

Global Health Governance and the Challenge of Holding Power to Account

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Table of contents

Executive summary	4
1. Introduction	5
2. Global health governance	6
3. Accountability and accountable GHG	10
4. Conclusions	13
5. Bibliography	14

WORKINGPAPER

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Executive summary

While there is much to celebrate about the many institutions, actors, and initiatives that form the global health system, there are also problems with how the system is governed. Some of these relate to inequities and unmanaged conflicts of interest that are rooted in power imbalances and which leave certain actors with excessive and undue influence. By contrast, poorer countries and communities with the biggest stake in the global health system working equitably, effectively, and efficiently have little power by which to hold the system accountable. This intersecting issue of power, accountability, and global health governance is the focus of this Working Paper.

The paper is broken into three sections. The first section discusses the meaning of global health governance and the role of accountability within governance structures and systems in general. It describes the current system of global health governance as being nested within a wider system of global political and economic governance, shaped by international relations, globalisation, and the dominance of neoliberal ideas and policies in recent decades. This has seen, among other things, shifts of power from state-based actors and institutions to more distant and less accountable global actors, as well as from democratic and public institutions to private actors and market forces. In doing so, the Working Paper draws particular attention to the power and accountability of powerful private actors and whether they are sufficiently held accountable.

The second section unpacks the concept of accountability and describes five elements that are required for accountability to function (standards; data and information; answerability; sanctions; and remedy). It highlights the importance of independence in accountability and the challenges of holding powerful actors accountable. It then presents a three-layered framework to map accountability as a component of good global health governance. The final section concludes by calling for more discussion about power and accountability in global health, while also emphasising the need for rigorous research in identifying and helping correct harmful and unhealthy accountability deficits.

1. Introduction

The past three decades have seen the emergence of a large complex of actors concerned with ‘global health’. Among the actors are governments, inter-governmental organisations (IGOs), private foundations, academic institutions, international non-governmental organisations (INGOs), and private for-profit organisations, all operating through a variety of global health structures and initiatives. The emergence of this complex of actors and the accompanying system of global health governance (GHG) has been mostly celebrated, coinciding with a five-fold increase in levels of global health spending and some tangible improvements in various health indicators in low- and middle-income countries (LMICs).

However, there have also been criticisms with how GHG is structured and how it operates. These include longstanding concerns about power asymmetries and colonial legacies between global health donors and their recipients, as well as the fragmented and top-down nature of much development assistance for health and its tendency to focus on biomedical and technological solutions without adequately seeking to improve the more fundamental social, political, and economic drivers of disease and health inequalities.[1] The unequal distribution of COVID-19 vaccines, accompanied by the extraction of exorbitant profits by transnational pharmaceutical companies, has also raised criticisms about the undue influence of powerful private actors (PPAs) over global health policies, priorities, and budgets.

Given these criticisms, this paper discusses the issue of power and accountability across the system of GHG, with a particular focus on the lack of accountability of PPAs. The paper is broken into three sections. The first section begins by defining the term GHG and presenting a description of what constitutes *good* GHG. It then describes the structures, systems, and institutions of global governance in general and how the system of GHG is located within this wider context and an evolving global political and economic landscape. The second section focuses on the concept of accountability and the different elements, mechanisms, and processes of accountability before then discussing the application of accountability to three layers of global health governance. The final section concludes by calling for more research and advocacy that can help improve global health governance by contributing to the correction of key accountability deficits across the global health system.

[1] These issues were well covered by the Commission on the Social Determinants of Health (2008) which noted that “the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally” and that the unequal distribution of health-damaging experiences “is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics”. More recently, McCoy et al (2024) describes the interface between colonialism and global health, and its implications for global health governance.

