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Reforming World Health Organization governance in a changing global health architecture: An integrated governance analysis informed by field observation, interview data, and policy mapping

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Abstract: Between January 2025 and early 2026, the World Health Organization (WHO) faced three interrelated structural pressures: a budget shortfall exceeding US$1.05 billion triggered by the announced United States withdrawal; a weakening of strategic governance functions at the Executive Board (EB) and the Programme, Budget and Administration Committee (PBAC); and the parallel emergence, outside WHO, of multiple Global Health Architecture reform agendas, including the Lusaka Agenda, the Accra Reset, the UN80 Initiative, and the America First Global Health Strategy. This study presents an integrated governance analysis using four complementary data sources: participant observation of WHO governing-body sessions (EB158, February 2026; the 79th World Health Assembly, WHA79, May 2026); semi-structured interviews with 10 professional staff serving at WHO headquarters and in regional and country offices; policy mapping of relevant reform-agenda documents, classified into four domains; and a companion quantitative analysis of governing-body document release timing. Triangulation revealed late release of budget documents, an unprecedented proposal to draw over US$ 400 million from the Programme Support Cost, contested governance reform, field-level constraints in prioritization, human-resource management and financial accountability. The findings suggest a bidirectional problem in which constraints on Secretariat function and difficulties in substantive Member State deliberation reinforce each other, while reforms remain headquarters-centric and may contribute to implementation gaps at regional and country levels. As a policy implication, the forthcoming Director-General selection and the UN80-linked reform cycle offer an opportunity for governance reform. These developments may offer opportunities for WHO Member States, including Japan and the Global South, to strengthen WHO's coordinating role.

***Keywords*:** sustainable financing, global health diplomacy, UN80 initiative, multilateralism, Global South

1. Introduction

1.1. Background: The governance crisis surfaced at the 79th World Health Assembly

On 20 January 2025, the new United States Administration announced its withdrawal from World Health Organization (WHO) and suspension of both assessed and voluntary contributions. As WHO's largest contributor (approximately 16% of its 2022–2023 budget), loss of United States funding, together with aid reduction by other Member States, left WHO a projected 2026–2027 budget gap of over US$1.7 billion, later narrowed to around US$1.05 billion (*1-4*). At the 42nd Programme, Budget and Administration Committee (PBAC) and the 78th World Health Assembly (WHA) in May 2025, the proposed 2026/27 programme budget of US$ 4.2 billion was tabled. Late release of the budget document, mid-session presentation of revised figures and financial assumptions absent from the original budget paper, and a proposal to draw over US$ 400 million from the Programme Support Cost (PSC) together constrained Member State scrutiny, and the budget was endorsed de facto without thorough review (*5,6*).

This sequence of events highlighted structural vulnerability of an Organization heavily dependent on a small number of major donors (*7,8*). In discussing WHO financing, this article distinguishes among assessed contributions (obligatory, un-earmarked, and predictable), voluntary contributions (the majority of which are

earmarked by contributors for specific programmes), the WHO Investment Round launched in 2024 to mobilise more flexible voluntary funding, and the broader question of sustainable financing addressed through Member State-led reform processes described below. These categories carry distinct governance implications and are treated separately in the analysis. We interpret it, however, not merely as a "financial problem" but as surface manifestation of a deeper structural governance crisis. Even before the United States announcement, some Global Health Architecture (GHA) reform agendas had begun to emerge, and others followed shortly thereafter, in parallel from outside WHO—the Lusaka Agenda (2023) (*9*), the Accra Reset (2025) (*10*), the UN80 Initiative (2025) (*11*), and the America First Global Health Strategy (2025) (*12*)—reflecting broader discontent with the WHO and its governance by Member States (*13,14*).

WHO itself has been advancing several internal reforms, including the Working Group on Sustainable Financing (WGSF) (WHA75(8)) (*15*), the Agile Member States Task Group on Strengthening WHO's Budgetary, Programmatic and Financing Governance (AMSTG) (EB152/33; WHA76(18)) (*16,17*), and the Member State-led governance reform submitted at the 158th session of the Executive Board (EB) (EB158/36) (*18*). These reforms, however, are insufficiently integrated, and decision-making in the WHA, EB, and PBAC increasingly fails to discharge strategic and normative functions originally expected of them.

1.2. Gaps in existing research

This governance crisis is unfolding bidirectionally. On the Secretariat side, limited financial and human resources make strategic judgement, priority setting, and budget management increasingly difficult (*19*). On the Member-State side, late release of decision-making documents compresses time available for domestic inter-ministerial coordination, regional-group consultation, and expert pre-consultation, constraining deliberative function that Member States are expected to exercise as sovereign right. In addition, rise of Global South has been accompanied by a growing number of countries that treat health as a strategic national interest and engage actively through their permanent missions in Geneva. Within these increasingly multipolar negotiation dynamics, major donor states, by contrast, contribute large sums but exert little substantive influence over WHO's work, fuelling donor disengagement.

Within the reform discourse (WGSF, AMSTG, EB158/36), "timing of document submission" and "ensuring prior consultation" have repeatedly emerged as concerns (*15-18*), yet empirical studies that longitudinally quantify the phenomenon and connect it to field-level experience remain limited. Similarly, few systematically examine how reform agendas formulated at headquarters are received and operationalised at WHO regional offices (ROs) and country offices (COs), and what implementation gaps arise. Studies that map full landscape of GHA reform agendas under a unified analytical framework and locate WHO's position within it are also scarce (*20,21*).

1.3. Research objectives

Building on this problem framing, the central analytical question of this study is how constraints on Secretariat capacity and constraints on substantive Member State deliberation interact with each other, and how this interaction conditions WHO's ability to respond to reform agendas reshaping the GHA. The three research questions (RQs) below operationalise this central question:

RQ1: How do the principal structural challenges of WHO governance; namely its fiscal base, human-resource and programme management, and the framework for engagement with non-state actors, manifest in deliberations of the central governing bodies (PBAC, EB, WHA) and in operations of WHO's ROs and COs?

RQ2: How constrained are time and information available to Member States for substantive deliberation, and how does this constraint shape governance outcomes? (The release timing of Secretariat documents, used as a measurable proxy for this constraint, is analysed quantitatively in a companion paper by our group (*22*); the present article draws on those findings and interprets them alongside the field, interview, and policy-mapping evidence.)

