



# Why the WHO is a Critical Global Actor for Addressing Gun Violence



Global Coalition  
for WHO Action on  
Firearm Violence

# Contents

<b>Acknowledgements</b>	<b>3</b>
<b>Overview</b>	<b>4</b>
Health-system and research leadership	4
A foundation in violence prevention	5
Normative and treaty-making authority	5
WHO's place within the wider multilateral treaty and policy ecosystem	7
Proven precedents in other global health challenges	10
An integrated agenda for prevention and care	11
<b>Path to a World Health Assembly (WHA) Resolution and Action Taken Once Adopted</b>	<b>12</b>
Infographic 1: Pathway to a WHA Resolution	15
<b>Post-Passage Actions and Timeline for a WHA Resolution</b>	<b>16</b>
Evidence of WHA Resolution Impact	17
<b>Works cited</b>	<b>20</b>
Selected WHO Governance Documents for Further Reference	21
Annex: Selected Analytical Literature on WHO Governance and Decision-Making (Non-WHO Sources)	21

# Acknowledgements

This primer on the importance of the WHO for gun violence prevention and care was written by Dean Peacock for the Global Coalition for WHO Action on Firearm Violence. In addition, we thank Lawrence Gostin, Founding Director, O’Neill Institute, and Distinguished University Professor, Georgetown University, for reviewing this document and for sharing his expertise on the WHO’s governance.

# Overview

The World Health Organization (WHO) is uniquely positioned to lead global efforts to prevent and respond to gun violence because of its public-health mandate, norm-setting authority, and operational reach across nearly every country. No other UN agency combines the ability to shape international norms, strengthen national health systems, and address the full continuum of care—from prevention and early intervention to emergency response, trauma recovery, and mental-health support.

WHO is the only global body with the mandate, infrastructure, and authority to frame gun violence as a public-health crisis across this continuum of care. Within the UN system, its universal membership, extensive country presence, and power to set global health norms through the World Health Assembly (WHA) give it unmatched influence (World Health Organization [WHO], 2006).

## Health-system and research leadership

At regional and country levels, WHO supports ministries of health to strengthen trauma and acute-care systems, develop hospital-based and community-linked violence-intervention approaches, and integrate mental-health and rehabilitation services for victims, health workers, and affected communities. Through initiatives such as the Acute Care Action Network (ACAN), and through collaboration with global and national networks supporting trauma-informed and violence-responsive care, WHO provides technical standards, surveillance systems, and workforce training that can be extended to firearm injury prevention and response (WHO, n.d.-a).

WHO's leadership in mental-health promotion, suicide prevention, and rehabilitation of trauma survivors directly aligns with firearm-injury reduction. As custodian of global health data and evidence translation, WHO is also uniquely placed to support the development of monitoring systems to capture gun-violence

trends and to generate health-focused evidence that can inform and strengthen other international instruments, including the Arms Trade Treaty, the UN Programme of Action on Small Arms and Light Weapons, and relevant Human Rights Council processes.

## A foundation in violence prevention

Over the past three decades, WHO has built the world’s most comprehensive violence-prevention architecture. Its flagship frameworks—*INSPIRE: Seven Strategies for Ending Violence Against Children*; *RESPECT Women: Preventing Violence Against Women*; *LIVE LIFE: An Implementation Guide for Suicide Prevention in Countries*; and *ALIVE: Accelerating Action for Men and Boys for Gender Equality and Health*—provide an integrated, evidence-based approach to preventing interpersonal and self-directed violence across the life course (WHO, 2016a; WHO, 2019; WHO, 2021).

These initiatives already address the domains most affected by firearms, including male homicide, adolescent and youth violence, suicide, child homicide, and intimate-partner femicide. Yet firearms—the principal instrument of lethal violence in many settings—remain under-integrated across these frameworks. Men and adolescent boys account for the majority of both firearm homicide victims and perpetrators globally, particularly in regions such as Latin America, the Caribbean, and southern Africa. Embedding firearm injury prevention and response more explicitly within these frameworks would strengthen their relevance to the populations most affected while addressing one of the world’s most preventable causes of premature death and disability.

## Normative and treaty-making authority

The World Health Organization’s authority is unusually strong among UN agencies and is rooted directly in its Constitution. **Article 2** mandates WHO to act as the “*directing and coordinating authority on international health work*,” establishing a clear leadership role rather than a purely advisory one. Article 19 empowers the World Health Assembly (WHA) to adopt binding conventions or agreements on any matter within WHO’s competence, while **Articles 21 and 22**

grant the WHA quasi-legislative authority to adopt regulations—such as disease nomenclature and international health regulations—that enter into force for all Member States unless they explicitly opt out. These provisions, described by global health law scholars as *exceptional in international law*, give WHO legal powers that extend well beyond those of most international organisations (Gostin, Sridhar, & Hougendobler, 2015; Meier et al., 2020).

