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THE WORLD HEALTH ORGANIZATION IN THE INTERNATIONAL CONTEXT OF HEALTH PROTECTION

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ABSTRACT

This article aims to analyze the context in which the World Health Organization (WHO) was inserted in the protection of health at the international level, the historical events that involved its creation, as well as to expose certain questions arising from its performance as a specialized agency of the United Nations (UN). It also sought to analyze the challenges that the WHO faces in relation to other entities that take care of the global health area. To this end, the present research was divided into two chapters. The first concerns the historical context in which the World Health Organization emerged as one of the extensions of the United Nations (UN). In turn, the second chapter covers the role played by the WHO in health-related issues at the international level. To achieve the objectives proposed here, we opted for a literature review and bibliographic and documentary research techniques, thus collecting, reading, and selecting scientific articles, books and other documents considered essential to the understanding of the theme.

Keywords: World Health Organization (WHO). Health Protection. International Scenario. Challenges. Crisis.

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INTRODUCTION

This article aims to analyze in which context the World Health Organization (WHO) was inserted in the protection of health at the international level, the historical events that involved its creation, as well as to expose certain questions arising from its performance as a specialized agency of the United Nations.

At a time when the right to health was considered on the international agenda, there was a manifestation, by several countries, of the desire to create and structure an institution that would be capable of dealing with problems that recurrently plagued the world population, such as epidemics caused by different pathogens, which needed to be controlled in order to achieve social and economic stability.

It was up to the WHO, the specialized international health agency, to assume this role of guiding local governments in relation to the procedures to be adopted to guarantee the health of the populations.

It so happens that the actions of the WHO were continuously overshadowed by other institutions that also began to develop actions in the health area, generally through considerable financial and technical contributions.

Because of this situation, the WHO has been the constant target of severe criticism about its performance, to the extent that it is questioned whether it would really be fulfilling the purposes for which it was created, whether it is essential for the development and maintenance of global health, whether the procedures adopted by it would be adequate, sufficient, transparent and without political interference.

Thus, the objectives of this investigation will be to seek to understand the dynamics of the WHO's action in relation to global health, through a brief historical incursion into its process of creation and consolidation in the international scenario, as well as the exposure of some problems that it currently faces for its financing and maintenance of its authority in health issues.

To achieve the objectives proposed here, we opted for a literature review and bibliographic and documentary research techniques, thus collecting, reading, and selecting scientific articles, books and other documents considered essential to the understanding of the theme.

The present research was divided into two chapters. The first concerns the historical context in which the World Health Organization emerged as one of the extensions of the

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United Nations. In turn, the second chapter covers the role played by the WHO in health-related issues at the international level.

BRIEF HISTORY OF THE WORLD HEALTH ORGANIZATION

The role played by health in the configuration of international relations, from the second half of the nineteenth century onwards, has not yet been sufficiently evaluated (Lima, 2002).

Awareness of the concept of "public evil", represented by communicable diseases, and the need to establish protective measures at the national and international levels have greatly contributed to the creation of forums and cooperation organizations with a global reach (Lima, 2002).

According to Lima (2002), different explanations could be listed, but the growing flow of goods and people, as well as diseases, stands out. Thus, health protection actions were constantly the subject of debates and attempts at normalization.

The urban phenomenon and the new knowledge concerning health impacted not only the internal level of nations, but also international relations, with the intensification of trade and the negative implications of the establishment of quarantines in seaports (Lima, 2002).

Even when the imminent outbreak of conflicts between national states highlighted the issue of war, due to the process of imperialist expansion, the health agenda intensified as an international issue (Lima, 2002).

During the nineteenth century, the disease that most marked this period was cholera, which gave rise to what was considered the first pandemic, in the period 1817-23, progressively affecting countries in the Persian Gulf and those also reached by the Indian Ocean (Veronelli; Testa, 2002).

On this occasion, the traditional pattern of the expansion of this disease was altered by the greater frequency of international trade and military movements arising from British domination in India (Veronelli; Testa, 2002).