RQ3: How is interaction between Secretariat capacity and Member State deliberation, identified in RQ1 and RQ2, situated within the external reform agendas reshaping the GHA, and what do these agendas imply for WHO's coordinating role and for engagement of major contributing Member States?

In addressing these questions, the article seeks to make two contributions: first, an empirically grounded account of how constraints on the Secretariat and constraints on substantive Member State deliberation interact with each other; and second, a systematic mapping of the current GHA reform landscape that locates WHO's position within it. All subsequent sections are organised around this single analytical framework.

2. Materials and Methods

The study was designed as an integrated governance analysis drawing on multiple complementary sources of evidence: *i*) a quantitative analysis of WHO governing-body document release timing reported separately by Komada *et al.* (*22*); *ii*) field observation of WHO governing body meetings (EB, WHA, PBAC); *iii*) semi-structured interviews with professional staff at WHO

headquarters, regional and country offices; and *iv*) a policy mapping of principal GHA reform agendas. By combining these methods and triangulating findings across them, we aimed to capture structural challenges of WHO governance that no single approach can adequately illuminate. The four sources were integrated through a convergent mixed-methods design: each source was first analysed separately, and findings were then brought together at the interpretation stage through the triangulation procedure described in Section 2.5. Each source was assigned a primary analytical role in advance: document release timing analysis addressing RQ2; field observation addressing RQ1 and RQ2 at the level of the central governing bodies; qualitative interviews addressing RQ1 at the RO and CO levels; and policy mapping addressing RQ3. Table 1 summarises data sources, their settings and samples, and their contribution to the integrated analysis.

2.1. Document release timing data (reported separately)

A quantitative analysis of release timing of Secretariat documents in WHO's central governing bodies (EB, PBAC, WHA) is reported in a companion paper by our group (*22*). That analysis measured the interval—between document release and session start—of governing-body documents from 2016 through 2026 and quantifies a longitudinal trend of progressively later release for the WHA, with EB timelines partly recovering after the COVID-19 pandemic period. The present paper draws on its core findings and interprets them together with the field observation, qualitative interview, and policy mapping data described below. The two papers are designed as companion outputs of a single research project: Komada *et al.* (*22*) present the quantitative analysis of document release timing, while the present article provides integrative interpretation that combines that analysis with field observation, qualitative interviews, and policy mapping.

2.2. Field observation at WHO governing body meetings

Two of the authors (HS, HN) attended the PBAC 43 (28–30 January 2026), the 158th session of the WHO EB (EB158, Geneva, 2–7 February 2026), PBAC 44 (13–15 May 2026) and the WHO WHA (WHA79, Geneva, 18–23 May 2026) as members of the Japanese government delegation. Field notes were taken during sessions on finance and budget, governance reform, GHA reform and the UN80 Initiative, and relations with non-State actors, covering Member State interventions, chair rulings, amendments to draft decisions, and the dynamics of informal caucuses. Field notes were recorded contemporaneously in written form during the sessions and consolidated by the observing authors immediately after each session. Notes were organised by agenda item, and analysis proceeded by structured comparison of the notes against corresponding official documents and records of each session; the governance implications summarised in Table 2 were derived from this comparison and reviewed within the research team. Observation was confined to public deliberations and public documents, in line with the obligation of confidentiality. No non-public information, including content of closed sessions, informal consultations not open to observers, or internal government communications, was used in this study. Because the observing authors attended these sessions as members of the Japanese government delegation, their access reflects an insider position; a statement on positionality is provided in Section 2.6, and associated limitations are discussed in Section 4.5.

2.3. Interviews

The interview component was intended to provide contextual and explanatory insight regarding operational realities across organizational levels. As one component of overall governance analysis, interviews were used

Table 1. Overview of the four data sources and their contribution to the integrated analysis

Data source	Setting / sample	Analytical role in the integrated design	Research question
Document release timing (companion paper, Komada *et al.* (*22*))	WHO governing body documents (EB, PBAC, WHA), 2016 to 2026	Quantifies the structural compression of Member State deliberation time; provides the quantitative foundation on which the integrated interpretation builds	RQ2
Field observation	PBAC43, EB158, PBAC44, and WHA79 (January to May 2026); public sessions and public documents only	Documents how governance constraints manifest in the deliberations of the central governing bodies	RQ1, RQ2
Semi-structured interviews	10 professional staff (P3 to P5, all in programme functions) serving at WHO HQ (n = 2), in one RO (n = 2), and in COs (n = 6) in two WHO regions, October 2025 to March 2026	Identifies how headquarters-level reforms are experienced and operationalised at regional and country levels	RQ1
Policy mapping	Official documents of the principal GHA reform initiatives, 2023 to 2026	Locates WHO's position within the external reform landscape and identifies the horizontal coordination gap	RQ3

Table 2. Principal observations from selected governance issues discussed at EB158 and subsequently followed through PBAC 44 and WHA 79

