

# R E V I E W   R E P O R T

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## WHO's interactions with Civil Society and Nongovernmental Organizations



### CIVIL SOCIETY INITIATIVE

External Relations and Governing Bodies



World Health Organization

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Graphic design: Tushita Graphic Vision, Carine Mottaz, Tushita Bosonet, Geneva.



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# The review process

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## Origins and purpose of the review

Governments and international institutions are having to take notice of an awakened and energised civil society mobilizing for greater inclusion in both local and global development processes. Reaching public health goals today requires the cooperation of a wide array of actors forming multiple partnerships and alliances. While national governments have the primary role in assuring the health of their citizens, the formulation and implementation of health policies and programmes are increasingly involving a wide range of civil society actors.

As the world's leading public health agency, the World Health Organization (WHO) works with 192 Member States in seeking new ways of strengthening these alliances. In recognition of the growing importance of civil society, Dr Gro Harlem Brundtland, Director-General of WHO, established the Civil Society Initiative (CSI) in 2001, to:

“Establish a programme of evidence collection, consultation with a broad range of actors and analysis – within and outside WHO – to identify and develop propositions for more effective and useful interfaces and relationships between civil society and the WHO. This work will be developed within the context of WHO's mandate, the expressed interests of the Executive Board and the World Health Assembly, and in response to interest shown by groups from civil society. (Civil society here includes social movements, voluntary organizations, nongovernmental organizations, grassroot organizations and other non-state and not-for-profit actors.) It is anticipated that within a year this initiative will be followed by concerted action at country, regional and Geneva levels.”

Dr Gro Harlem Brundtland,  
Message from Director-General,  
11 May 2001

As part of its mandate to submit concrete proposals within a year, CSI conducted a review of WHO's current policy and practice regarding civil society and nongovernmental organizations (NGOs). This report contains the key findings of the review and will serve to renew WHO's policy on interactions with civil society. Key aspects of this review should also form the basis of a draft resolution for consideration by the Executive Board and possible forwarding to the 56th World Health Assembly in May 2003.

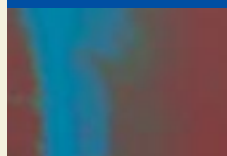
## Methodology

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The review process was carried out through a *desk review of documents* and a process of *consultations* during the period July 2001 – July 2002. Detailed results of the review are documented in CSI Working Documents.

### CSI Working Documents include:

WHO's Interactions with Civil Society Organizations, Short Historical Background (CSI/2001/WP1)	Summary of consultations with Civil Society Organizations (CSI/2002/WP2)
Summary of Interviews with Executive Directors and selected Directors (CSI/2001/WP2)	Analysis: NGO Participation in WHO Governing Bodies, 1998 to 2002 (CSI/2002/WP3)
Informal Consultation document (CSI/2001/WP3)	A Study of the WHO Official Relation system with Non Governmental Organizations. June 2002 (CSI/2002/WP4)
Strategic Alliances for Health: The role of civil society in achieving health goals. (CSI/2001/DP1)	Report of WHO Inter-Regional Meeting on Civil Society Involvement in Health and in the work of WHO (CSI/2002/WP5)
Inventory of WHO/HQ Relations with Civil Society Organizations (CSI/2002/WP1)	



## Desk Review

In order to explore current thinking, trends and challenges about the role of civil society organizations in health and their relations with WHO, the review drew on current literature, publications and WHO documents. The following analyses were made:

- Historic background of WHO's work with NGOs.
- Inventory of WHO/HQ department's collaboration with NGOs in 2001.
- Desk review of WHO Regional offices' relations with NGOs.
- Overview of policies and practices regarding NGOs and CSOs among UN and development partners.
- Legal assessment of the current principles governing WHO relations with NGOs.
- Analysis of NGO participation in WHO governing body meetings 1998-2002.
- Conceptual papers on what constitutes civil society and the role of civil society in achieving health goals.

## Consultations

The above analyses were complemented and enriched by consultations that included:

- WHO staff at HQ, including Executive Directors, Directors, and focal points for NGOs.
- Staff of WHO regional and country offices including Regional Directors, and selected WHO representatives.
- Representatives of NGOS/CSOs through organized meetings and E-mail consultations.