In 1826, a second cholera pandemic began, which quickly reached Russia. The Polish rebellion in 1830-1831 allowed this disease to reach the Baltic and eventually England. Cholera landed in Sunderland in 1831 and, in two years, it is estimated that there were about 30,000 deaths (Veronelli; Testa, 2002).

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It was the first time in history that cholera had reached Europe, and its successive visits were a cause not only of consternation, but also of speculation, about the nature of epidemic diseases in general and cholera in particular, as well as their relationship with sanitary, meteorological and geophysical conditions (WHO, 1958).

Thus, in the mid-nineteenth century, the International Sanitary Conferences began, which constituted forums for scientific debate on the controversies surrounding the causes and mechanisms of disease transmission, and political, since it concerned the establishment of common norms and procedures among countries facing problems such as cholera and bubonic plague epidemics. It should be noted that, generally, at the International Health Conferences, several scientific controversies were manifested (Lima, 2002).

These conferences mainly brought together European countries and expressed the contradiction between the growing insecurity, resulting from the expansion of epidemics and the very emergence of the concept of pandemic, and the idea of progress that was affirmed and found symbolic representation in the Great International Exhibitions (Lima, 2002).

Thus, it is noteworthy that in the first half century of internationalization of public health, progress was very slow. In fact, it is argued that it could hardly have been the other way around, since medical science was still looking for the key to the foundations of the problems under discussion (OWS, 1958).

In addition, the objectives and orientation of international health work were very simple and very limited. In this way, two main ideas dominated the International Sanitary Conferences: the first consisted of the removal of obstacles to trade and transport, and the second was the defense of Europe against exotic pestilences (WHO, 1958).

International cooperation in health would then have begun with the first International Sanitary Conference, in Paris, on July 23, 1851, whose objective was to harmonize and reduce, in order to maintain a minimum of safety, the conflicting and costly maritime quarantine requirements of the various European countries (PAHO, 2015).

This first Conference, which dealt with cholera, was ratified and entered into force at the Seventh International Sanitary Conference, which took place in Venice in 1892. Afterwards, two other conferences took place, in Dresden (1893) and Paris (1894), which resulted in two additional conventions also related to cholera (PAHO, 2015).

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The next conference, held in Venice (1897), approved a new international convention on the prevention of the spread of the plague. These four conventions were consolidated into just one International Sanitary Convention (1903) (PAHO, 2015).

During this period, it was agreed that a permanent international health office should be created. It is reported that the American Republics had already established the International Sanitary Bureau (1902), later renamed the Pan American Sanitary Bureau (PAHO, 2015).

Lima (2002) points out that, in relation to Latin America, due to the impact of the cholera and yellow fever epidemics, a sanitary convention was held in Montevideo (1873), which was attended by Brazilian, Argentine and Uruguayan sanitary authorities, which determined common measures for the prevention of Asian cholera, yellow fever, plague and typhus.

In 1887, these same countries met, once again, in the city of Rio de Janeiro, where the Rio de Janeiro Sanitary Convention was established (Lima, 2002).

At a meeting of representatives of various governments held in Rome (1907), the decision was made to establish an international public hygiene office (IOHP), located in Paris, with a permanent secretariat, as well as a standing committee of senior public health officials from Member State governments (PAHO, 2015).

This commission would have met for the first time at the end of 1908 and, subsequently, twice a year, except during the First World War (PAHO, 2015).

In this context, due to the war, the League of Nations was created, which had as one of its tasks to dedicate itself to adopting measures of international interest for the prevention and control of diseases, and all existing international agencies should be placed under its direction (PAHO, 2015).

It was believed that the International Office of Public Hygiene (OIHP) would be incorporated into the administrative structure of the League, however, this was not what happened, since, at the last moment, the United States, which was a member of the OIHP, but not of the League, vetoed this merger (PAHO, 2015).

Thus, in the period between the two world wars, two independent international health organizations coexisted in Europe: the OIHP and the League of Nations Health Organization, which cooperated with each other, together with the Pan American Sanitary Organization, currently called the Pan American Health Organization (PAHO, 2015).

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With the outbreak of World War II, it is said that international health work was almost completely paralyzed (PAHO, 2015).