Agenda item	Observation	Governance implication (analytical interpretation)
2026/27 programme budget (EB158/3, EB158/4)	Late release of the budget document; introduction of new assumptions during the session; proposal to draw over US$ 400 million from the Programme Support Cost (PSC); no strategic risk assessment presented to the session; adoption without substantive amendment.	Compressed timelines and mid-session changes constrained substantive Member State scrutiny; pattern consistent with endorsement of Secretariat proposals under time pressure (developed in Section 4.1).
Member State-led governance reform (EB158/36, EB158/37)	Proposals to limit the number of agenda items, streamline resolution/decision management, and improve meeting efficiency; North–South divergence over "inclusiveness" and "transparency".	Reform direction confirmed but binding force limited; no institutional design to mediate the trade-off between inclusiveness and agility.
GHA reform and UN80 (EB158/44)	Expectations expressed for WHO's "convening power" alongside methodological tension between comprehensive (Global South) and time-bound (high-income) processes.	Discussion on the connection between UN-wide reform and WHO's core functions is nascent; limited space for active Member-State debate.
Engagement with non-State actors (FENSA operations)	Renewal of relations with specific NGOs became politicised; Framework of Engagement with Non-State Actors (FENSA) procedure formally observed, decision adopted with reference to "Member States' sovereign rights".	Limits of rule-based governance when politicised; limited anticipatory risk identification and preventive engagement.
2026/27 budget execution and financing (PBAC44; Document A79/15)	Financing, Implementation and Performance Framework released two days before the linked PBAC session; execution/outlook papers tabled late; venue split across two sites during concurrent Hantavirus and Ebola emergencies.	Recurrence of the EB158 budget-timing pattern; minimal time for Member-State scrutiny of financial performance under operational strain.
Human resources: annual report (Document A79/21)	Staff of 8,569 as of 31 December 2025 (down 9.4% year on year); projected to decline to 7,283 by 30 June 2026, approximately 23% below the 9,401 staff recorded as of 1 January 2025 (A79/21; A79/21 Add.1); recruitment to resume under a restructured process prioritising matching of separated and serving staff, with new appointments on temporary contracts (Secretariat presentation, field observation).	Workforce contraction shaped by contractual and fiscal structures rather than strategic or programmatic criteria; risk to institutional capacity and continuity.
GHA reform and UN80 (joint task force)	Agreement on the composition and timeline of a joint Member State task force on GHA reform; the UN80 stakeholder-coordination proposal at PBAC44 was again tabled late.	Member-State-led step toward the horizontal coordination function the paper identifies as unassigned, but late documentation again constrained deliberation.
Conduct of proceedings and membership	Opening-day disputes over agenda adoption required repeated votes (Ukraine, Gaza, Gulf items); right-of-reply exchanges required chair intervention; the Taiwan question recurred; a resolution accepted Argentina's withdrawal and welcomed a possible return.	Intensifying politicisation crowds out substantive technical deliberation and extends the FENSA pattern (Row 4) into the plenary; membership volatility underscores the fragility of the universal participation and financing base.

Note: The "Observation" column reports what was directly observed in public sessions and official documents. The "Governance implication" column presents the research team's analytical interpretation, derived through structured comparison of field notes with corresponding official documents and records of each session (Section 2.2); these interpretations are developed further in the Discussion (Sections 4.1 to 4.3).

to inform interpretation of findings derived from field observation and policy analysis. Rather than seeking a comprehensive representation of WHO staff perspectives, interviews were intended to generate insight into governance-related challenges and implementation realities across organizational levels.

Between October 2025 and March 2026, we conducted semi-structured interviews with 10 professional staff serving at WHO headquarters (HQ, n = 2), in one regional office (RO, n = 2), and in country offices (COs, n = 6) located in two WHO regions. Specific regions are deliberately not named: each WHO region has a single Regional Office, and naming the region of the participating RO would identify the office concerned, and for CO participants the combination of a named region with grade and functional area could narrow identification within small country teams. For the same reason, attributes are reported only as aggregate counts and are not cross-tabulated. This safeguard formed part of the anonymisation approach explained

to participants. Participants were selected by purposive sampling to ensure diversity across grade (P5, P4, P3) and duty station (HQ, RO, CO); all 10 participants were serving in programme functions. Participants were recruited through professional networks of the research team, followed by snowball referral, with attention to avoiding concentration in any single office or functional area. Interviews were conducted in English or Japanese, according to preference of the participant. Memos were prepared in the language of the interview, and themes were developed and reported in English; no formal cross-language validation procedures were applied, consistent with the contextual role of the interview component described above. Each interview lasted 60–90 minutes, conducted in person or online, with memo-form records used to safeguard anonymity. Interviews were not audio-recorded and no verbatim transcripts were produced; instead, detailed written memos were taken during and immediately after each interview, and identifying details (name, office, country, and specific programme references) were removed at the point of recording. Accordingly, illustrative statements presented in Table 3 are composite reconstructions, each synthesising accounts from multiple participants on the basis of these memos, generalised and anonymised to protect participants; they are not verbatim quotations and are therefore presented without quotation marks.

The interview guide was developed by the research team on the basis of the research questions and the issues identified through field observation and document analysis. The same core domains were used in all interviews, with follow-up questions adapted to each participant's role and duty station; the guide was not formally piloted.

Topics included: (a) priority setting under Fourteenth General Programme of Work (GPW14) and three-tier (HQ–RO–CO) alignment; (b) human-resource management (WHO Representative appointments, mid-level appointments, junior development); (c) staff reductions under fiscal stress and equity; (d) financial accountability and external review; (e) relations with private foundations and other non-State actors; and (f) strategic engagement of major donors including Japan.

Analysis was informed by the general principles of thematic analysis (*23*) but the interview component was not designed or analysed as a stand-alone qualitative study. Memos were openly coded by one author (HS), and candidate themes were inductively extracted. The candidate themes and their interpretation were then presented by HS to the co-authors (KK, HN) and discussed at meetings of the research group of the funding project; themes were refined in light of the comments received before being finalised. Theme validity was anchored through team discussion and cross-referencing with the field observation data. Consistent with the role of the interview component described above, themes are presented as structured contextual findings, and no claim of thematic saturation is made (Section 4.5). The sample was considered adequate for this contextual purpose because participants were selected for direct professional experience of governance challenges under study and because the interview findings inform the analysis only in triangulation with other data sources. This rationale is broadly consistent

Table 3. Three core themes from interviews and illustrative composite statements (paraphrased and anonymised)

Theme	Structural problem	Illustrative composite statement (paraphrased and anonymised)
1. Limited operationalisation of GPW14 prioritisation and three-tier alignment	Institutional mechanisms for sustained HQ–RO–CO alignment are not fully established; under fiscal stress, the lack of agreed prioritisation across the three tiers leaves country and regional offices without a basis for deciding what to scale down.	When everything is treated as a priority, there is no shared basis for saying what should be protected and what should be set aside as resources shrink. We end up responding case by case rather than strategically.
2. Limited strategic linkage in human-resource management	Selection systems for senior leadership posts (including WHO Representatives) and mid-level appointments do not systematically assess capacities most needed in country settings—such as relationships with health authorities and resource mobilisation; post-appointment evaluation mechanisms remain to be institutionalised; under fiscal stress, the categories of staff most affected by reductions are determined more by contract type than by strategic value.	What the country actually needs from a senior post is the ability to engage the Ministry of Health and to mobilise resources. Current selection process does not really test for that, and there is no review afterwards. Technical specialisations in some offices are concentrated in areas of the leadership's background; expertise that the field actually asks for is at times not present.
3. Limited transparency in financial accountability	Information on resource allocation across countries and programmes is not always fully visible at the professional-staff level; institutionalised independent external review of regional and country office finances is not yet in place; expansion of private-foundation funding can create tension between funder priorities and WHO's normative agenda.	Even as a professional officer, I do not always have a clear picture of how regional and country budgets are allocated, or who reviews those decisions independently. When we accept earmarked funding, the topic does not always sit at the centre of our country strategy, and we then need to find space for our core work around it.

with the principle of information power, so that sample adequacy was to be judged by relevance of participants' experience to the study objectives rather than by numerical representativeness alone. The resulting themes are presented in Section 3.3.