- Staff of UN systems agencies, the World Bank ,EU, bilateral organizations and the UN Non Governmental Liaison Service (NGLS).

An “Informal Consultation document” was developed by CSI and used as a base for most of the above consultations.

## Understanding the terminology

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There is great variation between Member States and within the family of United Nations regarding the precise definition of the terms nongovernmental and civil society organizations (CSOs). Many use the term NGOs synonymously with CSOs.

Civil society is seen as a social sphere separate from both the state and market. The increasingly accepted understanding of the term “civil society organizations” is that of *non-state, not-for-profit, voluntary organizations* formed by people within the social sphere of civil society. These organizations draw from community, neighbourhood, work, social and other connections. CSOs have become an increasingly common channel through which people seek to exercise citizenship and contribute to social and economic change They cover a variety of organizational interests and forms, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause.

The term NGO is also commonly used to describe non-state, not-for-profit, voluntary organizations. However, they usually have a formal structure, offer services to people other than their members and are, in most cases, registered with national authorities.

In practice, however, state involvement in the funding and establishment of CSOs/NGOs may blur the borders between state and non-state. The borderline between market and non-market may also be blurred by organizations that are non-profit but closely related to commercial enterprises. (WHO defines commercial enterprises as the for-profit part of the private sector, EB 107/20, annex).

These include associations that are non-profit in nature but which represent business or commercial interests.

Reflecting the common usage of the time, the 1947 WHO Constitution refers to the word NGOs, a term that was used by subsequent World Health Assembly resolutions in setting up the current system of official relations. This review report, therefore, uses the word NGOs when referring to the official relations system. When referring to interaction with civil society in general, the wider term CSOs will be used.



# International developments: civil society organizations in health

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## Trends and challenges at global level

In recent years there has been a dramatic growth of civil society actors and an increase in their political influence in all areas of health, development and human rights. This development has been triggered by sweeping political, economic and social changes that have had a profound influence on the role of the nation state, bringing national and international health agendas closer together.

In addition, increasing concern about the perceived weakening of the nation states' authority vis-à-vis transnational corporations has led to an increased involvement of civil society in public policy debates on globalization, trade, development co-operation and health. Organized into national and global networks and supported by expanded access to information, CSOs have become more prominent as demand has grown for improved public accountability and responsiveness to citizen inputs at

local, national and global levels. This has had an impact on public health as well, widening the range of interests that WHO has to interact with in its mandate to improve global health.

## At UN level

ECOSOC revised its policy on NGO/CSO relations in 1996 and called on the United Nations system to do the same.<sup>1</sup> In July 1998, a report to the Security Council by the Secretary General (*Renewing The United Nations: A Programme For Reform*) stressed the need to reach out to civil society. The Millennium Summit Declaration in September 2000 similarly reflected the need for the UN to work in different types of partnerships with civil society.

<sup>1</sup> The Resolution 1996/31 of the 49th Plenary meeting "Consultative relationship between the United Nations and non-governmental organizations" outlines the proposed changes.



This has led to a general UN review of existing policies and strategies. New and improved forms of communication and collaboration are being introduced by many UN agencies. A number of UN entities have modified their accreditation system for attendance of CSOs to their governing bodies, “upgraded” and expanded headquarters units dealing with civil society issues and designated liaison officers at departmental level. Mechanisms are being established at senior management level for involvement of CSOs, with and without official status, in policy-making via “NGO Liaison Committees” and “Civil Society Advisory Committees”. One agency, UNAIDS, has also included representation of CSOs within its governing body.

### **At national level**

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CSOs have become critical in the health domain at the national level. They contribute resources and skills to the provision of services, particularly in reaching poor and disadvantaged populations and in strengthening primary health care and community-based health care. In many places, CSOs also assume a watchdog role in the protection of public health interests. Their commitment, experience and mobilizing capacity provides governments and WHO with unique options that may not otherwise be available.

Developments and processes at national level are becoming increasingly complex. The implementation of development aid programmes are increasingly being channelled through CSOs. Global health initiatives and national development processes, such as poverty reduction strategies, are involving CSOs as major actors at country level. The contracting out of health services to these organizations is being debated in many places.