It is noted that, in the period following the post-World War II, several institutions of global scope emerged, subsidized by the allied countries, such as the United Nations (UN), in 1945, and the World Bank, in 1944. These agencies were part of a structure of international institutions, aimed at sustaining the new post-war world order (Matta, 2005).

The post-war period imposed an unquestionable need, according to Matta (2005), and immediately subordinated to the UN, for the constitution of international collaborative actions for the care and reestablishment of health conditions in populations affected by the war and for the development of medicines, procedures and diagnostic methods initiated by the advances that occurred during the world wars.

In April 1945, during a conference for the founding of the United Nations in San Francisco, representatives of Brazil and China proposed the establishment of an international health organization, as well as the convening of a conference to structure its constitution (PAHO, 2015).

On February 15, 1946, the UN Economic and Social Council reiterated to the Secretary-General the request to convene this conference. Thus, from March 18 to April 1946, a preparatory technical committee met in Paris to prepare proposals for the Constitution, which were later presented to the International Health Conference, held in New York, in June 1946 (PAHO, 2015).

Based on these proposals, the Conference drafted and approved the Constitution of the World Health Organization, signed on July 22, 1946, by representatives of 51 UN members, as well as 10 other nations (PAHO, 2015).

The Conference also established a temporary commission to carry out certain activities of health institutions that existed at the time, until the Constitution of the World Health Organization (PAHO, 2015) came into force.

The preamble and Article 69 of the WHO Constitution state that the WHO should be a specialized agency of the United Nations, and Article 80 states that the Constitution would be in force when 26 UN members ratify it (PAHO, 2015).

Then, when 26 of the 61 governments ratified their signature, on April 7, 1948, this occurred, and the interim commission continued to carry out the work that was previously performed by the Health Organization of the League and the OIHP (PAHO, 2015).

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It is asserted that, for a long time, the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA) and the WHO interim commission have assumed responsibility for international health conventions and the international epidemiological report (PAHO, 2015).

The first Health Assembly was inaugurated in Geneva on June 24, 1948, with delegations from 53 of the 55 Member States, in which it was decided that the interim commission should be disbanded at midnight on August 31, 1948, to be immediately succeeded by the WHO (PAHO, 2015).

Currently, 194 States in six regions are part of the WHO, with a mutual commitment to achieve better health for all, everywhere (Who, 2020), and is considered one of the most decentralized agencies of the United Nations, with a high degree of autonomy from Geneva (Godlee, 1994a).

Thus, the World Health Organization (WHO) was founded on the principle that health is a human right and that all people should enjoy the highest standard of health, understanding health as complete physical, mental, and social well-being, and not just the absence of disease (WHO, 2020).

The World Health Organization is an international agency that exerts influence, monitoring, and evaluation of public health policies around the world. Thus, this institution adopts technical and scientific cooperation as its main strategy of action, so that it can intervene in the national health systems (Matta, 2005).

According to Mattos (2001), every international agency is constituted through an agreement between several national governments, in which its mission, the devices of its own government and those through which the agency will obtain the financial resources and the fundamental rules for its activities are established.

It is asserted that all the basic rules that govern the performance of an international agency can be reinterpreted and be subject to renegotiation at any time by the countries that are part of it (Mattos, 2001).

Considering that these pacts are politically signed between governments with different political, military and economic powers, as well as with different interests, they express the power relations between the different governments in a given international conjuncture, and, therefore, the strategies of disputes for hegemony (Mattos, 2001).

The WHO, except in exceptional situations, does not intervene directly in the provision of health care or disease prevention, a strategy that is adopted to avoid

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accusations of imperialism and to ensure that developments are sustainable in the long term (Godlee, 1994a).

In the twentieth century, international health initiatives were generally implemented by States, subject to the coordination of specialized bodies, such as the World Health Organization (Biehl; Petryna, 2013).

In this sense, the main source of authority was the State, which led the definition of priorities and the allocation of resources. Thus, international health care policies were, as a result, subject to the restrictions usually imposed by diplomacy (Biehl; Petryna, 2013).

The WHO and related agencies had a coordinating role, and the human rights discourse was often used to guide and instigate efforts (Biehl; Petryna, 2013).