2.4. Policy mapping of GHA reform agendas

We systematically collected official documents (strategies, declarations, final reports, decisions) of the principal GHA-related reform initiatives and compared them along three dimensions: *i*) actor; *ii*) objective; and *iii*) reform focus. Initiatives were included if they met three criteria: *i*) they claim system-level relevance to the GHA, rather than relevance to a single disease programme or institution; *ii*) they are articulated in official, publicly available documents issued by an identifiable institutional actor between 2023 and 2026; and *iii*) they were actively referenced in WHO governing body deliberations during the observation period. Initiatives that are primarily national health strategies, disease-specific replenishment campaigns, or academic proposals without an institutional sponsor were excluded. Documents were identified through monitoring of the issuing organisations' official publications and of documents referenced in WHO governing body proceedings during the observation period, and the document set was finalised and verified in early June 2026. Principal documents included the Lusaka Agenda, Accra Reset, America First Global Health Strategy, UN80 Initiative, Gavi Leap, Wellcome Trust strategic documents, WGSF final recommendations, AMSTG report, EB158/36 governance reform, and EB158/44 GHA reform. They were classified into four domains—financing efficiency; sovereignty, technology transfer and domestic production; institutional and governance reform; and ideas, knowledge and normative formation—and we analysed within-domain dynamics, cross-domain relationships, and WHO's position in each. The classification was developed iteratively within the research team: documents were grouped according to their principal reform focus, and groupings were consolidated into the four domains through team discussion. Positioning of each initiative along the two axes of Figure 1 reflects the research team's qualitative judgement of its principal orientation, consolidated through team discussion; placement is heuristic rather than derived from quantitative scoring. Full list of documents analysed, with issuing organisation, publication date, reason for inclusion, assigned domain, and basis for classification, is provided in Supplementary Table S1 (*https://www.globalhealthmedicine.com/site/supplementaldata.html?ID=125*). We note that the initiatives differ substantially in origin, purpose, scope, and political orientation; the four-domain classification is intended as an analytical device for locating WHO's position in the reform landscape, not as a claim that initiatives within a domain are equivalent.

2.5. Triangulation

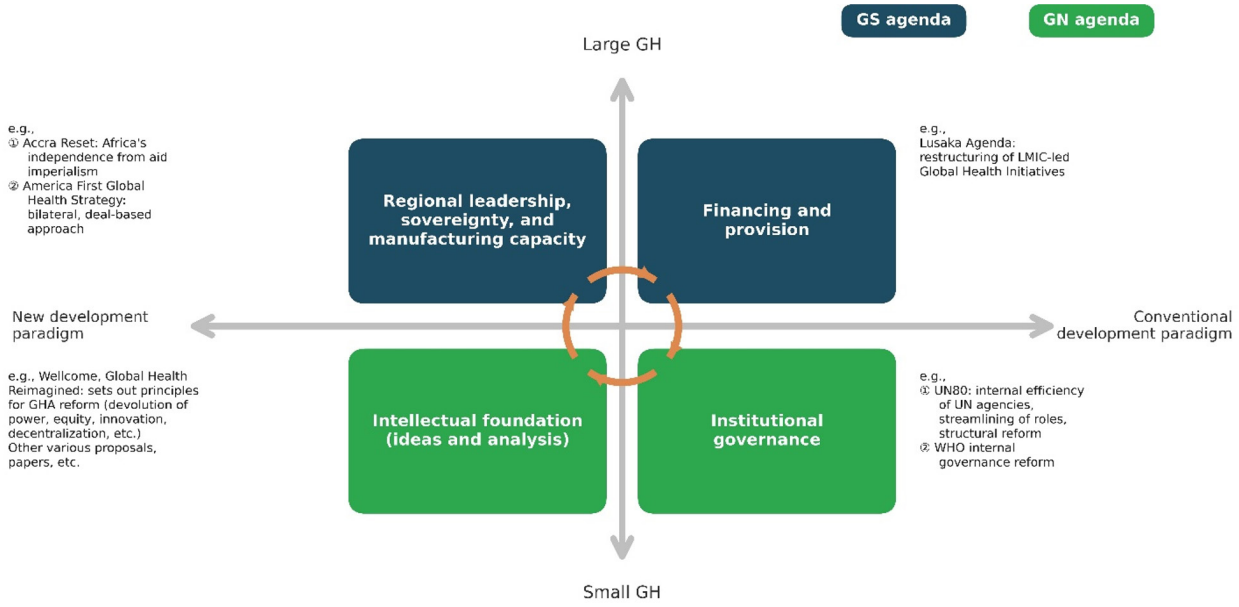

Figure 1. Mapping of contemporary reform proposals across the Global Health Architecture (GHA) debate. Proposals are positioned along two axes (vertical, scope of global health ambition; horizontal, new versus conventional development paradigms) and grouped into four domains. Dark blue denotes Global South (GS) agendas and green denotes Global North (GN) agendas; curved arrows represent WHO's horizontal coordinating role across the four domains. *Abbreviations*: GN, Global North; GS, Global South. *Source: Health, Labour and Welfare Research. Study on Strengthening Governance of the World Health Organization; Principal Investigator: Hiroki Nakatani, summary to be published in the MHLW Research Grant Database (in Japanese), Project ID: 25BA2001.*

Findings from the four data sources were triangulated to overcome limitations of any single method and to capture the structural problems of WHO governance in their multilayered form. Specifically, the quantitative finding of "structural compression of deliberation time" was connected to *i*) field observation of decision-making at WHO governing bodies, *ii*) qualitative interview accounts of perceptions and experience outside HQ, and *iii*) policy mapping of GHA reform agendas. The integration enables a structural interpretation of vertical relationships among the micro (operational), meso (RO/CO organisational), and macro (GHA structural) layers.