These processes are challenging governments to strengthen their own role at the same time that they are under pressure to open up to new actors in health. In some cases the situation has increased tensions between governments and CSOs regarding the handling of external funds to the health sector. Member States are increasingly looking to WHO for guidance and support in handling these issues and interactions.

### **At development partners level**

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Among bilateral donors and regional development partners the emphasis on enhancing relations with CSOs is perhaps even stronger. Work with them is closely linked to the aim of poverty reduction and forms a dominant feature in many development cooperation programmes. Review analysis reveals that among WHO’s most common donors an average of one-third of development aid is channelled through international CSOs.

All the donors studied have specific funding instruments for which northern CSOs can apply, some also fund southern organizations directly. Through northern and/or international CSOs, some donors are focusing more on building the capacity of national, southern CSOs to enable them to participate in and influence national policy formulation, programme development and implementation.

Most donors studied, however, see CSO support as a separate area in their programmes and not necessarily as part of an integrated CSO–health sector approach. This provides WHO with an opportunity to help integrate CSO support into health programmes as part of its general support to Member States.

# WHO-NGO relations

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## Brief history

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Interaction, consultation and co-operation with NGOs<sup>2</sup> is clearly encouraged by the WHO Constitution. In 1948, the first World Health Assembly (WHA) adopted a set of working principles governing admission of NGOs into Official Relations. These were amended and expanded by later WHAs<sup>3</sup>, with the current *Principles governing relations between the World Health Organization and nongovernmental organizations* having been in place since 1987<sup>4</sup>.

Collaboration with NGOs is a standing agenda item at both the Executive Board and WHA. It was the theme of Technical Discussions in 1985, and highlighted in the 1997 and 1998

Executive Board discussions and the consultations on the revised Health for All process in 1997<sup>5</sup>. WHO resolutions have called on NGOs and national governments to work in partnership with each other and WHO. The governing bodies of WHO have shown long-standing support and encouragement for strengthened WHO relations with NGOs.

WHO has also made a special commitment in the new *Corporate Strategy* approved by Governing Bodies in 2000.<sup>6</sup> It envisions broadening the scope of WHO's partnerships within new areas of work such as human rights and poverty reduction and to new actors spanning both the private sector and civil society.

<sup>2</sup> The word "NGOs" in this section refers to original usage found in the WHO Constitution and WHA resolutions.

<sup>3</sup> WHAs WHA 1.130, WHA3.113, WHA11.14 and WHA 21.28. The last amendment was made at the 1987 WHA (WHA 40.25).

<sup>4</sup> Principles Governing Relations between the World Health Organization and Non-governmental Organizations, WHO, Basic Documents Geneva 2001.

<sup>5</sup> See in particular EB61.R38; EB79/1987/REC/1,Part1; A38/Technical Discussion/1; A51/5.

<sup>6</sup> WHO "A corporate strategy for the WHO secretariat". Report by the Director General to the Executive Board 105th session. EB105/3.

To deal with potential conflict of interest in relations with the private sector, *Guidelines for interaction with commercial enterprises to achieve health outcomes* have been developed by the Organization. These guidelines are directed in particular to commercial enterprises but “can also apply to a variety of other institutions including State run enterprises, associations representing commercial enterprises, foundations... and other not-for-profit organizations...”<sup>7</sup> These guidelines, therefore, have a hitherto untapped potential in guiding WHO interactions with NGOs linked to private (for-profit) sector interests as well.

### **Current WHO-NGO interactions**

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The 1987 *Principles* constitute the current legal basis for all aspects of the relations between WHO and NGOs. They declare WHO’s objectives in working with NGOs to be the promotion of its policies, strategies and programmes, collaboration in the implementation of these, and the co-ordination or harmonization of intersectoral interests among the various sectoral bodies concerned in a country, regional or global setting. They define WHO interactions with NGOs to be formal (official relations) or informal.

<sup>7</sup> “Guidelines for interaction with commercial enterprises to achieve health outcomes  
“EB 107/20 Annex.

responsibility  
justice  
equity health  
poverty  
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affect  
rights trade  
freedom  
partner

### **Formal or official relations**

Only international NGOs can apply for official relations. As of July 2002, there are 189 NGOs in official relations. While they were originally drawn from the medical and public health fields, NGOs with broader mandates have increasingly been admitted. Both private sector NGOs (not-for-profit business associations) and public interest/citizen grouping NGOs have official relations status under the common title of “NGOs”.

