling within this broader protection mandate.

Value-added response: In practice, UNHCR supports primary health care in refugee settlements, coordinates disease surveillance and immunisation, and addresses the elevated health risks, including mental health burden, facing displaced populations.

74. **Basic response:** The Movement traces its origins to Henry Dunant's experience at the Battle of Solferino in 1859, leading to the founding of the ICRC in 1863, and operates

according to seven Fundamental Principles including humanity, impartiality, neutrality, and independence.

Value-added response: The Movement comprises the ICRC, mandated to protect victims of armed conflict, the IFRC, coordinating disaster response among national societies, and National Societies operating within individual countries as government auxiliaries.

75. **Basic response:** The Movement plays a substantial role in international health, providing emergency medical care, supporting blood transfusion services, and delivering first aid training and health education.

Value-added response: Its Fundamental Principles of neutrality and independence often grant it humanitarian access to populations in active conflict settings that other organisations may struggle to reach, making it a particularly important actor in the most challenging humanitarian environments.

Answers to Pilot Questions [Series 5]

Part 5.1

21. National government health services responsible for public health at points of entry; functions include inspection, vector control, and traveller response.
22. Port health services trace their conceptual origins directly to early quarantine practice at historical ports.
23. Designated points of entry must maintain the core capacities required under the IHR to detect and respond to public health events.
24. Limited staffing and equipment, and the difficulty of thorough inspection given high traveller and cargo volume.
25. Because multiple agencies, such as customs and immigration, share overlapping responsibilities at a given port.

Part 5.2

21. 1950; its core mandate is to protect refugees and displaced persons and seek permanent solutions to their situation.
22. Because adequate health care forms an essential component of the wider humanitarian protection UNHCR is charged with providing.
23. Supporting primary health care in refugee settlements and coordinating disease surveillance among displaced populations.
24. Increased risk of communicable disease transmission in crowded settlements, and significant mental health burden from displacement trauma.

25. Chronic funding shortfalls and the logistical difficulty of sustaining services during protracted displacement.

Part 5.3

21. It traces its origins to Henry Dunant's experience at the Battle of Solferino in 1859, leading to the ICRC's founding in 1863.
22. Humanity, impartiality, neutrality, and independence, among others.
23. The International Committee of the Red Cross, the International Federation, and National Societies.
24. Providing emergency medical care during conflicts and disasters, and supporting blood transfusion services.
25. Because neutrality and independence allow the Movement to assist all parties without taking sides, sustaining access and trust.

References and Attributions [Series 5]

- World Health Organization (2005, amended). International Health Regulations: points of entry provisions (3rd ed.).
- UNHCR (2023). UNHCR global report and health strategy overview.
- International Committee of the Red Cross (2020). The Fundamental Principles of the International Red Cross and Red Crescent Movement.
- International Federation of Red Cross and Red Crescent Societies (2022). IFRC annual report.

Figures, Plates, Tables, and Boxes

- Figure 5.1: A port health officer inspecting a shipping container at a seaport. AI-generated using the prompt: "A single clean, realistic illustration of a port health officer inspecting a shipping container at a busy seaport, calm daytime setting, natural lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
- Figure 5.2: A UNHCR health worker examining a child at a mobile clinic in a refugee settlement. AI-generated using the prompt: "A single clean, realistic illustration of a health worker examining a child at a simple mobile clinic table within an outdoor refugee settlement, calm daytime setting, natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
- Table 5.3: Comparing UNHCR and the Red Cross and Red Crescent Movement. AI-generated using the prompt: "Create a clean reference table titled Comparing UNHCR and

the Red Cross and Red Crescent Movement, listing feature, UNHCR, and Red Cross and Red Crescent Movement. Simple clinical reference table style with outside border."