Northeastern University
Center for International Affairs and World Cultures

World Cultures Explainer
Fall 2025

What Does the World Health Organization Do? A Global Public Health Institution at the Center of Cooperation, Crisis, and Controversy

Nandini Shah

The World Health Organization (WHO) is the primary international institution responsible for coordinating global public health efforts, setting health standards, and responding to disease outbreaks (WHO, 2023a). Established after World War II, the WHO was designed to promote health as a fundamental human right and to prevent health crises from destabilizing societies and international relations (UN, 1948). In recent decades, the organization has played a central role in combating infectious diseases, shaping global health governance, and coordinating emergency responses (Gostin, 2020). However, the WHO faces persistent challenges related to political influence, funding constraints, and limited enforcement authority within a state-centric international system (Kickbusch, 2021). This explainer examines the WHO's origins, functions, governance, achievements, and controversies to assess its evolving role in global affairs and the need for sustained reform and cooperation (Fidler, 2020).

INTRODUCTION: WHY THE WORLD HEALTH ORGANIZATION MATTERS

Health is often treated as a domestic issue managed by national governments through healthcare systems and public policy (McInnes & Lee, 2012). Yet infectious diseases, environmental hazards, and health emergencies frequently cross borders and affect multiple countries simultaneously (Heymann, 2015). Pandemics, antimicrobial resistance, climate-related health risks, and unequal access to medical resources demonstrate that health is deeply embedded in global politics and international cooperation (Labonté, 2018). The World Health Organization exists specifically to address these transnational public health challenges (WHO, 2023a).

As a specialized agency of the United Nations, the WHO serves as the central coordinating authority for international public health (UN, 1948). It does not function as a global government nor does it directly control national health systems (Fidler, 2004). Instead, it operates through guidance, coordination, technical expertise, and diplomacy (Kickbusch, 2016). Its influence depends largely on member-state cooperation, scientific credibility, and governments' willingness to act collectively in the interest of global health (Gostin, 2014). Understanding what the WHO does is essential for evaluating global responses to health crises and debates surrounding international governance (Fidler, 2020).

THE ORIGINS AND INSTITUTIONAL CULTURE OF THE WORLD HEALTH ORGANIZATION

International health cooperation predates the WHO by several decades (McInnes, 2014). During the 19th century, recurring outbreaks of cholera, plague, and yellow fever prompted governments to coordinate quarantine measures and disease surveillance (Baldwin, 2005). Early international sanitary conferences sought to standardize responses to epidemics primarily to protect trade and maritime routes (Howard-Jones, 1975). In the early 20th century, organizations such as the Office International d'Hygiène Publique and the League of Nations Health Organization attempted to formalize international health governance (Borowy, 2009). These efforts were constrained by weak enforcement mechanisms, geopolitical rivalries, and the collapse of the League of Nations during World War II (Fidler, 2004).

The devastation of World War II reshaped thinking about international cooperation and collective security (Mazower, 2012). The creation of the United Nations reflected a belief that peace required coordinated responses to military, economic, social, and humanitarian threats (UN, 1945). Health was increasingly viewed as a prerequisite for stability, productivity, and development (WHO, 1948). The World Health Organization was formally established in 1948, with its constitution declaring health a fundamental human right (WHO, 1948). This framing embedded public health within the emerging international human rights framework (Gostin & Mann, 1994).

From its inception, the WHO developed an institutional culture rooted in scientific expertise, technocratic neutrality, and the belief that health could serve as a bridge across ideological divides. Membership was open to all states regardless of political system, reflecting the understanding that pathogens do not respect borders (Fidler, 2004). During the Cold War, the WHO functioned as one of the few arenas where East and West cooperated through shared epidemiological data and vaccination initiatives (McInnes, 2014). This emphasis on technical credibility and diplomatic pragmatism became central to the organization's identity.