2. Global health governance

There are many definitions of GHG.[2] Here, we define it as the formal and informal structures, systems, and institutions through which actors: i) make decisions about global health standards, policies, and priorities; ii) finance, organise, and implement global health initiatives, programmes, and plans; and iii) influence and engage with actors, systems, or institutions that lie outside the health sector but impact on health. Our definition thus encompasses governance **within** the global health sector (i.e. the way global health-specific institutions, initiatives, and programmes are governed and managed); governance **of** the global health sector (i.e. how the global health system as a whole is governed); and global governance **for** health (i.e. how global health actors influence the impact of non-health-specific structures, systems, and institutions on global health). Such a definition of GHG is broad and acknowledges that global health outcomes and the system of GHG are influenced and shaped by actors, structures, and institutions that lie outside the health sector.

Because we seek not just to study GHG but also to improve it, it is necessary to outline a position on what constitutes **good** GHG. This is mostly a normative matter that involves determining what we want the system of GHG to achieve and how we want governance to be conducted. In terms of the former, good GHG would mean improving global health indicators efficiently, effectively, and equitably, with a strong focus on reducing social health inequalities within, between, and across countries. In terms of the latter, good GHG involves processes and practices that are procedurally fair, inclusive, and consistent with democratic values and the principle of universal human rights. Such a definition means that good GHG is contingent upon there being good governance more broadly.[3]

At the national level, a core element of good governance would be a government that is expressive of democratic values, and which typically includes but goes beyond a narrow understanding of representative or electoral democracy as well as a separation of powers and checks and balances across different branches of government and organs of the state, including an independent and fair judicial system. Democratic governance allows for the collective exercise of power through social and political institutions, based on processes that accord all people, irrespective of their designated race, class, ethnicity, gender, or caste, political equality.[4] Good governance, based on shared values and equal rights and opportunities, thus implies that government is held accountable by those being governed.

However, good governance is much more than just ‘good government’: it is also about the wider societal acceptance of norms, customs, and ideas that value fairness, probity, honesty, and social responsibility, and the idea of universal human rights. Most importantly, it is also about the existence of a healthy civil society and of key social institutions critical to good governance such as public-interest journalism and media willing and able to investigate and report on the conduct of powerful state and non-state actors; institutions of higher education that champion academic freedom and encourage informed public debate; and civic organisations with a mandate to represent the views and interests of marginalised groups in society.

[2] There are many published articles about ‘global health governance’ both as a concept and a real-world phenomenon. Useful readings include Lee and Kamradt-Scott (2014), Fidler (2010), and Frenck and Moon (2013).

[3] In speaking about democratic values, our intention is to highlight approaches to governance without advocating for any particular form of electoral process or government. This echoes Scholte’s (2002) use of the term democracy “as a general condition (that) needs to be distinguished from liberal-national democracy as a particular historical and cultural form of ‘rule by the people’”. Additionally, we would see ‘good governance’ as being incompatible with autocratic or plutocratic regimes that rule without consent or through fear or the abuse of financial power.

[4] This means that those with the least power (poor, marginalised, and minoritised populations) should have opportunities to shape, understand, judge, and challenge decisions that affect their lives.

Applying these features of good governance to the global level is more challenging due to the absence of a world state or government. Instead, global governance is largely based on a system of multiple inter-governmental organisations (IGOs). Key among these are the institutions of the United Nations (UN) and the Bretton Woods institutions (sometimes referred to as sister organisations of the UN). These include predominantly political bodies such as the UN Security Council and General Assembly; institutions of economic governance such as the World Bank, International Monetary Fund, and World Trade Organisation; specialised agencies such as the World Health Organisation (WHO) and the Food and Agricultural Organisation (FAO); and a rudimentary global judicial system that includes the International Court of Justice, International Criminal Court, ad hoc international tribunals, the WTO Appellate court, and the World Bank International Centre for Settlement of Investment Disputes.[5]

Another important aspect of global governance is the various international treaties and agreements that represent some agreed principles and standards for the conduct of international affairs and global governance, including those that reflect the features of good governance. These include the UN Charter, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights. The adoption of international goals such as the Sustainable Development Goals may also be considered an element of global governance. However, a vital complement to these treaties and agreements is the community of international and transnational civil society actors who champion international solidarity, global justice, and universal human rights. Their role in advocating for good global governance and holding the formal institutions of global governance accountable, including preventing them from being captured by powerful groups, is an important element of good global governance, just as an informed and independent civil society is important for good national governance.[6]