2.6. Ethical considerations and positionality

Interviewees received prior explanation of the study's purpose, data use, and anonymization policy, and provided verbal informed consent. Statements were generalized and anonymized so that no individual could be identified; remarks that might be construed as criticism of specific individuals within WHO were recast as institutional or structural issues. Although the authors attended these WHO governing body meetings as members of the Japanese government delegation, reporting in this study was restricted to public deliberations and publicly available documents, in line with the obligation of confidentiality. As part of governance analysis, the expert interviews were conducted with WHO staff in their professional capacity, collecting professional views on organizational, financial, and governance matters, and no information concerning any individual's health or other personal circumstances was collected. On this basis, the investigators judged that the study falls outside the scope of Japan's Ethical Guidelines for Medical and Biological Research Involving Human Subjects, which apply to research using information relating to individuals' health; no formal institutional determination was sought, and this position is one of non-applicability rather than exemption or approval. In addition to the safeguards above, consent was noted in the interview memo, identifying details were removed at point of recording, anonymised memos are retained by the corresponding author with access limited to the research team, and there was no supervisory or evaluative relationship between the researchers and participants, who were free to decline or withdraw at any time. In addition, because the study relied in part on interpretation of governance processes observed by members of the research team, consideration of author positionality is important for assessing potential sources of bias.

With regard to positionality, the authors combine professional histories in the Japanese government, WHO, academia, and civil society, and two authors (HS, HN) observed the governing bodies as members of the Japanese government delegation. This position provided proximity to deliberative dynamics and access to practical context of negotiations, but it also means that analysis is conducted from the standpoint of a major contributing Member State and may carry interpretive bias. To mitigate this, observation was restricted to public proceedings, factual claims were anchored in citable public documents, interpretations were deliberated within the research team, and associated limitations are stated explicitly in Section 4.5.

3. Results

Each subsection below reports findings from a single data source, identified in the subsection heading: Section 3.1 summarises quantitative findings reported in the companion paper (*22*); Section 3.2 reports field observation findings; Section 3.3 reports interview findings; and Section 3.4 reports policy mapping findings. Interpretation across sources is reserved for the Discussion (Section 4).

3.1. Structural compression of Member State deliberation time (summary of quantitative findings)

Komada *et al.* (*22*) show that over the past decade release of Secretariat documents has moved markedly closer to the session date for the WHA, while the EB has followed a different trajectory. For the WHA, the average interval between document release and opening of the session fell from roughly one month in 2016 to 2019 to 10.9 days for WHA79 (2026), the shortest interval observed. For the EB, after a sharp contraction during the COVID-19 pandemic period, the interval recovered to approximately 45 days before EB158 (2026). This divergence indicates that timely circulation remains operationally feasible but is not consistently applied across governing bodies, and that persistent compression is concentrated in the WHA (see Komada *et al.* (*22*) for details). A recent illustration is the Financing, Implementation and Performance Framework for the 2026 to 2027 Programme Budget (Document A79/15), released only two days before the PBAC session linked to WHA79, mirroring the late budget-document pattern observed at EB158 (Table 2). This compression structurally reduces time available to Member States for domestic scrutiny, inter-ministerial coordination, regional-group consultation, and expert pre-consultation.

The present article does not seek to re-verify these quantitative findings; instead, it uses them as a foundation for integrated interpretation of field manifestations and higher-order structural drivers described in the following sections.

3.2. Field observation of governance dysfunction at EB158 and WHA79

Consistent with the Komada *et al.* (*22*) findings, constraints on Member State deliberation were observed in multiple settings at EB158 and WHA 79. Table 2

summarises the principal observations. The interpretive connection between these observations and structural compression of deliberation time referenced in Section 3.1 is developed in Section 4.1.

Field observation at WHA79 (May 2026) corroborated and extended these patterns. The Assembly convened across two sites (the Palais des Nations and WHO headquarters) while managing concurrent hantavirus and Ebola emergencies, and several Secretariat papers, including the 2026/27 budget execution outlook and the proposal for stakeholder coordination on the UN80 Initiative considered at the linked PBAC44 session, were again released only shortly before deliberation, leaving limited room for substantive scrutiny. The human-resources annual report (Document A79/21) recorded a staff complement of 8,569 as of 31 December 2025 (down 9.4% year on year), and its addendum on the prioritization and realignment process (Document A79/21 Add.1) projected a complement of 7,283 by 30 June 2026, a reduction of approximately 23% relative to the 9,401 staff recorded as of 1 January 2025. In presenting the reports, the Secretariat signalled a phased resumption of recruitment under a restructured process that prioritises matching of separated and serving staff before external candidates, and places new appointments on temporary contracts (field observation, WHA79). These figures give quantitative form to field accounts in Theme 2 (Section 3.3), in which staff reductions follow contractual and procedural structures more than strategic or programmatic criteria. At the same time, the Assembly reached agreement on several governance-relevant items, including a one-year extension of negotiations on the Pathogen Access and Benefit-Sharing (PABS) system under the Pandemic Agreement, composition and timeline of a joint task force on GHA reform, and a resolution welcoming possible return of Argentina. Deliberation was also more politicised than at EB158: disputes over agenda adoption on the opening day required repeated votes, exchanges of the right of reply between delegations required the chair to intervene, and the politicisation observed in decisions under the Framework of Engagement with Non-State Actors (FENSA) (Table 2) extended into the plenary. Interpretation of these patterns is taken up in Section 4.1.

3.3. Reform impact outside headquarters (qualitative interview findings)

Interviews with professional staff at WHO ROs and COs surfaced three common structural challenges in how HQ-level reforms are experienced at RO and CO levels. Illustrative composite statements, each synthesising accounts from multiple participants as described in Section 2.3, are provided in Table 3.

Theme 1: Limited operationalization of GPW14 prioritisation and three-tier alignment

A recurring observation across duty-station levels was that prioritisation under the 14th General Programme of Work (GPW14, 2025–2028) has yet to translate fully into practice. Respondents described how priorities intended to be pursued jointly by WHO HQ, ROs, and COs can blur into a situation in which "everything is a priority", as mechanism for division of labour and coordination across the three tiers remain undeveloped. Under fiscal stress, this makes it harder to decide what to protect and what to scale down, and responses tend to be taken case by case rather than within a shared strategic framework.