The WHO's early decades were defined by ambitious disease-control and eradication campaigns that shaped its reputation and internal ethos (Gostin, 2014). The global smallpox eradication campaign, launched in 1967, remains the organization's most celebrated achievement (Gostin, 2014). Through coordinated surveillance, mass vaccination, and cross-border cooperation, smallpox was declared eradicated in 1980 - the first and only human disease to be eliminated globally (Gostin, 2014). The campaign reinforced a culture of data-driven intervention, logistical coordination, and measurable targets. Subsequent efforts to combat malaria, polio, and other infectious diseases were more complex and uneven, revealing both the promise and limits of vertical eradication strategies (Fidler, 2004). These campaigns nevertheless entrenched a belief within the WHO that scientific consensus, standardized protocols, and coordinated implementation could generate transformative global outcomes (Fidler, 2004).

By the early twenty-first century, the WHO expanded its normative authority beyond infectious disease control. A landmark example includes the 2003 Framework Convention on Tobacco Control (FCTC), the first international treaty negotiated under WHO auspices (Gostin, 2014). The FCTC demonstrated the organization's capacity to translate scientific evidence into binding international law, addressing

noncommunicable diseases through regulation of advertising, taxation, and labeling (WHO, 2013). Unlike earlier eradication campaigns, the FCTC required sustained political negotiation and confrontation with powerful commercial interests, illustrating the evolution of the WHO from a primarily technical body to a more assertive norm-setting institution (Fidler, 2004; Kickbusch, 2016).

Overall, a hybrid of scientific authority, diplomatic negotiation, and incremental norm-building have shaped the WHO's institutional culture. Its legitimacy rests less on coercive power than on expertise, consensus formation, and moral framing of health as a global public good (Gostin, 2014).

GOVERNANCE AND STRUCTURE OF THE WHO

The WHO currently has 194 member states, all of which participate in the World Health Assembly (WHA), the organization's highest decision-making body (WHO, 2023b). The WHA sets strategic priorities, adopts resolutions, and approves the budget. The Executive Board, composed of health experts nominated by member states, oversees implementation of these decisions (WHO, 2023b). The Director-General serves as the organization's chief executive and primary public representative (Gostin, 2014).

The WHO also operates through six regional offices, which adapt global strategies to regional contexts (WHO, 2023b). This structure reflects a compromise between centralized coordination and regional autonomy, reinforcing the organization's identity as both a technical authority and a forum for political negotiation (Kickbusch, 2016).

CORE FUNCTIONS OF THE WORLD HEALTH ORGANIZATION

At its core, the WHO serves as the central coordinating authority for international public health. Its primary functions include setting global health norms and standards, facilitating disease surveillance and information sharing, providing technical assistance to member states, and coordinating responses to public health emergencies (WHO, 2023b).

Through the development of guidelines and legal instruments, the WHO shapes international expectations regarding disease classification, vaccination protocols, pharmaceutical safety, and environmental health standards (Fidler, 2004). The International Health Regulations (IHR), revised in 2005, represent the organization's most significant binding framework. The IHR obligates states to develop core surveillance capacities and report potential public health emergencies of international concern (WHO, 2005). Although enforcement depends largely on state cooperation, the regulations institutionalize shared norms of transparency and rapid response (Gostin, 2014; Fidler, 2020).

The WHO also functions as a global hub for epidemiological data and outbreak monitoring. By coordinating cross-border information sharing, it strengthens early warning systems and supports countries with limited public health infrastructure (Heymann, 2015; Labonté, 2018). The organization also provides technical assistance aimed at strengthening national health systems, training health workers, improving laboratory capacity, and supporting vaccination campaigns (Kickbusch, 2016). These efforts reflect the WHO's broader commitment to reducing global health inequalities and building long-term resilience (Gostin, 2014).

When health emergencies arise, the WHO mobilizes expertise, deploys field teams, and coordinates international responses. While the organization does not possess enforcement authority, it plays a critical convening and coordinating role that no other institution replicates (Fidler, 2020).

