The global health landscape is characterized by a multitude of actors, including nation states, international organizations and non-governmental organizations, all of which play substantial roles in addressing global health issues. The range of organizations involved means a substantial heterogeneity with respect to their structure, mandate, legal standing, and obligations. As well as this diversity, they are substantially differentiated with respect to the power, influence, and the financial resources they are able to mobilize in order to advance their organizational mission. This variety also continues further through to the ability to determine accountability, with each organization differing in the stakeholders to whom it is accountable; some may be accountable to shareholders or a Board of Directors, while others will be accountable to governing bodies, national parliaments, or to the member states which comprise the organization. As such, concepts of accountability are often limited to ensuring accountability for the success of the organizational leadership in achieving the goals related to the mission of the organization[1]. Thus, the fundamental motivations of organizations are broadly "self-regarding" in nature. This issue, and how this range of actors may be governed in a truly global constitutional system has been considered by a number of scholarly perspectives, resulting in robust, academic discussions on what the global constitutionalized system in global health ought to look like.[2] However, one thing which has not yet been addressed fully in the literature, and which adds a distinct layer of complexity in current practice, without this fully formed constitutionalized system, is the fact that, when considering the relationships that organizations have with other relevant actors in the area; the extent to which enforceable obligations are owed between actors is unclear, and it is this which we focussed on in the present paper. In this case we are not so much interested in beneficiaries of services provided by organizations, or services which have been formally contracted for between organizations, but rather, what sorts of obligations do organizations have towards each other, beyond any services which may or not have been contracted for.

This question is becoming increasingly important because, whilst such organizations typically work only within their pre-defined mandate, on some occasions, typically during an emergency event, a multitude of actors come together to work towards a

common goal. A good example of how this can play out was evidenced in the Ebola outbreak of 2014-2016. The outbreak had all the chaotic features of a global health emergency, and brought a wide variety of actors to respond to the crisis, including: local civilian healthcare workers; voluntary foreign healthcare workers; domestic military forces; foreign military forces; private philanthropic organizations; international organizations; non-governmental organizations; universities; and foreign government departments. Fragmentation and poor co-ordination was characteristic of the early response, as were allegations of ineptitude, foot-dragging, and politically motivated decision making.[3] Even with an attempt by the World Health Organization (WHO) to develop some sort of coordination of action, this was still unsuccessful and lacking. Without an overarching understanding of the coordination of relationships, even attempts at ad hoc cooperation remain stunted.

In this paper we will explore issues related to the governance of inter-organizational relationships - taking the multi-layered response to the 2014 West African Ebola Outbreak as our point of departure. We note that, ideally organizations engaged in global health activity would have a clear set of governance rules that would guide their behaviours, and set expectations for collaborating with other organizations, though this is rarely the case. More broadly, we highlight that there is no overarching set of principles that would cover all the possible ways in which collaborations can take place. We conclude by suggesting some principles to guide collaboration between organizations engaged in global health in the future.

1. Global Approaches to Inter-Institutional Relations: a Lack of Coordination?

We take as our starting point for this analysis the international legal framework, as the organizations we are engaging with in this analysis will be actors on the international stage in global health. The regulatory framework at the international level focuses upon the actions of states; international law is built around the concept of the state.[4] The original nature of international law as solely addressing sovereign states shifted in the twentieth century with the emergence and growth of, firstly international organisations, and later other varied actors beyond the state. Many initially considered institutions as being a part of a move towards an international ‘community’ that would

contribute to providing a check on the authority of the state.[5] The growth of institutions was seen as positive as developing an increased capacity for the rule of law.[6] Franck, in this sense, famously claimed that international law had moved into a "post-ontological era" and into a mature legal system.[7]

In spite of these early hopes, however, the significant proliferation of institutions in the latter half of the twentieth century and into the twenty first century manifested in more of a challenge to the rule of law than a benefit.[8] The expansion was not simply in terms of number but also, more significantly, in terms of power and ability. A number of institutions can now be considered to exist as autonomous legal actors, operating beyond the control of their founding member states. In addition to this expansion, there has been a growth in the number and powers of numerous non-governmental organizations, as well as a greater involvement of business and other actors, such as philanthropic organizations. Nowhere is this more true that global health.[9]

This significant expansion and progress towards autonomy simply was not accompanied by sufficient development of the legal system to regulate these actions; the legal system Franck talked of has simply not developed into its 'mature' state. Not only do rules of international law continuing to depend upon states for their authority, but also, rules continue to be demarcated with regard to the particular kind of actor to which they are addressed. These actors, furthermore, continue to be either states or institutions, which are constituted by states.