However, there are also various limitations and constraints to the practice of good global governance. International rivalry, national self-interest, and power asymmetries among nation-states (including unequal levels of control and influence of key global institutions like the Security Council, World Bank, and IMF) work against the multilateral system operating as it should. Furthermore, given the lack of direct democracy at the global level, democratic deficits at the national level are easily transposed to the global level of governance, especially given the distance and remoteness of global governance structures from ordinary communities. The sprawling and uncoordinated nature of the UN, with its multiple structures with overlapping mandates, makes accountability enforcement further challenging.[7]

The democratic deficit in global governance has also been exacerbated by other factors. Most notably, a dominant neoliberal policy paradigm and an erosion of national economic sovereignty due to economic globalisation have shifted power from state-based actors and institutions to more distant and less accountable global actors, as well as from democratic and public institutions to private actors and market forces. The deregulation of the financial sector and the subsequent increased financialisation and privatisation of national and global economies, coupled with the widened scope of a dizzying array of bilateral, plurilateral, and multilateral trade, tax, and investment agreements that have been negotiated in spaces hidden from parliamentary or public oversight, have further contributed to a de-democratisation of global governance.

[5] Regional human rights tribunals, such as the Inter-American Court of Human Rights and the European Court of Human Rights, as well as quasi-adjudicatory forums of treaty-monitoring bodies also play a de facto role in global governance.

[6] See Carayannis and Weiss (2021) for more discussion about the ecosystem of non-state actors who interact with the intergovernmental machinery of the UN and the important role they play.

[7] See Grant and Keohane (2005) for a deeper discussion about accountability and global governance and the challenge of overcoming the democratic deficits that are intrinsic to global governance.

Alongside these changes has been the growth of private organisations with enormous levels of power and political influence. These include large oligopolistic transnational corporations (TNCs) that today dominate virtually all markets and economic sectors, trillion-dollar private financial institutions,[8] individuals with extreme levels of wealth, and private foundations that spend billions of dollars annually across a range of policy areas including global health.[9] Meanwhile, a proliferation of multi-stakeholder forums and public-private partnerships (PPPs) established to develop and implement various international agreements, policies, and programmes have created greater opportunities for non-state actors (NSAs) to engage in global governance, which PPAs are especially able to take advantage of. Finally, public forms of global governance have been weakened by the institutionalisation of entirely private modes of global governance over certain issues. Examples include Investor-State Dispute Settlement adjudication, the International Accounting Standards Committee, and the unappealable judgments of credit rating agencies.