CONTEMPORARY CHALLENGES AND POLITICAL CONSTRAINTS

Although the WHO's formal mandate centers on coordination and norm-setting, its effectiveness is shaped by broader political and structural constraints. The COVID-19 pandemic exposed tensions between scientific authority and geopolitical rivalry, as governments debated the timing of alerts, travel restrictions, and vaccine distribution (Gostin, 2020; Kickbusch, 2021). These disputes underscored the organization's dependence on member-state transparency and cooperation. The WHO emphasized vaccine equity during the pandemic, arguing that unequal access would prolong global transmission (WHO, 2021a). Through the COVAX initiative, the WHO sought to distribute vaccines to low- and middle-income countries (Gavi, 2021). Although implementation faced challenges, the effort highlighted the WHO's commitment to health as a global public good (Gostin, 2021).

Financial structure further complicates institutional autonomy. While assessed contributions from member states provide a baseline budget, voluntary contributions - often earmarked for specific initiatives - now constitute the majority of funding (WHO, 2023c; Kickbusch, 2016). This funding model limits flexibility and can skew priorities toward donor preferences rather than collectively determined needs (Fidler, 2020). These dynamics highlight a central tension within the WHO's institutional design: it is expected to provide authoritative global leadership, yet it operates within a state-centric international system that constrains independent action (Fidler, 2004). Geopolitical rivalries can undermine trust, delay information sharing, and weaken collective action (Kickbusch, 2021).

EXPANDING THE WHO'S AGENDA: CLIMATE CHANGE, NONCOMMUNICABLE DISEASES, AND DIGITAL HEALTH

In recent years, the World Health Organization's mandate has expanded beyond infectious disease control to address broader structural and long-term determinants of health (WHO, 2023b). Global health challenges are increasingly shaped by environmental change, demographic transitions, and technological transformation, requiring the WHO to adapt its priorities and tools (Kickbusch, 2016). Climate change, noncommunicable diseases, and digital health have emerged as three areas that now occupy a central place in the organization's agenda (Labonté, 2018).

Climate change is widely recognized as one of the most significant threats to global public health in the 21st century (WHO, 2021b). Rising temperatures, extreme weather events, air pollution, and shifting disease vectors contribute to increased mortality, food insecurity, and the spread of infectious diseases such as malaria and dengue fever (Watts et al., 2018). The WHO has played a key role in framing climate change as a health issue rather than solely an environmental or economic concern (Kickbusch, 2021). By producing research, setting guidelines, and advocating for health-centered climate policies, the organization seeks to integrate public health considerations into global climate governance (WHO, 2021b).

The WHO has also emphasized the disproportionate impact of climate-related health risks on low- and middle-income countries (Labonté, 2018). Vulnerable populations often lack resilient health systems, making them more susceptible to climate shocks and long-term environmental degradation (Gostin, 2014). Through technical assistance and policy guidance, the WHO works to support climate-resilient health systems and promote adaptation strategies at the national level (WHO, 2021b). However, the organization's influence in this area remains limited by political resistance and insufficient financing (Fidler, 2020).

Alongside climate change, noncommunicable diseases (NCDs) represent a growing share of the global disease burden (WHO, 2023c). Conditions such as cardiovascular disease, cancer, diabetes, and chronic respiratory illnesses now account for approximately 70 percent of global deaths each year

(WHO, 2023c). Once viewed primarily as problems of wealthy countries, NCDs increasingly affect low- and middle-income nations due to urbanization, changing diets, and reduced physical activity (McInnes & Lee, 2012).

The WHO has sought to address NCDs through global action plans, standardized guidelines, and campaigns targeting tobacco use, unhealthy diets, and harmful alcohol consumption (WHO, 2013). One of its most notable achievements in this area is the Framework Convention on Tobacco Control, the first international treaty negotiated under WHO auspices (Gostin, 2014). This treaty illustrates the organization's potential to shape national policy through legally binding instruments, even in politically sensitive areas (Fidler, 2004). Nevertheless, progress on NCDs has been uneven, reflecting tensions between public health objectives and powerful commercial interests (Kickbusch, 2016).

Digital health and technological innovation represent another expanding frontier for the WHO (WHO, 2023c). Advances in data analytics, artificial intelligence, and telemedicine offer new opportunities for disease surveillance, health service delivery, and emergency response (Kickbusch, 2021). The WHO has developed digital health strategies to support the ethical and effective use of technology in health systems, particularly in resource-constrained settings (WHO, 2020). These initiatives aim to improve access to care, enhance data collection, and strengthen early warning systems for outbreaks (Heymann, 2015).