In practice, WHO has relied primarily on **soft-law instruments** authorised by **Article 23**, including WHA resolutions, global strategies, technical guidelines, and codes of practice. While non-binding, these instruments carry significant normative weight: they authorise Secretariat action, shape global standards, trigger reporting expectations under **Article 62**, and are frequently incorporated into national law, policy, and professional practice. Gostin and colleagues argue that WHO has under-used its formal treaty-making and regulatory powers not because of constitutional limits, but due to political caution, resource constraints, and Member State reluctance. They contend that **greater legal ambition—carefully calibrated to political feasibility—is warranted for large-scale, transboundary, and preventable harms**, with soft law often serving as a strategic entry point and potential precursor to harder norms.

For firearm violence, this constitutional toolkit is directly relevant. WHO does not need to regulate weapons or duplicate arms-control treaties to exercise authority. Rather, it can deploy its existing powers to establish global health norms for prevention, injury surveillance, and health-system response; standardise data and classification through its regulatory authority; and require regular reporting on progress. The Global Coalition for WHO Action on Firearm Violence seeks to help mobilise this under-used authority—starting with soft-law action through the WHA, without foreclosing the future use of stronger legal instruments should political conditions permit.

WHO's record of global health governance illustrates how this constitutional authority has been exercised in practice. Through instruments grounded in its Constitution—including WHA resolutions, binding conventions, and regulated engagement with

non-State actors—WHO has set global norms and coordinated action on health-harming products and practices. This includes WHA49.25 declaring violence a public-health priority, the negotiation of the Framework Convention on Tobacco Control (FCTC), and the adoption of the Framework of Engagement with Non-State Actors (FENSA), each of which demonstrates WHO’s capacity to move contested issues into the realm of health governance and sustained institutional action (World Health Organization [WHO], 2006; WHO, 2016b).

The forthcoming *World Report on the Commercial Determinants of Health* represents a further exercise of this authority, extending WHO’s normative work to examine how corporate products, practices, and marketing shape population health. By situating gun violence alongside tobacco, alcohol, and other commercially mediated harms, the report provides a platform for recognising firearm violence as a commercial determinant of ill-health and violence, and for addressing it through evidence-based public-health and regulatory approaches consistent with WHO’s constitutional mandate.

## WHO’s place within the wider multilateral treaty and policy ecosystem

The World Health Organization’s (WHO) role in addressing firearm violence must be understood within the broader landscape of international treaties and policy processes that govern weapons, crime, human rights, and development. Instruments such as the Arms Trade Treaty (ATT), the United Nations Programme of Action on Small Arms and Light Weapons (PoA), and the United Nations Firearms Protocol play essential roles in regulating international transfers, preventing diversion and illicit trafficking, and strengthening national legal and enforcement frameworks (United Nations, 2001; United Nations, 2004; United Nations, 2013). These mechanisms address the **supply, control, and legality of weapons**—functions that sit largely outside WHO’s mandate.

WHO operates in a **distinct but complementary governance space**. Its authority is grounded not in arms regulation or criminal justice, but in **health norm-setting, prevention, and health-system action**.

Where arms-control instruments focus primarily on weapons and state compliance, WHO focuses on **population-level harm, risk, and preventability**. It brings tools that other regimes do not: epidemiological surveillance of firearm injury and death (including non-fatal injury, disability, and mental-health consequences); global standards for data collection and classification; evidence-based guidance on prevention, emergency and trauma care, rehabilitation, and mental-health response; and sustained engagement with ministries of health and social sectors that are often peripheral to arms-control processes (World Health Organization [WHO], 2006; Gostin et al., 2015).

Critically, WHO strengthens **prevention upstream of violence**, rather than intervening only after harm has occurred. Through its violence-prevention frameworks, suicide-prevention guidance, alcohol-harm-reduction work, and health-equity mandate, WHO addresses the conditions under which firearms are most likely to be used lethally (WHO, 2016a; WHO, 2019; WHO, 2021). Ministries of health, education, and social development—central actors in prevention—are rarely core participants in ATT or PoA implementation, yet they bear the downstream burden of firearm violence through overwhelmed emergency services, long-term disability care, and mental-health systems. WHO brings these sectors into play, embedding firearm-violence prevention within routine public-health policy and practice.

WHO also adds value through its **normative and reporting functions**, which reinforce other multilateral efforts rather than duplicating them. World Health Assembly (WHA) resolutions, technical guidelines, and classification systems establish global health standards for injury surveillance, non-fatal harm, and health-system impact that make firearm violence visible in ways arms-control instruments do not. These data are indispensable for prevention planning and can also strengthen arms-control processes by providing independent, health-based evidence to inform risk assessments, diversion prevention, and policy evaluation under existing treaties (Gostin et al., 2015; Meier et al., 2020).

A further area of comparative advantage lies in **WHO's authority to address the marketing and promotion of health-harming products on public-health grounds**, including in cross-border and

digital environments. WHO has a long history of developing global norms on harmful marketing, including the *International Code of Marketing of Breast-milk Substitutes*, recommendations on the marketing of foods high in fat, sugar and salt to children, and guidance related to alcohol advertising and promotion (WHO, 1981; WHO, 2010; WHO, 2019). These instruments establish health-based standards that shape national regulation, professional practice, and corporate behaviour, even where domestic advertising and consumer-protection regimes are weak or fragmented.