Theme 2: Limited strategic linkage in human-resource management

Multiple respondents noted that linkage between organisational strategy and HR practice has not yet been systematically established in appointment of WHO Representatives and other senior and mid-level posts. The examination- and roster-based qualification system used for WHO Representative selection does not by itself capture some of the capacities most needed in the field, such as relationships with national health authorities and resource mobilization, and institutionalised post-appointment evaluation and feedback mechanisms are not yet in place for WHO Representatives and for other senior leadership positions. Appointments at the P4/P5 level are shaped by judgement of unit Directors, so that staffing reflects technical priorities and professional expertise of individual units alongside the organisation's broader programme priorities, which can at times create a mismatch between available human resources and work required. Under fiscal stress, staff reductions tend to follow legal and contractual structures of employment more than strategic or programmatic criteria; consequently junior, non-regular, and locally recruited staff are more often affected, while long-tenured staff are largely retained. Several respondents suggested that this pattern, shaped more by procedural feasibility rather than substantive judgement, may over time weaken the medium- to long-term human-resource base of the Organization.

Theme 3: Limited transparency in financial accountability

Respondents noted that strengthening flow of resource-allocation and expenditure information in both directions across WHO headquarters, ROs, and COs would support not only financial accountability but also the three-tier alignment discussed above. Developing independent external review further, and articulating accountability lines for specific decisions more clearly, were likewise seen as ways to reinforce both strategic budget execution and organisational trust. Respondents also reflected on the broader tension that can accompany expansion of fundraising from private foundations: priorities of individual funders do not always align fully with WHO's normative agenda, and the need to mobilise resources can at times draw programmatic attention toward areas that are not always central to the Organization's strategic priorities. Accounts varied in

emphasis across duty stations rather than in direction. Consistent with the contextual role of the interview component (Section 2.3), these themes are presented as structured contextual findings rather than as generalisable results.

3.4. Mapping of GHA reform agendas (policy mapping findings)

Mapping the principal GHA reform agendas revealed four domains within the current GHA reform landscape (Figure 1 and Table 4). The agendas mapped comprised the Lusaka Agenda, Accra Reset, America First Global Health Strategy, UN80 Initiative, Gavi Leap, Wellcome Trust strategic documents, WGSF, AMSTG reports, EB158/36, and EB158/44.

Domain 1: Financing efficiency. Centred on the Lusaka Agenda and the Gavi Leap, focusing on aligning limited resources with national health strategies and improving efficiency.

Domain 2: Sovereignty, technology transfer and domestic production. The Accra Reset and the America First Global Health Strategy, while differing politically, both emphasise national sovereignty, domestic industrial base, and visibility of outcomes.

Domain 3: Institutional and governance reform. The UN80 Initiative, WGSF, AMSTG, EB158/36, and EB158/44 belong here, aiming at financial stabilisation, decision-making efficiency, and organisational restructuring.

Domain 4: Ideas, knowledge and normative formation. The Wellcome Trust is emblematic: emphasising scientific evidence and long-term perspective while bearing no governance responsibility.

These four domains are organised around distinct constraints and objectives; they are partly complementary and partly in tension. As noted in Section 2.4, initiatives grouped within each domain differ in origin, purpose, and political orientation; the classification reflects their principal reform focus rather than any equivalence among them. A critical observation is twofold: none of the external reform agendas engages with the redesign of WHO governance itself, and the WHO-internal reform streams included in the mapping (WGSF, AMSTG, EB158/36, EB158/44) are directed principally at financial stabilisation and internal efficiency rather than at defining a horizontally coordinating role across the four domains. None of the mapped agendas, external or internal, explicitly assigns WHO itself a horizontally coordinating role across all four domains (*20,24*).

4. Discussion

4.1. Integrated interpretation: bidirectional difficulty of substantive deliberation

Existing discussion of WHO governance has tended to treat three problems as separate, each addressed by

Table 4. Four-domain classification of GHA reform agendas

Domain	Principal initiatives	Reform focus	WHO's position
1. Financing efficiency	Lusaka Agenda/Gavi Leap	Coordination across Global Health Initiatives, alignment with national health strategies, avoidance of duplication, results orientation	Identified as one coordinating actor; the cross-GHI financing rationalisation pursued here has not been operationally linked to WHO's internal financial stabilisation under WGSF
2. Sovereignty and production	Accra Reset / America First Global Health Strategy	National sovereignty, domestic production capacity, technology transfer, bilateral cooperation, visibility of outcomes	Faces a fundamental challenge to the model of universal norm expansion; no coordination interface yet developed between these agendas and WHO's internal governance reforms
3. Institutional/ governance reform	UN80 / WGSF / AMSTG/ EB158/36 /EB158/44	WGSF: financial stabilisation through raising assessed contributions; AMSTG: transparency, accountability, and decision-making efficiency under Member State-led governance; EB158/WHA79: meeting and decision management while framing WHO as convening and coordinating actor; UN80: UN-wide budget reduction, organisational restructuring, mandate review	WHO's internal reforms (WGSF, AMSTG, EB158/WHA79) strengthen institutional base for a coordinating role, but substantive alignment with UN-wide reform (UN80) remains to be worked through
4. Ideas / norms	Wellcome Trust	Scientific evidence, long-term perspective, knowledge as public good	WHO remains the principal institution responsible for translating evidence and ideas into globally recognised norms and coordinated action, yet no dedicated mechanism currently links the growing ecosystem of knowledge-generating actors with system-wide governance processes.

its own reform agenda: late release of governing-body documents, weakening of Secretariat capacity, and difficulty of substantive Member-State deliberation. Integrated reading made possible by our four data sources points to a different framing. Document release timing (Section 3.1), governance dynamics observed at EB158 (Section 3.2), field-level structural challenges identified through interviews (Section 3.3), and WHO's position within current GHA reform agendas (Section 3.4) are not parallel phenomena that can be addressed in isolation. They are mutually constitutive elements of a single bidirectional dynamic, in which Secretariat constraints and Member-State deliberative constraints sustain one another. Late release of documents, for example, is not problematic in isolation; combined with weak strategic governance, it reinforces a pattern of de facto endorsement of Secretariat proposals, as observed at EB158 and WHA79 (Section 3.2). Constraints on Member State deliberation likewise arise less from any single procedural failure than from the interaction of compressed deliberation time (Section 3.1), fiscal stress (Sections 3.2 and 3.3), and intensifying politicisation (Section 3.2). Read separately, each data source would support only a partial diagnosis: that the Secretariat is under-resourced, that Member States are under-prepared, or that the reform agenda is fragmented. Read together, they indicate that none of these elements can be addressed effectively without addressing the others.