The consequence is that in spite of some hopes within the twentieth century, institutions did not lead to an overall constitutionalized global order. This continues to be lacking. Most particularly, and the claim that is central to the present paper, there is a limitation in engaging in the interactions between international actors. Perhaps Franck's concept of a post-ontological system has been proven solely in relation to states, and more recently has developed in relation to institutions, but his focus on institutional autonomy is highly limited, as discussed below. Not only this, but it, furthermore, continues to lack in an overarching sense when considering numerous actors working together within the same legal space. The possession of the same legal

space by multiple different varieties of actors is where a significant gap within the global legal order can now be tracked.

If a coherent system had been comprehensively established, under which these different actors functioned, the issues arising from coordination between actors would not be as pressing. There would exist a framework within which these relationships could be regulated. Rather than a constitutionalized system, however, there exists a pluralist system within which differing legal orders interact. The commonality between the majority of these legal orders is, furthermore, their continued focus on, or deference to, state sovereignty. Without first of all engaging in the difficulties and weaknesses of this overarching framework, the issues arising in the increasing collaborations between the new actors in global health cannot be fully understood.

It is the collaborations between actors at the global level generally, and in global health more specifically, that pose a substantial number of difficulties. The question arises as to their relationship and the existence, or not, of a framework addressing these interactions. Institutions are often highly specialist, which has substantial benefits in their ability to respond to different situations. There is a significant lack, however, of any sort of overarching legal framework to address the relationship between these entities. Some can be considered to have developed into autonomous legal systems of their own, such as the European Union.[10] Whereas others have a substantial role within the development and upholding of a particular area of international law; consider the role, for example, of the International Federation of the Red Cross and Red Crescent Societies and its role in International Humanitarian Law.[11] Each entity possesses its own remit and it is only if some sort of overarching international, or perhaps global, constitutionalized order could be identified that the interactions between the institutions and different legal norms and systems will gain clarity. Such an order does not exist, however. Rather than an overarching hierarchy of norms, the global system sees a pluralistic interaction of principles and actors. As Von Bogdandy has termed it, a “normative pluriversum”.[12]

This lack of an overarching constitutionalized system really becomes exposed when considering the 2014-16 Ebola outbreak. Each institution and legal system had their

individual role and remit to address the crisis, but the lack of coordination either created conflict between actors or left gaps in the ability of the global health community to adequately address the crisis. Responding organizations had to rely on ad hoc collaboration and discussions rather than there existing a clear framework within which they worked.

Not only is there a lack of an overarching global system, but furthermore even when limiting the focus to the law of international organizations (such as the UN and the WHO), and excluding other actors such as non-governmental organizations and states, the law remains unclear and underdeveloped regarding some of the fundamentals. For example, the primary source for determining the powers and structures of the institution is the constitution of the institution itself.[13] The discussion of what law applies to an international organization, if it is considered to have legal personality, has been a long and complex one. They are certainly able to be party to treaties[14], have more recently been argued to be subject to customary international law and general principles of international law,[15] although this remains controversial.[16] The discussion as to whether there may be the practice and development of a "common law" of international organizations[17], has not been straightforward. Relationships between international organizations, where not governed by treaties, are generally left to be dealt with by unspecified general principles, or in an ad hoc manner.

In the context of global health, there is often a pressing question or common concern that is driving the need for collaboration. It is usually the case that no single organization has the required resources to address the issue. In cases where there is a global health problem of significant magnitude such as a disaster or emergency (including Public Health Emergencies of International Concern as defined by the International Health Regulations) a variety of diverse organizations may come together voluntarily, despite the IHR only being binding upon state parties. It may be presumed that they are working towards a common goal, but tensions in the structure and purpose of organizations may lead to conflicts if there is no means of negotiating organizational differences. Indeed, it is the presumption of common goals that is the problem. We may be better off presuming conflict rather than presuming accord.