NGOs in official relations are conferred privileges such as participation in WHO meetings, committees and conferences including those of WHO governing bodies and the right to make a statement at these meetings.

As part of the requirement for official relations, NGOs need to establish a joint programme of work and a 3-year plan with a technical department of WHO. Designated Technical Officers are appointed as the focal points for such collaboration. Admittance into official relations is authorized by a formal decision of the WHO Executive Board. A review process of these relations is based on 3-year reports and the drawing up of new work plans.

Regional offices use the list of NGOs in official relations to invite participation at Regional Committee and other regional meetings.

### **Informal or working relations**

All other relations with NGOs are considered informal. NGOs that have informal relations with WHO at HQ, regions and countries outnumber those in official relations. The inventory undertaken of WHO (HQ) relations with NGOs revealed that out of a total of 473 established relations, 45% were with NGOs in official relations and 55% were with NGOs not in official relations.

Informal relations include a wide range of interactions. Although the informal status does not prevent NGOs from attending technical meetings or working successfully with a technical programme in WHO, these NGOs are not given the privilege to participate in, or to deliver a statement to, WHO's governing bodies.

## Range of organizations interacting with WHO

WHO interacts with a wide range of organizations. There is a great diversity in the structure, focus, mandate and funding sources of these organizations. The various structures can include, among others: memberships organisations, companies, foundations, federations and networks. Organizations can be financed by diverse funding sources such as governments, the commercial sector, foundations, individuals, churches or charities.

The basic focus of organizations vary. The examples below are illustrative:

- professional associations (such as those representing nurses);
- disease specific NGOs (such as those dealing with malaria);
- development NGOs (such as those working on poverty reduction);
- humanitarian NGOs (such as those dealing with emergency situations);
- patient group NGOs (such as those representing diabetic patients);
- public interest NGOs (such as those representing consumers);
- scientific or academic NGOs (such as those involved in medical research);
- health-related NGOs (such as those involved in occupational health, education, technology or safety and who have health as one of their objectives); and
- not-for-profit organizations that represent or are closely linked with commercial interests (such as those representing the pharmaceutical industry).

## Spectrum of WHO interactions

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WHO's interactions with these diverse organizations cover a wide spectrum of activities at HQ, regional and country level. They range from simple interactions of a very informal nature to more structured ones based on formal contracts or agreements. The range is illustrated in this table below:

<u>Informative interactions</u>	<u>Ad hoc relations</u>	<u>Systematic relations</u>	<u>Structured collaboration</u>
Passive/occasional exchange of information and ideas.	Active <i>ad hoc</i> participation in WHO meetings, events, campaigns and consultations.	Regular contributions to WHO policy and normative work.	Collaboration as defined by a formal contract, or written agreement on joint work plans.
<ul style="list-style-type: none"><li>– Inclusion in address lists, e-mail list serves.</li><li>– Exchange of newsletters, reports, publications and other materials.</li><li>– Exchange visits.</li></ul>	<ul style="list-style-type: none"><li>– Promotion of WHO advocacy materials.</li><li>– Exchange and mutual support in campaigns and events such as World Health Day.</li><li>– Participation in WHO training events and consultations.</li></ul>	<ul style="list-style-type: none"><li>– Participation in expert committees, policy discussion fora, development of guidelines, or standard setting.</li></ul>	<ul style="list-style-type: none"><li>– Collaboration and research on products, methods, development of tools and guidelines and service outreach in countries.</li></ul>

# Assessment of WHO-CSO interactions

## General benefits for WHO

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### Advocacy support

CSOs are instrumental in advocating issues of public health promoted by WHO and taking it to a broad audience. They perform a watchdog function in the protection of public health concerns. They are also able to bring up sensitive issues that WHO, as an intergovernmental organization, may not be in a position to address for political reasons. This is especially true for CSOs working with a rights-based approach.

### Access to public opinion

By collaborating with CSOs, WHO can ascertain the direction and content of public opinion on various health matters. This can prove invaluable when formulating programmes and provides a reality check for WHO. CSO collaboration in policy development also strengthens the democratisation of international relations and cooperation. It makes the work of WHO

more visible and transparent and contributes towards actively building public accountability within the context of the widening UN framework for governance in global policy.