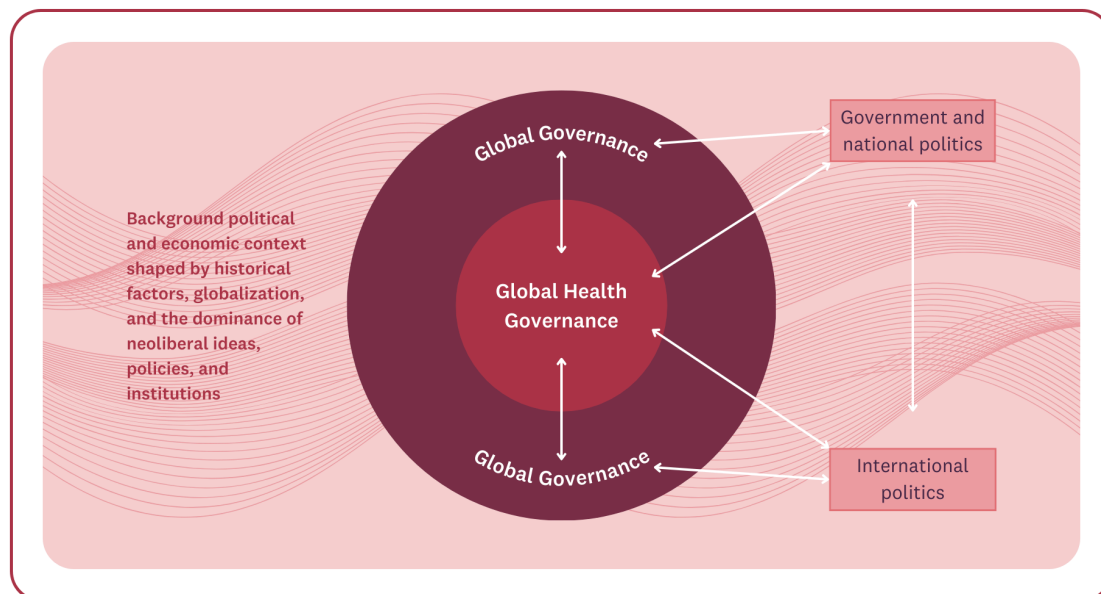
These features of global governance are especially prominent within the sphere of GHG. The past few decades have seen, for example, a relative weakening of the WHO, with power and influence over health policy and health systems development being ceded to organisations such as the World Bank and with many aspects of public health policy and regulation coming under the purview of the WTO and the international regime of trade and investment agreements. Its increasing dependence on conditional grants has also placed WHO more under the influence of its major governmental and private funders. The global health sector has also experienced rapid growth in the number and type of global health organisations, initiatives, and programmes, making GHG more complex and less clear about where responsibilities lie and how lines of accountability operate. The growth in the influence of private foundations across the global health system[10] and mushrooming of multi-stakeholder forums and health-related PPPs have further accentuated the influence of private actors and expanded the number and reach of global health programmes and initiatives that have weaker forms of accountability to governments or the general public.

[8] There are a wide array of different private financial institutions including private equity, venture capital, and hedge funds, as well as private investment and commercial banks. The three firms that dominate the private equity sector – Blackrock, Vanguard, and State Street – manage trillions of dollars’ worth of assets. The role of private financial institutions in shaping the determinants of health is generally poorly understood and under-appreciated. See Hunter and Murray (2019).

[9] The growth in power and influence of TNCs and their central role in driving so-called ‘industrial epidemics’ are documented in a growing body of literature on the commercial determinants of health. See, for example, the recent Lancet Series on the Commercial Determinants of Health as well as the third paper of the Lancet Series on Breastfeeding.

[10] Presently, the Bill and Melinda Gates Foundation is the dominant private foundation in global health and is arguably the most influential single actor in global health. But other private foundations such as the Wellcome Trust and the Rockefeller Foundation play equally influential roles within more specific parts of GHG. Private foundations have significant advantages in being private and independent, and through their ability to shape markets and influence other actors through their grant-giving programmes.

Figure 1: Global health governance in context



The current system of GHG is thus both complex and dynamic. Crucially, as illustrated in Figure 1, GHG consists of a sphere of actors, structures, and systems that is: i) located within and influenced by a bigger sphere of global governance; ii) influenced by a wider political and economic context that has been shaped by historical factors, globalisation, and a dominant neoliberal policy paradigm; and iii) affected by national politics (especially of the wealthier and bigger states), as well as by international politics. Equally, as illustrated by the bi-directional arrows in Figure 1, it may be argued that global health actors have a responsibility and professional mandate to also shape the wider global political and economic context in which they operate, as well as to influence international relations and national politics in order to promote equitable and sustainable global health.[11]

Efforts to promote better GHG, including through forging appropriate and effective accountability systems, should be informed by an understanding of this complexity of the global health system and its subjection to political forces and dynamics. But what would more accountable GHG consist of? What follows is a more in-depth discussion about the concept of accountability and its application to GHG.

[11] Much has been written about the potential role of health actors in promoting, for example, peace and development, through foreign policy and global health diplomacy. See for example, Labonte and Gagnon (2010) and Kickbusch and Liu (2022).