This mutual reinforcement is sustained by feedback operating in two directions. From below, field-level constraints identified in Section 3.3, namely limited three-tier alignment, weak strategic linkage in human resources, and limited transparency in financial accountability, mean that governance decisions taken at headquarters do not reliably translate into improved performance in ROs and COs. Member States therefore deliberate without confidence that better decisions will produce visibly better outcomes, which reduces incentive to invest in substantive engagement. From above, the HQ-centric framing of current GHA reform agendas concentrates attention on document timing and meeting efficiency, leaving field-level conditions that determine whether reforms actually work largely outside the reform scope.

Taken together, these two dynamics suggest that the current reform cycle addresses the manifestations most visible at headquarters while leaving field-level conditions that sustain mutual reinforcement largely outside its scope. Without engaging that field-level component, the bidirectional difficulty is unlikely to be interrupted even where HQ-level governance improves. Recent reform discussions in the EB, PBAC, and WHA illustrate this pattern: they have advanced Member State-led arrangements at the headquarters level while leaving the RO and CO structural challenges identified in Section 3.3 largely unaddressed, thereby contributing to the implementation gap discussed in Section 4.3.

It should be emphasised that Member States are not merely constrained actors in this dynamic. Field observations in Section 3.2 indicate that Member States themselves shape the agenda, multiply agenda items and reporting requests, delay consensus through politicised disputes, and invoke sovereign prerogatives in ways that crowd out substantive technical deliberation, as seen in repeated votes over agenda adoption, exchanges of the right of reply, and politicisation of FENSA-related decisions. The bidirectional dynamic described here is therefore jointly produced: Secretariat constraints compress space for deliberation, and Member State behaviour in turn consumes and fragments deliberative space that remains.

4.2. Connection with GHA reform

The four domains identified in Section 3.4 do not simply describe parallel agendas. Together, they generate a structural demand for horizontal coordination that none of them assigns. Each places coordination responsibility elsewhere: the Lusaka Agenda on the Global Health Initiatives themselves; the Accra Reset and the America First Global Health Strategy on national governments and bilateral cooperation; and UN80 on the UN system as a whole. The Wellcome Trust, for its part, positions itself as a knowledge provider, with a remit centered on evidence and long-term perspective rather than system-wide governance coordination. While such actors contribute substantially to agenda-setting and knowledge generation, no corresponding mechanism exists to translate these ideas systematically into globally accepted norms and coordinated action across the broader GHA landscape. The need for an actor that can hold these pressures together, reconciling financing efficiency with sovereignty and institutional restructuring with normative continuity, therefore arises from coexistence of these agendas rather than from any single one of them.

In our reading, this gap is the central strategic question for WHO governance. We interpret that WHO may be well placed to coordinate across all four domains; this is an interpretation grounded in WHO's institutional characteristics rather than a conclusion directly demonstrated by the study data, and it rests principally on the mandate in Article 2(a) of the WHO Constitution, which lists among the Organization's functions to act as "the directing and coordinating authority on international health work". The Accra Reset and the Wellcome Trust sharpen this point. The former reframes international health as a matter of sovereignty and industrial capacity rather than universal norm extension; the latter positions itself around evidence and long-term perspective rather than system-wide coordination. Neither sovereignty-focused agendas nor knowledge-focused actors can themselves take on the coordinating role, which leaves it unclaimed unless WHO claims it explicitly.

WHO's internal reforms each address a distinct

precondition for this role. The WGSF aimed to stabilise the financial base by raising assessed contributions; the AMSTG sought to improve transparency, accountability, and decision-making efficiency under Member State-led governance; and EB158/WHA79 accelerated meeting and decision management while explicitly framing WHO as convening and coordinating actor in the GHA. In practice, however, their connections to the external GHA agendas have remained largely discursive. WGSF's financial stabilisation has not been operationally linked to the cross-GHI financing rationalisation pursued by the Lusaka Agenda; governance improvements under AMSTG have not produced a coordination interface with sovereignty-focused agendas such as the Accra Reset and the America First Global Health Strategy; and the EB158/WHA79 reference to UN80 has not been worked through into substantive alignment with UN-wide reform. Internal reforms have therefore strengthened the financial and organisational base needed to play the coordinating role, without yet engaging the strategic question of how that role should be structured in relation to external agendas.

4.3. HQ-centrism of reform and implementation gap

The integrated reading of our data sources points to an implementation gap that is more than an oversight; it is reproduced by the way reform processes themselves are structured. Reform discourse in the EB, PBAC, and WHA concentrates on actors and instruments that are procedurally visible within those venues, namely delegations, document timelines, and decision and agenda management, while WHO RO and CO conditions enter discussion only indirectly, mediated through Secretariat reports. Reform success is correspondingly measured by HQ-level process completion (resolutions adopted, governance instruments revised) rather than by changes in field-level performance. This procedural framing offers a structural explanation for why field-level constraints identified in Section 3.3 persist even as HQ-level reforms advance.

Implications are twofold. First, evaluation of reform should explicitly include WHO RO and CO indicators of whether HQ-level decisions translate into operational change. Without such indicators, reform discourse continues to address manifestations most visible at HQ while leaving conditions that determine reform efficacy outside its scope. Second, organisational decisions on downsizing, function transfer, and resource allocation should be assessed not only through the logic of financial rationalisation but through their consequences for WHO's core normative and coordinating functions (*25*), especially at the field level. Under fiscal constraint, an organisationally shared strategic vision of what to protect and what to entrust needs to operate across HQ, ROs, and COs, supported by feedback mechanisms that allow field-level realities to inform HQ-level reform choices.