Table 1. Mission, Values and Policies of Global Health Actors

To make this clear, consider Table 1. It is not inconceivable to think of a situation where the WHO, MSF, Gates Foundation, NIH, FDA and universities such as Oxford and Harvard are brought together to collaborate. This table indicates the stated mission, vision, values, partnership policies, oaths and accountability structure (where such information was easily attainable). It is apparent that there will inevitably be conflicts between the missions of the organizations. For example, both Oxford and Harvard are competitive in their aspirations to be the world`s preeminent academic institution. The NIH seeks to advance fundamental knowledge in the area of health, whereas the FDA wishes to protect public safety in the United States by ensuring that medical treatments are safe and effective. MSF is pledged to come to the aid of populations in danger, and the WHO seeks to be the leader and standard setter in global health. Interestingly both the WHO and MSF have strong language regarding independence of action. The WHO has a pledge in its Code of Ethics and Professional Conduct obliging employees to "to discharge those functions and regulate my conduct with the interests of the WHO only in view". Therefore it is imperative that this sort of *a priori* mission clash between organizations be acknowledged and managed expectantly.

Currently there is no governance instrument to guide representatives of organizations in their interactions with other organizations not otherwise specified in legal agreements. Holzscheiter comprehensively studied the nature of intergovernmental organizational behaviour. Noting the extreme fragmentation characteristic of these relationships she discusses the need for norms in terms of what she has termed inter-organizational convergence:

> The entire organizational convergence to global health governance as driven by norms or appropriate organizational behavior in the face of fragmentation allows moving away from a portrayal of global health as an apolitical technical domain and strategy to seeing its political and ideological dimensions.[18]

Understanding the political and ideological dimensions of inter-organizational relationships is an important move forward. Holzscheiter identifies what she calls moderate governance norms and principles that guide these relationships.[19] In terms of principles, she argues for the recognition of coherence, that is the congruity of the values, interests, actions and goals and harmonization of different values recognizing that different organizations may have incongruent visions and that the principles may in fact be in conflict.[20] However, the analysis that Holzscheiter provides focuses only on the elements of official intergovernmental inter-organizational cooperation, such as those between the WHO and the UN, and does not address issues related to different organizations of different types moving forward. There is good reason to believe as evidenced by Table 1, that the fragmentation and lack of convergence is even greater when taking into account the heterogeneous organizations involved in global health.

Aside from the divergent mission, vision and values that different organizations exemplify, it is important to acknowledge as per Holzscheiter, the political dimensions of inter-organizational behaviour. It is evident that there are inherent power imbalances between different groups in the global health sphere. Organizations such as the Bill and Melinda Gates Foundation, the U.S. National Institutes of Health and the U.S. Food and Drug Administration exert differential financial and normative power in the market place of ideas and moral suasion. Organizations such as the World Health Organization should be neutral with respect to the interests of stakeholders in global health. MSF may pick and choose where they wish to engage. In essence, these organizations are not answerable in any straightforward substantive way to anyone but themselves, and most certainly not to each other - and yet we presume goodwill and accord when these organizations work together on a common mission.

2. The Current Options: inter-agency working protocols and their failure

With no set framework or code within which institutions operate it is worth considering the ad hoc collaboration that currently takes place, as well as its effectiveness. This is generally done through inter-agency working protocols, which

are often disparate in nature. The WHO signed a Letter of collaboration between the International Federation of Red Cross and Red Crescent Societies IFRC in 2005.[21] This agreement was reached on the basis of the two agencies "complementary approach to vulnerability to disease as a major cause of poverty" and the agencies commit, through the 2005 letter to: enhance contacts; build new relationships; support activities; and exchange technical contact points. The 2005 letter contains within it a stating that "the cooperation outlined in this letter will be valid for a period of 5 years from its date of signature", and does not appear to have been renewed. The WHO also entered into a Letter of Understanding with the International Medical Corps, in 2008.[22] The WHO-IMC LoU sets out that the parties intend "where possible and appropriate" to strengthen their collaboration regarding: surge emergency response; early recovery; capacity building. The cooperation included within this LoU is "to be reviewed every two years…until such time as it is terminated" - but does not appear to have been updated since 2008.