3. Accountability and accountable GHG

The concept of accountability is broad and applicable across many different relationship types.[12] Here we are concerned with accountability relationships within and across the system of GHG. While some actors are willing to be accountable because it is consistent with their worldview or commitment to democratic values, others will evade or minimise their accountability to others, or even actively oppose or obstruct efforts to hold them accountable. For these reasons, many accountability relationships and mechanisms need to be enforced through the law, placing the state and IGOs (including WHO) in a critical role of establishing and managing the ‘rules’ of governance and accountability at the national, international, and global levels.[13] In addition to governments and IGOs being fundamental to the institutionalisation of good GHG, civil society, including the epistemic community of non-state global health actors, are also vital for ensuring that governments and IGOs discharge their duties and are protected from being captured or compromised by PPAs with vested interests.

While discussions about accountability in global health tend to emphasise relationships between funders and their recipients (with the latter often subjected to heavy reporting requirements and donor-imposed metrics), this paper is more concerned with enabling less powerful actors to hold more powerful actors accountable, and with the many ‘horizontal accountability relationships’ that should exist amongst organisations working collaboratively or in partnership with each other. This includes particular interest in how PPAs are held accountable by actors with formal GHG responsibilities including states and IGOs like the WHO, as well as by civil society members of the international community of global health actors (e.g. health-related NGOs and social movements; research institutes and academic departments; health journals and journalists; and health professional associations).[14]

Before discussing these political dimensions of governance and accountability further, it’s worth unpacking the concept of accountability itself. Several conceptual frameworks have been developed to describe the different dimensions of accountability; here, we describe it in terms of five interrelated elements: standards; data and information; answerability; sanction; and remedy.[15]

[12] For example, accountability may be applied within personal relationships between individuals; within markets between sellers and buyers; within contractual relationships between a principal and its agent; or between employees of a single organisation.

[13] Clearly for laws to contribute to good and accountable governance, they must be just. Furthermore, as noted earlier, laws by themselves may be insufficient. Laws must also be implemented and prosecuted fairly, efficiently, and affordably and can play a role in helping civil society actors.

[14] Implicit in state actors, IGOs, and privileged sections of the international community of civil society actors advocating for systems of accountability that comply with principles of good GHG, is the assumption that poorer countries and communities should have more purchase over the governance of the global health system including being better able to hold PPAs accountable.

[15] Bovens (2007) notes that in much political and scholarly discourse, ‘accountability’ serves as a conceptual umbrella for various other concepts, including transparency, democracy, efficiency, responsiveness, responsibility, integrity, ‘good governance’, or virtuous behaviour. Koppell (2005) notes five dimensions of accountability: transparency, liability, controllability, responsibility, and responsiveness. The One World Trusts’ Global Accountability Report described accountability as a process and set of mechanisms consisting of four elements: transparency, answerability, stakeholder involvement, and sanctions.

- The first element is the **standards** against which actors are held accountable. Standards may come in different forms: for example, as performance indicators of effectiveness or impact, or as standards of behaviour and conduct. Standards may be expressed or defined quantitatively or qualitatively. In the case of good GHG, standards would reflect, among other things, adherence to principles of universal human rights, fairness, and equity.
- The second element relates to the concept of transparency and the availability of **data and information** that can be used to assess the decisions, actions, and impacts of an actor or institution. Here, the type, quality, scope, source, regularity, and accessibility of data and information are crucial variables, along with the ability of relevant stakeholders to analyse and interpret data and information critically.
- The third element is **answerability** and the requirement for actor(s) to respond to questions or requests for explanations or justifications about their decisions, actions, and impacts. Answerability may be retrospective or prospective. The former is applied after there has been a failure of performance or a breach of standards of behaviour while the latter is applied in an on-going manner to maintain or improve standards or prevent a future failure of performance or breach of standards.[16]
- The fourth element is some form of **sanction** or threat of sanction in the event of an actor or institution failing to meet expected standards of behaviour or performance or being responsible for injury or harm caused to others. Sanctions may come in many forms, including financial penalties, criminal prosecution, or loss of reputation.
- The fifth element is **remedy** following the identification of harm or injury that results from poor performance or misconduct. Remedies may take the form of restitution, rehabilitation, compensation, and corrective actions to prevent any future replication or repetition.