It is observed that this dynamic has only undergone a little change in the context of the Millennium Development Goals, elaborated by the United Nations, which recognized health as an essential value and as a pillar of development (Biehl; Petryna, 2013).

Notwithstanding this, it is argued that the World Health Organization has a unique place in global health, due to its visionary constitution, which affirms, as previously stated, a social vision of health and health as a human right (Legge, 2012).

The WHO Constitution would provide a forum, a resource and an instrument to help national health authorities fulfil their responsibilities in relation to health (Legge, 2012).

The unification of several international health institutions in the World Health Organization would not have been as simplistic as the historical description made by this institution (Matta, 2005).

For example, PAHO, which had been in operation since 1902, had a consolidated organization, with a more expressive structure and budget than the newly established WHO. As a result, PAHO claimed autonomy from the WHO, due to its institutional and technical capacity to sustain it (Matta, 2005).

The WHO, from the beginning, has sought its hegemony in the area of health, both in relation to the political aspect and in the construction of international technical standards and consensus (Matta, 2005).

Initially, the WHO made efforts to review the International Health Consensus, with the standardization of disease classifications and their epidemic potential (Matta, 2005).

The first review of the WHO's policy related to its influence on member countries took place in 1973, during the 26th World Health Assembly, in which a report prepared by

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the executive group was presented, whose conclusion was that there would be immense dissatisfaction with health systems (Matta, 2005).

In view of this finding, the Assembly decided that the WHO should be more active, contributing to the countries that make up it, through the development of practical standards for national health systems, no longer being a mere spectator (Matta, 2005).

A new WHO policy was launched in 1977, with the initial objective of providing a standard of health that would allow all people to have the opportunity to lead a socially and economically productive life (Matta, 2005).

In 1978, this project, which was entitled "Health for all in the year 2000", was presented on the occasion of the Alma-Ata Conference, which adopted the Declaration on Primary Health Care as the cornerstone of this policy, in a partnership between the WHO and UNICEF (Matta, 2005).

The planning of the project "Health for All in the Year 2000" received financial and political support from various governmental, private, and non-governmental institutions, scientific and academic communities (Matta, 2005).

The WHO sought to consolidate itself as an organization that not only advised the member states that composed it, in a disease-centered perspective, but also, and mainly, intervened and proposed health and social policies and strategies (Matta, 2005).

Despite the relevance of the Alma-Ata Conference, the WHO, during the 1980s, would have its influence diminished. For example, the work of the World Bank contributed to this, as it began to allocate resources to health, as well as to propose various sectoral reforms, emphasizing the reduction of the role of the state (Matta, 2005).

Thus, it results that the actions undertaken by other international agencies have affected the leadership capacity of the World Health Organization, placing it in a political position considered unstable and not very strategic in relation to changes in the world political and economic order (Matta, 2005).

THE WHO AND ITS ROLE IN HEALTH PROTECTION AT THE INTERNATIONAL LEVEL

The World Health Organization has an image problem. People know it exists, and most know that it has eradicated smallpox, but few have a clear idea of what it does (Godlee, 1994a).

There are those who think it is a kind of world medical association, others see it only as a source of standard technical medical reports, still others as just another faceless

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organ of the United Nations, where overpaid bureaucrats carry out their careers (Godlee, 1994a).

Physicians in the developing world respect the WHO for its advice and technical support, but criticize the waste of money on unnecessary salaries and bureaucratic procedures (Godlee, 1994a).

Thus, critics of the World Health Organization accuse it of being involved in bureaucracy and politics. The World Health Organization has been facing a crisis for a long time. From decade to decade, the nature of this crisis can change (Hawkes, 2011).

For example, the media woke up at the WHO in the year 1993, when a political and financial scandal seemed to erupt due to the re-election of its then director general, Dr. Hiroshi Nakajima (Godlee, 1994a).

The result of an external audit fell short of the media's hopes; found financial mismanagement and misuse of the organization's funds, but released the general director of any involvement (Godlee, 1994a).

Amid the denunciation of decadent negotiations and the repetition of mostly unsubstantiated stories, the real factors limiting the effectiveness of the WHO have received little attention (Godlee, 1994a).