At the same time, digital health raises concerns related to data privacy, misinformation, and unequal access to technology (Gostin, 2021). The COVID-19 pandemic demonstrated how rapidly false health information can spread across digital platforms, undermining public trust and compliance with health measures (Kickbusch, 2021). The WHO has responded by increasing its engagement with technology companies and expanding efforts to counter misinformation through public communication and partnerships (WHO, 2020). However, regulating digital spaces remains beyond the organization's formal authority, limiting its capacity to address these challenges comprehensively (Fidler, 2020).

Together, climate change, noncommunicable diseases, and digital health illustrate how the WHO's role has evolved from a narrow focus on epidemic control to a broader conception of global health governance (Labonté, 2018). These issues require long-term coordination, cross-sectoral cooperation, and sustained political commitment that extend beyond traditional health policy (Kickbusch, 2016). The WHO's ability to navigate these complex challenges will significantly shape its relevance and effectiveness in the decades ahead (Gostin, 2014).

CRITICISMS AND CALLS FOR REFORM

The WHO has been criticized for bureaucratic inefficiency, slow decision-making, and limited authority (Moon et al., 2015). Some reform proposals call for stronger enforcement mechanisms, while others warn against undermining state sovereignty (Fidler, 2020). Suggested reforms include increasing assessed contributions, strengthening the IHR, improving transparency, and insulating the organization from political pressure (Gostin, 2021). Despite its limitations, the WHO remains indispensable to global health governance (Kickbusch, 2016). No other institution combines comparable legitimacy, technical expertise, and global reach (Gostin, 2014). As health challenges intensify due to climate change, urbanization, and globalization, the need for coordinated international health governance will grow (Labonté, 2018).

CONCLUSION

The World Health Organization emerged from the postwar conviction that health is integral to peace, security, and human rights (WHO, 1948; UN, 1945). Over time, its institutional culture has been shaped by ambitious eradication campaigns, norm-setting initiatives, and the steady expansion of global health governance (Gostin, 2014; Kickbusch, 2016). While constrained by political realities and financial dependence, the WHO remains the central forum for coordinating international public health. Its authority derives from expertise, legitimacy, and the capacity to build consensus across diverse political systems (Fidler, 2020). As global health challenges grow more complex, the organization's ability to maintain scientific credibility while navigating geopolitical tension will determine its future relevance in the international system. Ultimately, strengthening the WHO will require renewed political commitment to collective health security and international solidarity (Kickbusch, 2021).

Northeastern University
Center for International Affairs and World Cultures

The Center for International Affairs and World Cultures (CIAWC) was relaunched in 2023 as a new home for research and timely discussion on major world events. CIAWC is poised to be a leading venue for the discussion and investigation of global security issues, policy solutions, and timely analysis. Building on strengths in interdisciplinarity, regional expertise, and networks beyond the university, we aim to be a resource for the Northeastern community and beyond.

Nandini Shah is a sophomore at Northeastern University majoring in International Affairs and International Business. She is very interested in political science, humanitarian law, and global business operations, and is passionate about understanding how institutions and markets shape international systems. Currently, she is on co-op at MFS Investment Management, where she works as a Global Retail Marketing Co-op, gaining hands-on experience in global markets and strategic communications. In her free time, she enjoys playing squash, and is a member of Northeastern's women's squash team. She also enjoys reading, watching movies, hiking, and spending time with friends!

This paper was advised by Professor Panagoula Diamanti-Karanou in INTL 3400 International Conflict and Negotiation.