### Programme implementation

CSOs are often involved in the testing of methods and approaches at field level, in building up the national capacity of health systems and implementing WHO programmes at country level. National CSOs concerns for equity in health, closeness to local communities and capacity to respond to community needs are strengths that WHO can draw upon. Collaboration with some CSOs makes outreach to remote areas and disadvantaged populations possible for WHO. In emergency relief, WHO effectively benefits from the flexibility and rapid response of humanitarian NGOs/CSOs by channelling aid through them.

## **General benefits for CSOs**

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### **Capacity support**

Interaction with WHO provides CSOs with enhanced access to expertise, skills and resources, especially on technical and policy issues. This access helps improve the work of CSOs in general.

### **Enhances public relations**

Being associated with an international agency like WHO strengthens the status, credibility and recognition of CSOs and enhances their public relations and fund-raising opportunities.

### **Outreach and influence**

Working with WHO enables CSOs to reach beyond their immediate audience and contribute their valuable expertise, experience and advocacy support to the technical and policy work of WHO and public health in general.

## **General constraints for WHO-CSO relations**

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### **Gaps in communication and information**

The lack of access to and transparency about WHO processes at HQ, regional and country level was highlighted by many CSOs. Inadequacies were identified in the range of topics on which material was produced as well in the dissemination of this information and material. CSOs were also uncertain about how to approach WHO, including possible participation at meetings and activities of the Organization. Information needs range from understanding how WHO governance works to gaining updated knowledge on specific technical issues.

### **Lack of distinction between types of CSOs/NGOs**

The current *Principles* offer no guidance in distinguishing between public interest NGOs and those linked to commercial interests. Voices from the CSO community therefore urged that business-linked organizations be classified as the private (for profit) sector and not fall within the CSO/NGO classification.

### **Insufficient safeguards on conflict of interest**

While it was generally accepted that all opinions should be heard and interactions encouraged, concern was expressed that the very nature of some organizations may represent a potential conflict of interest. The closer the involvement of CSOs in the work of WHO and in the setting of policies, norms and standards, the more important it is for WHO to be aware of, make transparent and eliminate all risks of real or perceived conflict of interest. Review participants from both CSOs and the Secretariat pointed out that the *Principles* do not make provisions for such safeguards. Newly developed conflict of interest mechanisms have not been used very extensively and should be supplemented by additional measures.

## **Specific constraints of the official relations system**

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### **Lengthy, onerous and rigid procedures**

The detailed procedures contained in the *Principles* allow for little flexibility to meet new challenges and needs. This was amply demonstrated during the tobacco treaty sessions of the Intergovernmental Negotiating Body when NGOs not in official

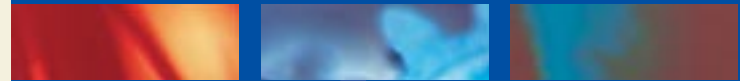


relations, but with strong working relations with WHO, sought ways of participating in the sessions. Special “fast-track” procedures were created (endorsed by the EB) to enable some NGOs to obtain the official status they needed to participate.

The process surrounding admittance of NGOs into official relation also demands drawn out procedures (different stages over 3-4 years) and a substantial amount of administrative work both for the Secretariat and for the concerned NGOs. The process is perceived as among the most complicated of UN agencies. The requirement of establishing joint work plans and reporting on these every third year was found to be overly bureaucratic, difficult to monitor and not always relevant especially since WHO has two-year work plans. The task of the NGO Standing Committee of the Executive Board to admit or to consider the continuation of official relations for 60 to 80 NGOs every year was also considered overly bureaucratic. More often than not, the work of the committee was limited to approving recommendations from the Secretariat.

### **Personalised linkages**

The linkage between the NGOs in official relations and WHO is between two individuals – the focal point in the NGO and the WHO designated technical officer. Therefore, the quality and endurance of the relationship can sometimes boil down to the personal commitment and rapport between the two individuals. This individual link can be broken during a turnover of WHO and NGO staff, leading to difficulties in re-establishing the relationship when new people take over.



act health  
implement  
produce build  
challenge  
justice poverty  
freedom  
rights power  
influence

### **Insufficient information on NGOs**

The *Principles* have no formal requirement to analyse and make public the information received on NGOs. Basic information on NGOs in official relations have not been sufficiently updated or highlighted. NGOs have been questioned on funding sources and mechanisms only at the time of applications but not in the triannual reviews. There is a lack of systematically accumulated knowledge about the sponsors and the interest groups behind individual NGOs. There is also a lack of information regarding those who govern NGOs or sit on NGO boards. This information can be important when board members have connections to certain industries whose goals are considered contrary to WHO's basic public health goals, such as the tobacco or arms industry.