A crucial feature of all these elements of accountability is that there is an adequate degree of independence amongst those involved in the accountability process. In addition, effective accountability requires that a sufficient degree of power or protection is accorded to those actors who undertake reviews and judgements of the performance or conduct of powerful actors, and those who decide and act upon the implementation of sanctions or remedies.

Each of these elements also involve mechanisms and instruments that may range from being formal and legally enforceable to being informal and voluntary. While accountability elements that are voluntary and non-enforceable are often weak (especially when designed to hold powerful actors accountable), some accountability mechanisms are powerful even if not enforced legally. For example, sanctions in the form of consumer boycotts, damage to reputation, or public shaming may have some effect in keeping some powerful actors accountable.

Because different actors have different roles, responsibilities, and agendas, there is no standard or uniform approach for applying these elements of accountability. The design of accountability systems and mechanisms, including the extent to which they are legally enforced, needs to be tailored to individual actors or actor types, as well as to the political and economic context. It is also important to note that most actors exist within a web of multiple accountability relationships that may also reinforce or conflict with one another. For example, the WHO is made up of multiple components (World Health Assembly, Executive Board, Secretariat, Regional Offices, etc.) that have accountability relationships with each other as well as with a diverse range of stakeholders (funders, national governments, other global health actors, and the world's people) with differing agendas, interests and priorities.

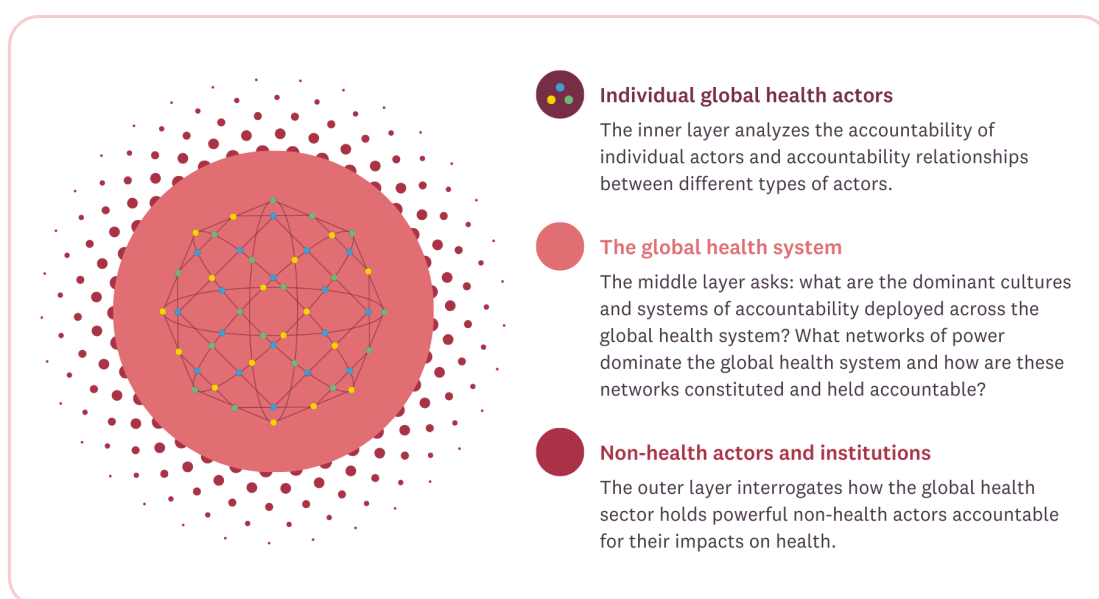
[16] These first three elements involve the act of monitoring and evaluation – often also considered a core element of accountability.