The functions of the WHO are at the center of the debate about the need for reform, given that it has overcome a markedly hygienist origin to reach a great expansion of its domains of action (Perez; Ventura, 2014).

The work of the WHO can be divided into three broad categories. First, it provides information on disease outbreaks and trends and new developments in diagnosis, prevention, and treatment, and formulates standards, technical manuals, and guidelines (Mccarthy, 2002).

Second, it promotes efforts to control communicable and non-communicable diseases; Such efforts include disease eradication programs and mass vaccination. And third, it provides support for the development of health services and policies, including technical assistance for policy development, internal training of health personnel, and travel scholarships (Mccarthy, 2002).

Created as an agency to advise governments at a time when their health departments were the main drivers of health policy and delivery, it seems outdated alongside start-ups like the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI

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Alliance (formerly known as the Global Alliance for Vaccines and Immunization) and private philanthropies. such as the Bill and Melinda Gates Foundation (Hawkes, 2011).

The WHO, as the world's reference agency in all public health matters, today would be outdated, underfunded, and excessively politicized. In a world of rapid technological change, travel, and trade, the WHO moves with the speed of bureaucracy (Chow, 2010).

His advice to health authorities is often overshadowed by the need for consensus. For Chow (2010), regional leadership positions are exercised as political prizes.

Underfunded and overburdened, the organization has been attacked for being easily influenced by big pharma. In a world where foundations, NGOs, and the private sector are transforming global health, the WHO simply would not have adapted (Chow, 2010).

According to Chow (2010), it is not just a matter of the WHO losing its advantage. Together, these numerous dysfunctions would be making the WHO increasingly close to irrelevance in the world of global health.

Among the numerous difficulties faced by the WHO in carrying out its functions, Perez and Ventura (2014) identified, both in the literature and in official documents, the five main elements of the crisis in the organization. They are: the erosion of its protagonism; the scarcity and nature of its funding; the conflicts of interest of the experts, which came to light during the management of the influenza A (H1N1) pandemic; communication difficulties; and the problems of internal governance.

In relation to the crisis of leadership, the predominant model of international health, from the beginning, was, as already adduced in the previous chapter, the predominance of the action of States, under the coordination of the WHO (Biehl; Petryna, 2013).

Thus, when the WHO was created as a UN technical agency shortly after World War II, government ministries of health were the predominant global health authorities (Chow, 2010).

The new UN body was to serve as a reservoir of experience and knowledge at the service of countries in need of help (Chow, 2010).

By way of illustration, mention should be made of the smallpox eradication campaign, proposed by the WHO in 1959, which was later restructured in 1967, when this agency increased funding for the production of immunizers in laboratories located in endemic countries, ensured greater supervision of the quality of the products, and introduced the lyophilized vaccine and the bifurcated needle on a large scale (Muniz, 2011).

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Thus, the WHO would have a dual character and mission: as a moral voice for global health and as a servant of its Member States. Their political and technical leadership can help countries address a range of public health concerns (WHO, 2011).

At the same time, the WHO considers itself to be the servant of its Member States, which meet every year at the World Health Assembly in Geneva to define policies for the Organization, approve the Organization's budget and plans, and, through the Assembly's Executive Board, elect the Director-General every five years (WHO, 2011).

It follows that the scientific and technical aspirations of the WHO for global health are constantly conditioned by the multiplicity of points of view, needs and references of its Member States (WHO, 2011).

The WHO then essentially became a health consultancy for developing countries, providing advice, analysis and best practices, although it did not directly implement health programmes. This was an invaluable service at the time. Today, however, its mission and operations remain largely unchanged (Chow, 2010).

The WHO's stagnation is juxtaposed with a public health world that is changing more and more rapidly than ever before. Legions of new drugs, vaccines, and diagnostics have strengthened the medical profession (Chow, 2010).

Governments are no longer the sole stewards of public health; New players are entering the field, both public and private. For example, the Bill and Melinda Gates Foundation has revolutionized global health by investing $13 billion in health grants, ranging from research into malaria vaccines to treatment of tuberculosis and HIV/AIDS (Chow, 2010).