### **Uneven participation at governing bodies**

Among the NGOs in official relations, only about 40% have attended WHA and only 25% have attended EB sessions during the last four years. The general profile of NGOs attending has remained almost unchanged from session to session. The right to speak has been also used to a relatively small extent: the number of NGO statements has been on average 16 during the WHA and 11 during the sessions of the EB.

### **Imbalance between North and South**

There was a perceived imbalance between participation of organizations from the North/West and those from the South/East at meetings of WHO governing bodies (including Regional Committees).

### **Specific constraints in informal or working relations**

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#### **Lack of participation of CSOs not in official relations**

Many CSOs that are in not official relations, but working with WHO, would welcome the opportunity to attend meetings of the governing bodies regardless of whether they want to speak at them or not. Under current rules they can attend only as part of the public or as a member on the delegation of an NGO in official relations. This system of linking official relations to certain privileges has created a perception of two categories or classes of CSOs that bears little relation to the quality or importance of their collaboration with WHO.

#### **Lack of relevant guidelines**

The review found that the existing *Principles* do not offer the needed managerial and policy guidance for WHO staff interacting with CSOs at the HQ, regional and country office level. This contributed significantly to the lack of staff capacity and skills in relating effectively with CSOs. Some of the specific needs identified were: administrative advice on types of agreements; methods for assessment of suitable CSO partners including methods for identifying and addressing conflict of interest; and information on methods for civil society involvement in health promotion, health reforms and health systems.

#### **Regional and country level concerns**

Regional and country offices expressed a need for guidance on how to assist governments in strengthening partnerships with CSOs and in facilitating government dialogue with CSOs.

This was especially important in a context where development aid is increasingly being channelling through CSOs at the country level, with or without government consent. Country office staff were also uncertain about circumstances under which they were allowed to work with CSOs directly or whether government endorsement was needed for all WHO collaboration with a national CSO. These uncertainties may not only have prevented WHO from seeking valuable CSO inputs to their work but reduced WHO's ability to strengthen the capacity of CSOs as well.

Strengthening the profile of WHO at country level as a resource centre and support for all actors in health, including CSOs, is currently being explored by some country offices and merits further attention. Country offices also recommended that WHO's Country Cooperation Strategy include participation of CSOs.

# New policy proposal

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In summary, the review underscored an overall consensus that the current *Principles* are inadequate and less relevant to the realities of WHO and to the needs and aspirations of civil society.

## New policy

Based on the review findings, CSI suggests that the *Principles* be replaced by a new policy. In keeping with the WHO Constitution and general UN practice, the policy would continue to use the term NGOs defined as non-state, not-for-profit, voluntary organizations. The policy would, however, establish principles to distinguish between different kinds of NGOs and their related interests. It is suggested that this new policy would consist of:

a. *An accreditation policy*: this would serve to guide the participation of NGOs to WHO governing body meetings. In contrast to the current “official relations” system, accreditation would not be conditional on working relations with the Secretariat.

b. *A collaboration policy*: this would enhance general interactions between the WHO Secretariat and NGOs, including clarity on differentiating between organizations and the role of WHO in supporting Member States work with civil society.

## This two-fold policy shall be based on:

### **Basic agreement of aims and purposes**

For both accreditation and collaboration, the basic interest of NGOs shall be consistent with the WHO Constitution and not in conflict with its public health mandate.

### **Clarity about nature of interests**

Whether for accreditation or for collaboration, the interests of each party shall be clear and transparent. This would include NGOs readily disclosing information on structure, membership, activities, and source of financing.

## **An accreditation policy for governing bodies**

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A new accreditation system is needed to simplify the bureaucracy and procedures surrounding attendance of NGOs at WHO governing body meetings. NGOs will include organizations such as public interest NGOs, professional associations and business associations.