At a regional level the WHO Regional Office for Africa (WHO/AFRO) and the International Federation of the Red Cross and Red Crescent Societies signed a memorandum of understanding for collaboration in 2007.[23] The memorandum only mentions that the parties shall "act in close cooperation and consult with each other, not less than once a year, on matters of common interest…." No further information regarding what form this coordination ought to take is provided in the document.

The Basic Documents of the WHO also contain the "Principles governing relations between the WHO and NGOs",[24] which has a limited approach to NGOs for the WHO to partner with, which certainly does not reflect the cross-section of organizations involved in global health, included those that are operationally and normatively influential, such as MSF and Gates respectively. In order to be considered an NGO for the WHO to partner with the organization "must have a constitution or similar basic document, and established headquarters, a directing or governing body, an administrative structure at various levels of action, and authority to speak for its members through its organization representatives. Its members shall exercise voting rights in relation to its policies or actions"[25] Such criteria would rule out a number of operationally active organs such as MSF, as well as key actors in the

above scenario such as universities engaging in research, the FDA, the Bill and Melinda Gates Foundation, and member state military bodies. The Principles do make allowances "in exceptional circumstances" for engagement with a national organization subject to the approval of the relevant WHO Regional-Director, and Member State in which the national organization is active,[26] but again, this demonstrates a limited framework for engagement with relevant actors during a public health emergency. Moreover, it is unclear if the "Principles governing relations between the WHO and NGOs" are even still operational or not, because, despite being included in the most recent version of the "WHO Basic Documents" attached the WHO Constitution, this document repeatedly refers to "the standing committee on Nongovernmental Organizations", which was abolished in 2016 by Resolution WHA69.10.[27]

In 2016 the WHA passed Resolution WHA69.10 "Framework of engagement with non-State actors" (FENSA), which abolished the Standing Committee on Nongovernmental Organizations, created a new pathway by which NGOs could partner with the WHO, and created the "Overarching Framework of Engagement with Non-state Actors" which serves as the guiding principles for WHO-external NGO relations. This document acknowledges that "The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors" whilst protecting WHOs role as "the directing and coordinating authority in global health in line with its constitutional mandate". These relations are to "protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards; not compromise WHO's integrity, independence, credibility and reputation; be effectively managed, including by, where possible avoiding conflict of interest and other forms of risks to WHO; be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect."[28]

This document is more expansive than the previous one which only considered NGOs, expanding the list of actors the WHO may engage with to include: private sector organizations; international business associations; philanthropic organizations; and academic institutions. It is positive that the WHO has expanded its principles of

engagement to include highly influential bodies in the sector, that do not have one-member one-vote decision making protocols, such as MSF and the Gates Foundation. The participation envisaged by the Framework is largely driven towards participation in the decision making processes of the WHO (albeit without voting rights), although there is acknowledgement of technical collaboration refers to other collaboration, including: "product development; capacity-building; operational collaboration in emergencies; contributing to the implementation of WHO's policies." Prior to any engagement under this Framework the WHO conducts due diligence and a risk assessment on the relationship, and the collaboration "must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States."

What engagement there is within this document that could be considered 'guiding principles' are all top-down in nature, designed to protect the WHO's identity and independence. There are provisions for due diligence as mentioned above, but also provisions for "monitoring and evaluation" of the relationship, which includes "non-compliance" with the Framework, which is monitored by the Secretariat. Non-compliance is taken to include: significant delays in the provision of information to the WHO register of non-State actors; provision of wrong information; use of the engagement with WHO for purposes other than protecting and promoting public health, such as for commercial, promotional, marketing and advertisement purposes; misuse of WHO's name and emblem; attempt at undue influence; and abuse of the privileges conferred by official relations. This list, whilst expansive, only includes the WHO monitoring the non-state actors it engages with, and does not acknowledge that non-compliance could happen on the part of the WHO too. Once again, the WHO considers itself to be an organization which holds others to account, not one which is held to account.[29] The Framework does, however, give significant leeway to the WHO during the scenario in which we envisaged above. In respect of implementation it states:

> The Director-General, in the application of this framework, when responding to acute public health events described in the International Health Regulations (2005) or other emergencies with health consequences, will act according to the WHO Constitution and the principles identified in this framework. In doing so, the Director-General may exercise flexibility as might be needed in the application of the procedures of this framework in those responses, when he/she deems necessary, in accordance with WHO's responsibilities as health cluster lead, and the need to engage quickly and broadly with non-State actors for coordination, scale up and service delivery. The Director-General will inform Member States through appropriate means, including in particular written communication, without undue delay when such a response requires exercise of flexibility, and include summary information with justification on the use of such flexibility in the annual report on engagement with non-State actors.[30]

FENSA has also been criticized for its ambiguous provisions with respect to engagement with industry. While acknowledging that FENSA is a step forward, Buse and Hawkes argue, FENSA is "a necessary but insufficient response to the significant part the private sector plays determining population health outcomes."[31] Balancing the scales would require a greater respect for public interest NGO's as partners rather than adversaries. This underscores the need for guidance in this sphere.

While all of this collaboration is positive in enabling a response to circumstances, it does not progress towards providing a long term solution and a reliable framework for addressing the institutional responses. It all demonstrates optional responses that institutions have chosen to engage with. This motivation may also arise for any number of reasons; the specific collaboration may not always be best designed to respond to the circumstances at hand. The ad hoc nature of the collaboration, furthermore poses a problem as there is a lack of consistency in response. With a lack of clarity on the relationships at play here, together with inconsistency in response, there also arise a number of questions on the consequences of actions and what happens when things go wrong.

2.1 **Inter-institutional Collaboration and the Need for Accountability.**

The increased collaboration between actors in global health not only causes complexity in terms of addressing who will act in any given situation, but it also raises questions for the consequences of those actions when things go wrong. The legal frameworks on accountability and responsibility are both built around specific actors, in particular states, and to a lesser degree international organizations. They are often, furthermore, predicated on the idea of being able to identify a single actor who has committed the harmful act.[32]

Accountability has a wide range of meanings but is generally understood to ensure the explanation and justification of actions.[33] Fundamental to notion of accountability are ideas of the appropriate exercise of power and the duty to account for the exercise of power. Accountability has, furthermore, long been accepted within liberal democratic systems as fundamental to the exercise of power.[34] One of the key elements of an accountability framework is that it is oriented to determining the outward or external obligations of organizations.[35] A key element of accountability is answerability, that is, how does an organization explain, justify and take responsibility for the consequences of its actions in the presence of external scrutiny.

The existence of accountability mechanisms provides a positive starting point in this area. However, these are often limited by the framework within which they have been created. When considering, for example, the WHO, a standalone accountability framework has existed for some time but the difficulties that arose with the Ebola crisis and the poor action, or inaction, demonstrated by the WHO show the inadequacies of this framework.[36] It has flaws in its simple application to the WHO's action, when considering the significant involvement of other agencies and actors within the Ebola situation, it was entirely inadequate.

This idea of answerability is central to the legitimation of international action. The concept of accountability responds to individual actors; the legal framework considers the accountability of states, or perhaps institutions, for their individual action. It does not necessarily consider the coordination of action and the possibility of collective action. This is one of the difficult aspects of accountability. Not only is the legal framework ill-equipped to deal with increased collaboration, but the lack of clarity in

the interaction between these agencies can precipitate the need for accountability; a lack of coordination may lead to a gap in action or inappropriate action.

As noted, accountability theory, for the most part, relates to obligations of organizations and, in the context that we are discussing, organizations which engage in global health under a set of conditions where there is no clear instrument of legal accountability. However, the idea of answerability is one that plays a role that we believe can be adapted to further articulate a set of conditions for collaboration.

The specific form of accountability envisioned here is distinct from those proposed for a variety of other situations such as global public-private health partnerships (GHP). While GHP's are acknowledged governance mechanisms, systematic evaluation of their performance indicates salient gaps in performance, particularly with respect to ethical issues such as managing conflicts of interest or ensuring governance mechanisms to ensure transparency and inclusiveness in decision making.[37]

3. Possible Solutions

It is clear that the international legal framework in which international organizations and non-governmental organizations operate is not sufficiently able to ensure appropriate collaboration between such organizations in global health. This is largely due to the constitutional inadequacies of the international legal order, and the fact that such organizations exist in silos as standalone entities. The gap is conspicuous and as things currently stand there is little to prevent the type of situation that occurred during the 2014-2016 Ebola outbreak to occur again. Therefore, some form of governance document, representing "soft law" norms may be of benefit in the future. In what follows we will outline in broad strokes a possible way forward to manage and structure inter-organizational activities.