4.4. Policy implications

Implications set out in this section are normative policy recommendations derived interpretively from the findings; they are presented separately from empirical results in Section 3 and should be read as the authors' policy judgement rather than as findings themselves. The findings yield policy implications across four layers. In terms of feasibility, recommendations differ in the level at which action is required: some are feasible at the level of the Secretariat and the Director-General; others require collective Member State decision-making through the PBAC, EB, and WHA processes, including the governance reform stream under EB158/36 and the joint task force on GHA reform; and others again require coordination beyond WHO, with other global health institutions and with the UN80 process.

(a) Member States

What is required of Member States goes beyond procedural fixes to document timing and meeting management; it is the willingness to take collective responsibility for the strategic direction of WHO governance itself. As this study has shown, none of the external reform agendas explicitly assigns WHO a horizontally coordinating role across the four GHA domains. The strategic question of whether WHO should assume this role, and under what governance structure, must be answered by Member States as a collective body.

Concretely, this requires: *i*) formation of strategic agreement on the maintenance and strengthening of WHO's core normative and coordinating functions; *ii*) substantive engagement with the definition of WHO's role as a horizontal coordinator across the four GHA domains; *iii*) institutionalisation of feedback mechanisms that bring WHO RO and CO realities into reform discussions; and *iv*) development of national capacity to articulate the strategic purposes of each state's WHO contribution and to express them substantively in deliberations.

These responsibilities are shared by all Member States, irrespective of region or income level. The growing presence of the Global South and the multipolarisation of negotiation dynamics should not be read as a return to a bipolar contest among Member States; rather, relationships among Member States need to be reconstructed as a collective responsibility for the strategic direction of WHO.

(b) WHO Secretariat and Director-General

What is required of the Secretariat goes beyond procedural improvements to document timelines and risk assessment; it is the responsibility to articulate substantive strategic choices that Member States can engage with. Under constraints identified in this study, the Secretariat needs to make its own strategic judgements explicit: which core functions it intends to protect, which functions it proposes to delegate or share, and how it intends to position WHO within the four

GHA domains. Such substantive choices give Member States real content to scrutinise and decide upon, rather than leaving deliberation as a reactive process oriented toward documents whose strategic implications are not articulated. The Secretariat also needs to build RO and CO realities into its strategic proposals at the outset, rather than treating field-level operationalisation as a post-decision implementation question.

The Director-General (DG) carries additional responsibility of articulating WHO's strategic positioning as the horizontal coordinating actor that no external GHA agenda has explicitly assigned. This requires the DG to set out, proactively, how WHO's mandate under Article 2(a) of the Constitution is to be operationalised across the four GHA domains, and to lead mediation not only between Member States but also between headquarters and regional and country offices whose realities must inform that strategic positioning.

(c) Next Director-General selection

Selection of the next DG is, in light of these findings, a particularly important moment for embodying leadership required for WHO governance redesign at the GHA maturation stage (*26*). Required qualities include: *i*) ability to operate normative and managerial functions complementarily; *ii*) mediation capacity in political disputes; *iii*) constructive collaboration with the Global South; and *iv*) strategic linkage with UN80 and GHA reform.

(d) Role of Japan

Japan is discussed as an illustrative case of a major contributing Member State; the research team's institutional base makes the case that the authors can specify in greatest detail (Section 4.5). Findings suggest three areas in which a major contributor can support WHO governance: *i*) clarifying the strategic objectives of its engagement with WHO; *ii*) aligning financial and human-resource contributions with those objectives; and *iii*) fostering constructive partnerships with countries of the Global South in support of WHO's coordinating and normative functions. For Japan, these translate into priorities such as universal health coverage, healthy ageing, and infectious disease control, building on its record of measured, evidence-based engagement in the EB. The same logic applies to other major contributing Member States, whose combined behaviour will substantially determine whether the deliberative space identified in this study can be restored.

4.5. Limitations

This study has the following limitations. First, the interview component was based on a small purposive sample (n = 10, drawn from the headquarters, one RO, and COs in two WHO regions, all serving in programme functions). It was intended to provide contextual insight rather than a comprehensive representation of staff views. Formal thematic saturation was not assessed. Second, although field observation covers both EB158 (February 2026) and WHA79 (May 2026), these two sessions are close in time, and longitudinal observation across multiple governance cycles will be needed to capture change over time. Third, quantitative analysis of document release timing is reported in a companion paper (*22*); the present article uses its findings as reference. Fourth, as the study was conducted by a Japanese research team, policy implications for Japan's WHO engagement receive particular attention. Fifth, the authors' positionality shapes the analysis: two authors observed the governing bodies as members of the Japanese government delegation, and analysis was conducted from the standpoint of a major contributing Member State; this insider position afforded access and contextual understanding but may introduce interpretive bias, which we sought to mitigate through measures described in Section 2.6. Sixth, the purposive and network-based recruitment of interview participants may have produced selection bias, and views of participating staff cannot be assumed to represent the entire workforce of the RO and COs concerned. In addition, distribution of participants across regions and offices was not reported in order to protect anonymity, which constrains readers' ability to assess composition of the sample. Seventh, policy mapping involves interpretive judgement in classifying heterogeneous initiatives, and alternative groupings are possible. These limitations notwithstanding, the study provides empirically grounded insights into emerging governance dynamics within WHO. Comparative and international collaborative studies are warranted to complement these limitations.

5. Conclusions

WHO faces one of the most significant structural governance challenges since its founding. The integrated approach of this study supports interpretation that this challenge takes the form of a bidirectional structure: constraints on Secretariat function and difficulty of substantive Member-State deliberation reinforcing each other and that HQ-level reform proceeds with an implementation gap at regional and country levels.

As a policy conclusion, we propose that the maturing GHA stage requires redefinition of WHO as the horizontally coordinating actor across the four domains (financing efficiency; sovereignty and production; institutional governance; and ideas and norms), and a governance design that operates normative and managerial functions in a complementary manner. The next Director-General selection and the unfolding UN80-linked reform cycle constitute a critical opportunity to advance that redesign. The practical implication of this study is that reform effort directed at either side of the bidirectional dynamic alone, whether at Secretariat document management or at Member State meeting efficiency, is unlikely to restore substantive deliberation;

redesign needs to address both sides together, and to build regional and country office realities into the reform process from the outset.

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