Even the U.S. government has entered the world of change, tackling HIV/AIDS in Africa through a $25 billion program that put 3.2 million people on treatment in just half a decade (Chow, 2010).

What sets these pioneering WHO efforts apart is that they are nimble, well-funded, and less burdened by bureaucracy. It is difficult to understand, in this scenario, how the WHO could compete (Chow, 2010).

Gradually, other agencies emerged on the international scene with policies focused on health, intervening and prescribing guidelines for national health systems. UNICEF and the World Bank began to dispute the leadership of a field that was the exclusive domain of the WHO (Matta, 2005).

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There are two fundamental moments, according to Matta (2005), that marked the entry of UNICEF and the World Bank into the dispute for dominance of global health strategies. The first was UNICEF's distancing from the comprehensive proposals of Health for All, which adopted isolated actions through vertical intervention programs to reduce infant mortality and immunization.

These actions would have received support from powerful international organizations, such as the World Bank, through the hiring of professionals, training of human resources and the supply of inputs (Matta, 2005).

The second would have been the release of the 1993 World Development Report, called "Investing in health". The theses expressed by the report proposed structural economic adjustments, the financing of health care by private capital, and a scathing critique of the universality of access to health (Matta, 2005).

In this new atmosphere, where organizations are taking health into their own hands, it is not clear exactly what role the WHO should play (Chow, 2010).

Offering your expertise is not as simple as it once was and the biggest players in global health are not asking for assistance as governments have asked. The WHO also cannot set its own advisory priorities, since its funding comes from donors, mainly national governments (Chow, 2010).

With its limited resources, the WHO would be caught in a trap, appealing to donors' interests in fighting specific diseases, such as polio, HIV/AIDS or malaria, as well as giving broader priorities to health. The WHO would no longer be setting the global health agenda, but rather struggling to keep up with it (Chow, 2010).

The WHO's activities are seen by many as disparate and uncoordinated. They encompass the full range of health problems, from major threats to life such as AIDS and tuberculosis to minor threats such as oral disease (Godlee, 1994a).

Therefore, the WHO remains committed to what it calls a "full menu" approach and aims to cover all aspects of health. Critics say, however, that there is little logic in how resources are allocated and that diseases in the developed world take up a disproportionate amount of WHO time and money (Godlee, 1994a).

According to Legge (2012), the WHO faces a crisis, which could be alleviated if member states could be persuaded to "untie" their donations and give the organization leeway to control its budget and set priorities, preventing the WHO from becoming increasingly irrelevant, with disastrous consequences for global health.

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The WHO has two different sources of revenue: regular revenue, represented by contributions from member countries and associate members, and revenue from other sources, represented by voluntary contributions from member countries and other sources of donations and incentives (Matta, 2005).

In addition to the eradication of smallpox and the control of poliomyelitis in the world, perhaps the most politically influential moment of the WHO at the international level occurred during the Alma-Ata Conference on Primary Health Care, in 1978, which generated, in 1979, the Declaration of Alma-Ata (Matta, 2005).

Alma-Ata took place during the administration of Halfden Mahler, a skilled and diplomatic manager who managed to convey the need to establish a global pact for health, together with another UN agency, UNICEF (Matta, 2005).

The structure of what would be suggested at the conference was designed during the 30th World Health Assembly, in 1977, and unanimously approved by the WHO member countries (Matta, 2005).

In 1978, in Alma-Ata, Kazakhstan, the former Soviet Union, 134 countries signed an agreement, with the presence of representatives of 67 international and non-governmental organizations, which aimed to achieve a level of health that would allow all citizens of the world, by the year 2000, a socially and economically productive life, being called "Health for All in the Year 2000" (Matta, 2005).

According to Matta (2005), at this historic moment for global public health, the WHO would have reached the apogee of its international influence, through the call on health systems around the world to redirect their policy towards health as a human right, which would be built by social and economic policies that were capable of reducing inequality and allowing social participation.

The WHO left the purely technical arena of a specialized agency to directly influence the conduct of social policies, impose values such as the right to health, social participation, equity in access to resources and, above all, the adoption of policies aimed at intervening in social inequalities and reducing the gap between rich and poor countries (Matta, 2005).