References

Baldwin, P. (2005). Contagion and the state in Europe, 1830–1930. Cambridge University Press. https://www.cambridge.org/core/books/contagion-and-the-state-in-europe/

Borowy, I. (2009). Coming to terms with world health: The League of Nations Health Organisation 1921–1946. Peter Lang. https://www.peterlang.com/document/1042763

Fidler, D. P. (2004). SARS, governance, and the globalization of disease. Palgrave Macmillan. https://academic.oup.com/book/9294

Fidler, D. P. (2020). The World Health Organization and pandemic politics. Council on Foreign Relations. https://www.cfr.org/backgrounder/world-health-organization

Gavi, the Vaccine Alliance. (2021). COVAX explained. https://www.gavi.org/covax-facility

Gostin, L. O. (2014). Global health law. Harvard University Press. https://globalhealthlaw.georgetown.edu/global-health-law-book/

Gostin, L. O. (2020). Global governance of COVID-19: The role of the World Health Organization. JAMA, 323(18), 1761–1762. https://jamanetwork.com/journals/jama/fullarticle/2763158

Gostin, L. O. (2021). Vaccine nationalism undermines global health security. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20210125.264349

Gostin, L. O., & Mann, J. M. (1994). Toward the development of a human rights impact assessment for the formulation and evaluation of health policies. Health and Human Rights, 1(1), 58–80. https://www.jstor.org stable/4065313

Heymann, D. L. (2015). Data sharing and outbreaks: Best practices exemplified. New England Journal of Medicine, 372(4), 385–387. https://www.nejm.org/doi/full/10.1056/NEJMra1406036

Howard-Jones, N. (1975). The scientific background of the International Sanitary Conferences 1851–1938. World Health Organization. https://apps.who.int/iris/handle/10665/62873

Kickbusch, I. (2016). Global health governance. World Health Organization. https://www.who.int/publications/i/item/WHO-HIS-SDS-2016.13

Kickbusch, I. (2021). The political determinants of health in the COVID-19 era. BMJ, 372, n84. https://www.bmj.com/content/372/bmj.n84

Labonté, R. (2018). Globalization and health: Reflections on the path forward. Global Health Action, 11(1). https://www.tandfonline.com/doi/full/10.1080/17441692.2018.1425039

Mazower, M. (2012). Governing the world: The history of an idea. Princeton University Press. https://press.princeton.edu/books/paperback/9780691157848/governing-the-world

McInnes, C. (2014). Global health diplomacy. Chatham House. https://www.chathamhouse.org/2014/07/global-health-diplomacy

McInnes, C., & Lee, K. (2012). Global health and international relations. Polity Press. https://www.politybooks.com/bookdetail?book_slug=global-health-and-international-relations--9780745642699

Moon, S., Sridhar, D., Pate, M. A., Jha, A. K., Clinton, C., Delaunay, S., Fallah, M., Fidler, D. P., Gostin, L. O., Lee, K., & Piot, P. (2015). Will Ebola change the game? Ten essential reforms before the next pandemic. The Lancet, 386(10009), 2204–2221. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00946-0/fulltext

United Nations. (1945). Charter of the United Nations. https://www.un.org/en/about-us/un-charter

United Nations. (1948). Universal Declaration of Human Rights. https://www.un.org/en/about-us/universal-declaration-of-human-rights

Watts, N., Amann, M., Arnell, N., Ayeb-Karlsson, S., Belesova, K., Berry, H., … Costello, A. (2018). The 2018 report of the Lancet Countdown on health and climate change. The Lancet, 392(10163), 2479–2514. https://www.thelancet.com/commissions/climate-change

World Health Organization. (1948). Constitution of the World Health Organization. https://www.who.int/about/governance/constitution

World Health Organization. (2005). International Health Regulations (2005). https://www.who.int/teams/ihr

World Health Organization. (2013). Global action plan for the prevention and control of noncommunicable diseases 2013–2020. https://www.who.int/publications/i/item/9789241506236

World Health Organization. (2020). WHO Director-General's opening remarks on COVID-19. https://www.who.int/director-general/speeches

World Health Organization. (2021a). Climate change and health. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health

World Health Organization. (2021b). COVID-19 vaccine equity. https://www.who.int/campaigns/vaccine-equity

World Health Organization. (2023a). About WHO. https://www.who.int/about

World Health Organization. (2023b). WHO funding and budget. https://www.who.int/about/funding

World Health Organization. (2023c). WHO emergencies programme. https://www.who.int/emergencies