The current problem can only be addressed through a multitude of actions. While there may be arguments for an ability to continue as things stand, the status quo option is, if the above analysis has any purchase, untenable. While the ad hoc and fragmented nature of inter-organizational relations will no doubt serve the ends of

particular organizations, it in no way serves a greater common good in global health. If no common good that transcends the particular mission of any organization necessitating the need for collaborative action exists then the collaboration is moot. We hope that more than ritual interaction is called for in such circumstances.

Rather, we propose that some action needs to be taken to address this problem. Below we present three options, the adoption of any single one, or combination, would, we argue, make some progress towards improving the current issues. These options are:

1. Ethical Framework
2. Code of Conduct
3. Accountability Framework.

1. An ethical framework may help to guide high level norms and expectations among organizations. An ethical framework may be of use in helping to articulate and mediate the competing values of organizations. Ethical frameworks are commonplace in global health. They have been employed by the WHO and other organizations in a variety of contexts such as public health surveillance, pandemic influenza planning, epidemic management and tuberculosis control.[38] Frameworks should be viewed as resources that aid in the understanding of ethical problems and in decision making. Frameworks have been proposed as a way of making complex landscapes tractable and to aid in the analysis of ethical issues and to guide reflection and decision-making. As global health organizations represent an immensely complex set of interactions, there is a need to include the multiplicity of perspectives required to be understood and balanced. Frameworks can be very useful because they attempt to capture what is relevant to the matter at hand. They help to simplify and make explicit factors relevant to a situation. However, they can also be problematic if they are applied blindly.

2. Codes of conduct have typically been structured to set expectations for members of organizations, in essence an “intra” rather than an “inter” organizational instrument. Codes of conduct have been defined as:

> "Principles, values, standards, or rules of behaviour that guide the decisions, procedures and systems of an organization in a way that (a) contributes to the welfare of its key stakeholders, and (b) respects the rights of all constituents affected by its operations."

In the context of global governance, similar to the declaration of values, commonalities between codes of conduct can be determined. In this case the attention would be directed to the principles, values and standards of behaviour that guide interactions between organizations. Again, our task is not to set out a comprehensive Code of Conduct for inter-organizational behaviour, as we have no legitimate grounds to speak on behalf of organizations,

3. An accountability framework in this context would necessarily need to be set at the international level to encompass the actions of the various actors within it. The focus would need to be on providing a mechanism that would ensure answerability for both the internal and external obligations of the institutions concerned. This aspect is inextricably linked to those earlier mentioned solutions to this problem; in developing an accountability framework this could ensure the upholding of an ethical framework as well as a code of conduct. In drawing the other elements together, this aspect is central to ensuring a workable solution to this issue. It is difficult to conceive of a comprehensive approach within the limitations of the international system as it currently stands.[39] A full and comprehensively developed framework is beyond the scope of the current paper but ensuring frameworks of accountability, both internal and external to the organization would be the ideal scenario. An internal framework would specify obligations and would designate roles within the organization for checking whether the organization is meeting these aims sufficiently. The ideal vision of an external framework would include an independent mechanism to ensure scrutiny of action of the organization in terms of its compliance with its internal, and its international obligations. It could also be

utilised in combination with either option one or two in ensuring compliance with an ethical framework or a code of conduct. The creation of such a mechanism would not be without its difficulties but it would show the gold standard in ensuring accountable institutional actions.

From the above, it seems that there are a minimal set of desired steps that should be carried out in the context of inter-organizational collaboration in global health.

The first step would be the comparative analysis of the values of the organizations involved including clear articulation of the values and an analysis of their convergence and divergence. Included in this is the articulation and sharing of organizational priorities that motivate the need to collaborate in the first place. A general statement of mutual respect could be developed to indicate good will between organizations. An agreed upon decision making framework that aspires to transparency and the reduction of power imbalances within the collaboration should be articulated. Finally, an accountability framework which specifies the obligations of each organization to each other should be created to respond to the answerability criterion. Ideally, such answerability would entail some form of public reporting. It would be important to include a high order statement or collective pledge to the solution of the problem over optimizing organizational imperatives. The designation of a lead organization to coordinate the activities would be desirable.