For the WHO, Alma-Ata is an icon of success and failure simultaneously. This success was due to an influential past, when it was able to bring together the majority of national states, conduct proposals, influence the design of health systems and economic and social policies (Matta, 2005).

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On the other hand, failure is represented by the fact that it is a goal never achieved, a proposal that was pulverized with the same speed as it emerged, a discrediting of an ambitious action and a date never met (Matta, 2005).

Matta (2005) also highlights the inability of the WHO to manage international political and economic negotiation processes and within national states and the retreat in the face of the pressures of large economic interests in the capitalist world.

During this period, for example, the WHO began, according to Matta (2005), to suffer pressure from industries, economic groups and member countries. The first of these clashes occurred in the late 1970s, when international pressure was mounting to stop the marketing of breast-milk substitutes in the developing world (Godlee, 1994b).

At a joint meeting of the WHO and UNICEF, an international code on breast-milk substitutes was drawn up, which was approved at the World Health Assembly in 1981 by 118 votes to one. The United States was the only country to oppose the code, and it did so on the grounds that the WHO was interfering with global trade (Godlee, 1994b).

The second major confrontation followed the launch of the WHO's essential medicines program in 1977. The WHO's objective was to stimulate a more rational drug policy, based on a list of essential medicines, and thus encourage countries to develop their own skills to produce the drugs they need most (Godlee, 1994b).

The pharmaceutical industry was strongly against this initiative, and so in 1985, in protest of the essential medicines program, the U.S. contained its contributions to the WHO's regular budget. At that time, the U.S. owned 11 of the 18 largest pharmaceutical companies (Godlee, 1994b).

It is stated that there are considerable differences in how the WHO should carry out its work. One such debate is the perennial argument over whether the WHO should be predominantly a normative agency—setting standards, developing guidelines, and providing information that can be used by governments and agencies in implementing their own programs—or whether the WHO should also be involved in the implementation of programs itself (Mccarthy, 2002).

Proponents of the first position argue that what the WHO does best is to gather information and knowledge and refine it, but that it lacks the resources and organization to implement large and complicated programs in practice (Mccarthy, 2002).

It would be not only a political discussion, but also an economic one, in the sense that it is about the use of the resources invested by the member countries in the WHO and

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the return on these investments in terms of the resolution of certain health problems (Matta, 2005).

WHO's ability to provide the necessary leadership and momentum would be compromised by serious budgetary and organizational deficiencies, including donor dependency, contradictions in human resource management, excessive decentralization, and a lack of accountability on the part of Member States for the stewardship of this critical global institution (Legge, 2012).

CONCLUSION

The World Health Organization, since its inception, has faced numerous challenges to establish itself as an international reference in health, both for its member states and for other countries around the world.

It is an institution that constantly faces severe crises, some of which are very long-lasting, which call into question its indispensability in the context of global health protection.

Excessive bureaucracy, political influences, corruption, for example, are issues that emerge from within the WHO and are revealed to the world, causing the continuous weakening of its discourse as a health authority legitimately forged to act in the fight against epidemics, diseases and other aspects that directly influence the health of the population.

Some argue that it would be necessary to implement reforms to enable the WHO to survive in the international health scenario, since changes in the structuring of health require this to occur.

In addition, the WHO would need a change in the behavior of the countries that are part of it, which should participate more, support its projects and maintain its funding according to the previously assumed commitment, keeping possible political divergences and particular interests at bay.

On the other hand, there are those who maintain its dispensability, arguing that it is an outdated institution, which has not been able to keep up with the changes that have occurred over time, extremely bureaucratic and has lost its space in health protection.

Other institutions, more modern and that mainly have significant funding, are able to develop projects in the health area more efficiently in various parts of the world.

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It is inferred that the WHO experienced a time of apogee, in which it acted as a defender of health policy, exercised hegemonic leadership in relation to it and its guidelines were therefore considered extremely relevant for national governments.

However, what has been observed is a progressive decline of the WHO, which continues to carry out important work, but with reduced resources and without considerable political and financial support, not being able to propose convincing initiatives to confront health threats, indicating that it will still need to undergo changes capable of enabling its survival.

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