In addition to basic agreement with WHO's Constitution and disclosure of interest, the following shall be *criteria* for NGOs seeking accreditation:

### **Relevance**

Competence in a field of activity related to the work of WHO, whether it is a technical issue related to public health or a social, economic and inter-sectorial issue related to the determinants of health.

### **Established structure**

A constitutive act, accountability mechanisms and existence for not less than three years. Membership organizations shall have authority to speak for their members, a representative structure and accountability to their members.

### **International scope**

International membership or activities.

### **Transparency**

In addition to being asked for basic information on the application form, NGOs will be provided with categories representing different kinds of organizations and requested to place themselves in one or more categories. This information will be made

publicly available in a database. The Secretariat can initiate a regular information collection procedure to periodically update the basic information.

In application of the accreditation policy, Regional Committees can decide to set up additional rules to invite sub-regional and national NGOs to Regional Committee meetings.

## **A collaboration policy with NGOs**

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This part of the revised policy framework would deal with the Secretariat's interactions with NGOs and would involve the development of guidelines for such interactions. Collaboration with NGOs representing commercial interests will be guided by the existing *Guidelines for interaction with commercial enterprises to achieve health outcomes*.

In addition to basic agreement with WHO's Constitution and disclosure of interest, a collaboration policy shall be based on the following *criteria*:

### **Reciprocity**

Each party shall respect the autonomy, integrity, limits and differences of the other.

### **Responsibility**

Collaboration shall be based on clearly agreed responsibilities by the parties involved when agreeing to common plan of action, identification of resources or strategies for implementation and monitoring.

## Implementing both policies

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Guidelines will need to be developed in order to implement both the accreditation and collaboration policy. Priority areas for work include:

### Strengthening capacity for the Secretariat

Staff training and development of capacity support modules at all levels of the WHO system will be needed to implement both policies, backed by an adequate procurement of resources.

### Assisting management

In order to implement the accreditation policy, guidelines on the application of the new procedures, mechanisms for admission, information and database design, methods for assessment and reporting to the EB, and transitional arrangements for a shift from the current “official relations” system to the accreditation system will have to be developed.

New guidelines for collaboration with NGOs will need to be developed to clarify the authority and the flexibility given to WHO staff in their interactions with NGOs. This would include types of contracts or agreements, funding arrangements, cosponsoring of meetings, methods for identifying and choosing NGOs, and contribution to and use of a NGO database.

### Building a knowledge base

A data base with basic information on accredited NGOs needs to be developed, updated and made public. The building up of a knowledge base would assist collaboration by ensuring that experiences gained in WHO-NGO relations and civil society’s contributions to global health policies are documented and accessible to a wide audience. This would include the role of civil society and NGOs in national health governance, health systems and services.

There is a clear need to merge civil society research with health systems research. The production of a series of documents providing “state of the art” and policy analyses would serve the WHO Secretariat and the Member States in their work.

### Formulating a communication strategy

Communication and information sharing between WHO and civil society actors needs to be improved for both accredited NGOs and those in collaboration. NGOs need “lay” materials and information on WHO governance and decision-making processes, on WHO policies, programmes and priorities, and practical guidance on how they can participate in WHO’s work. On the other hand, WHO Secretariat would benefit from information on how to best arrange consultations with NGOs or how to locate civil society issues within current health debates. New types of NGO consultations and dialogues are needed to contribute to WHO’s advocacy, policy and technical work. A web site, practical tools and information documents need to inform the communication strategy.

## Conclusion

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A new policy guiding WHO’s relations with civil society is clearly overdue given the importance of these relations to WHO in particular and public health in general. This review report contains the core elements that need to inform this policy. The main conclusion has been that the current *Principles* need to be replaced by a policy that looks at two aspects: accreditation and collaboration. More detailed work is now required to translate the needs identified by both WHO staff and civil society into relevant policy criteria and guidelines.

For more information, please contact:

**CIVIL SOCIETY INITIATIVE**

External Relations and Governing Bodies

World Health Organization

Avenue Appia 20

CH-1211 Geneva 27

Switzerland

Tel: (+41-22) 791 44 10

Fax: (+41-22) 791 13 80

E-mail: [barbozag@who.int](mailto:barbozag@who.int)



World Health Organization