A minimal requirement is that organizations be explicit about their espoused values and that some time and effort be devoted to articulating and examining the convergence and divergence of these values prior to collaboration or interaction. This may seem a lofty ambition in the context of an emergency, but there seems be a core set of organizations and organizational phenotypes that regularly interact in global health. It would seem evident that this kind of exercise is imminently sensible and feasible providing there is political will. Determining the key agreed upon values that are agreed upon sets up the opportunity to manage difference proactively.

Conclusion

In this paper we have identified a problematic set of gaps in global governance that require urgent attention. The West African Ebola outbreak exposed current deficits with respect to governance. We have identified some avenues that could possibly mitigate some of the current problems. We invite organizations involved in global health to take up the challenge of improving global health by improving inter-organization practice.

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[21] WHO-IFRC, Cooperation between the International Federation of Red Cross and Red Crescent Societies, and the World Health Organization (Geneva, 2005) available at: http://www.who.int/hac/network/interagency/news/WHO%20IFRC%20Letter%20of%20Collaboration%20English.pdf?ua=1

[22] WHO-IMC, 'WHO - International Medical Corps (IMC) Letter of Understanding' (Geneva, 2008) available at: http://www.who.int/hac/network/interagency/imc_letter_of_understanding.pdf?ua=1

[23] WHO/AFRO-IFRCRCS, 'Memorandum of Understanding for Collaboration between the World Health Organization/AFRO and the International Federation of Red Cross and Red Crescent Societies' (Geneva, 2007) at: http://www.who.int/hac/network/interagency/news/ifrc_who_afro_11-may2007.pdf

[24] WHO, 'Basic Documents', 48th ed, (Geneva. World Health Organization, 2014) p.97

[25] Article 3.3, ibid.

[26] Article 3.5, ibid.

[27] World Health Assembly, 'Resolution WHA69.10: Framework of engagement with non-State actors' Sixty-Ninth World Health Assembly (Geneva, 2016)

[28] 5(e), ibid.

[29] Mark Eccleston-Turner & Scarlett McArdle. "Accountability"

[30] World Health Assembly, 'Resolution WHA69.10: Framework of engagement with non-State actors' Sixty-Ninth World Health Assembly (Geneva. World Health Organization 2016) at 73

[31] Kent Buse & Sarah Hawkes, "Sitting on the FENSA:WHO engagement with industry", The Lancet Vol 388 July 30, (2016) pp446-447

[32] For a discussion on the difficulty of attribution regarding international organizations see: Pierre Klein. "Attribution of Conduct to International Organizations" in James Crawford, Alain Pellet, and Simon Olleson (eds), *The Law of International Responsibility: Oxford Commentaries on International Law* (Oxford. Oxford University Press, 2010)

[33] Richard Mulgan. "Accountability : an Ever-Expanding Concept?", Public Administration 78 (2000), 555.

[34] The need for mechanisms to hold those with power accountable can be traced back to Ancient Greece. see: Diedre D. von Dornum. “The Straight and the Crooked: Legal Accountability in Ancient Greece,” Columbia Law Review 97(1997): 1483-1518.

[35] Nigel White, “Accountability and Democracy within the United Nations: A Legal Perspective,” International Relations 13(1997): 1-18; Jutta Brunnee, “International Legal Accountability through the Lens of the Law of State Responsibility,” Netherlands Yearbook of International Law 36 (2005): 3-38; International Law Association, “*Final Report of the ILA Committee on the Accountability of International Organizations”* (Berlin: ILA, 2004), http://www.ila-hq.org/download.cfm/docid/6B708C25-4D6D-42E2-8385DADA752815E8.

[36] Mark Eccleston-Turner & Scarlett McArdle. “Accountability"

[37] Kent Buse, & Sonja Tanaka, "Global Public−Private Health Partnerships: lessons learned from ten years of experience and evaluation." International dental journal 61 (2011): 2-10.

[38] See, for example, WHO Guidelines on ethical issues in public health surveillance http://www.who.int/ethics/publications/public-health-surveillance-guidelines/en/ Accessed April 2, 2018

[39] Kelsen. *Principles of International Law*