Given the increased informality and complexity of GHG, and the growing use of PPPs and multi-stakeholder forums, it is also necessary to look beyond the accountability of individual actors to looking at networks of power and how these shape the global health system and its culture and practice of accountability. Networks that may consist of NGOs, academic organisations, researchers, think tanks, journals, and funders that are coalesced around a set of shared ideas, narratives, and priorities are more difficult to hold accountable than individual actors, but are nonetheless crucial to understanding how the global health system is governed.

A final dimension of accountability and GHG is the role of the global health community or sector in holding non-health actors and institutions accountable for their impact on health and health inequalities. These non-health actors and institutions may include those departments within the Bretton Woods Institutions that are responsible for global economic and fiscal policy, or those actors with a responsibility for averting the climate crisis, for example. Given the importance of political, economic, and environmental determinants on health and health systems, the global health community should be able to argue that it has a mandate to hold accountable those actors with political, economic, and environmental responsibilities.

Operationalising any approach to correcting the accountability deficits within and across the system of GHG, and with a focus on PPAs, should thus involve a three-layered approach (see Figure 2). The inner layer is concerned with the accountability of individual actors. In addition to mapping the multiple accountability relationships of different individual actors, there is also a need to look at the responsibility of state actors in shaping the overarching legal and political framework for ensuring good governance and systems of accountability for PPAs, as well as the critical role of civil society actors in advocating for a positive culture of accountability across the system and being willing to question and challenge powerful actors on behalf of the wider public or common interest. This dual approach of looking at accountability relationships between individual actors as well as their role and responsibilities in shaping the overall culture and practice of accountability relates to the middle layer which involves looking at the global health system as a whole and the wider power dynamics that shape GHG. By spotlighting systems of power and accountability, this middle layer of analysis provides a basis for identifying the structural challenges and changes that may be needed to improve GHG. Finally, the outer layer is concerned with how global health actors are addressing the upstream determinants of health by holding non-health actors accountable.

Figure 2: A three-layered approach to correcting accountability deficits in GHG



4. Conclusions

The system of GHG is both complex and large, and includes many actors that should be accountable, including but not limited to: the WHO and other health-related IGOs; GHPs such as the Global Fund and Gavi; global health private foundations; and the governmental aid agencies who contribute major amounts of global health funding. While these organisations all have some existing mechanisms of accountability, the aim of this paper is to catalyse discussion about whether these mechanisms are complete and adequate.

This paper has also drawn particular attention to PPAs, and has done so for two reasons: first, they have outsized impacts on health outcomes; and second, they have a growing influence over the system of GHG itself. As such, questions about the adequacy of current mechanisms and systems of accountability within the system of GHG need to include whether and how these actors are held accountable, as well as whether (and to what extent) the global health system is captured, overly-influenced, or compromised by PPAs, especially those that produce or supply commodities that are potentially harmful to health, or that have a pecuniary interest in decisions about health financing and spending.

Any agenda to take these issues forward would first need a willingness amongst global health actors to discuss the sensitive and charged issue of power and influence. Two other streams of work would be important: first, a 'research stream' to better empirically describe the current state of accountability systems, mechanisms, and cultures within and across the global health system and the impact of accountability deficits on the performance of the global health system; and second, a 'policy stream' to create opportunities for discussion amongst a broad range of actors about how to effect change and better GHG.

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The UNU International Institute for Global Health (UNU-IIGH) in Kuala Lumpur, Malaysia, operates as the designated UN think tank specialising in global health. With a mandate to facilitate the translation of research evidence into policies and tangible actions, UNU-IIGH serves as a hub connecting UN member states, academia, agencies, and programs.

Established through a statute adopted by the United Nations University Council in December 2005, the institute plays a pivotal role in addressing inequalities in global health. UNU-IIGH contributes to the formulation, implementation, and assessment of health programs.

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