This authority is directly relevant to firearm violence in the contemporary media environment. Firearms are increasingly marketed through **digital platforms, social media, gaming ecosystems, and influencer-driven content**, often circumventing traditional advertising rules and regulatory oversight. Evidence shows that firearms manufacturers, distributors, and lobby groups make extensive use of lifestyle branding, influencer marketing, algorithmic amplification, and youth-oriented online content to normalise weapon carrying, militarised identities, and gendered narratives of power—particularly among young men (Peacock, 2025). These practices operate transnationally, exploit regulatory gaps, and function as a **commercial determinant of firearm harm**, yet fall largely outside the scope of existing arms-control treaties and criminal-law frameworks.

WHO is uniquely positioned to address these dynamics through a health lens: by synthesising evidence on the population-level impacts of digital and influencer-based firearm marketing; by developing normative guidance on harmful marketing practices consistent with its precedents in tobacco, alcohol, and infant nutrition; and by supporting Member States to regulate online firearm promotion where it contributes to preventable injury, death, and psychological harm. In doing so, WHO's role extends beyond response and care into **primary prevention**, addressing commercial and digital practices that shape exposure, norms, and behaviour long before firearms are used.

Beyond arms-control regimes, WHO's work also intersects with and reinforces **human-rights, development, and peace and security** processes. Firearm violence undermines the right to health, the rights of women and children, and progress toward

the Sustainable Development Goals, particularly those related to health, gender equality, and reduced inequalities (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2023). WHO's normative guidance and reporting functions help translate these commitments into **measurable health outcomes**, providing a bridge between international obligations and national implementation.

In this sense, WHO does not compete with existing multilateral mechanisms; it **fills a critical governance gap**. Arms-control treaties address whether and how weapons move. WHO addresses the **conditions that turn weapons into large-scale public-health harm**, and the systems required to prevent that harm before it occurs. The Global Coalition for WHO Action on Firearm Violence seeks to strengthen this ecosystem by ensuring that WHO's constitutional authority, prevention expertise, and convening power are fully mobilised alongside existing treaties and processes. Doing so does not fragment global action on firearms—it makes it more coherent, evidence-based, and oriented toward preventing avoidable death and disability.

## Proven precedents in other global health challenges

WHO has repeatedly transformed issues once viewed as beyond the scope of public health by combining authoritative research, normative guidance, and Member State-led action. The Framework Convention on Tobacco Control confronted a politically powerful industry and contributed to substantial reductions in global tobacco use. WHO's leadership during the HIV/AIDS crisis catalysed treatment access, financing mechanisms, and global norms around universal access to care. Its sustained work on alcohol harm reduction, violence against children (VAC), and violence against women (VAW) has reshaped how these issues are understood and addressed—moving them from social or criminal domains into evidence-based public-health frameworks, national action plans, and international accountability mechanisms.

Similarly, WHO's research and normative guidance on the marketing of breast-milk substitutes helped establish global standards to protect infant and maternal health, influencing legislation and

practice in countries worldwide. Across malaria, road safety, maternal and child health, and nutrition, WHO has demonstrated how rigorous evidence synthesis, guideline development, and World Health Assembly resolutions can shift policy, mobilise resources, and drive measurable health gains even in politically contested environments.

Taken together, these precedents demonstrate WHO's capacity to combine scientific authority, coalition-building, and political strategy to elevate complex and contested issues as mainstream global-health priorities. Firearm violence—like tobacco, alcohol, interpersonal violence, and unsafe commercial practices—fits squarely within this tradition of WHO leadership.

## An integrated agenda for prevention and care

Gun violence undermines nearly every WHO mandate—from gender equality and child protection to mental health, poverty reduction, and education. Integrating firearm violence across WHO's prevention frameworks and its work on social and commercial determinants of health would mobilise governments, civil society, and researchers around a multisectoral response that recognises the disproportionate toll borne by men and boys while addressing the gendered harms experienced by women and children.

In short, the WHO's reach, legitimacy, and scientific authority make it indispensable to global firearm-violence prevention. By embedding gun violence across its proven violence-prevention frameworks and regulatory agenda, WHO can catalyse a coordinated global effort to save lives, reduce inequities, and strengthen health systems worldwide.

# Path to a World Health Assembly (WHA) Resolution and Action Taken Once Adopted

This section outlines the pathway through which a proposed resolution advances within WHO governance processes prior to adoption at the World Health Assembly.

## GOVERNANCE NOTE: HOW WHA RESOLUTIONS ENTER THE AGENDA

Under the Rules of Procedure of the World Health Assembly, any WHO Member State may propose agenda items and draft resolutions, including preliminary text. Executive Board membership is not required to sponsor a resolution. Proposed items are reviewed through established governing-body processes, and the Executive Board recommends items for inclusion on the provisional agenda of the World Health Assembly following technical, legal, and financial review. Final consideration, negotiation, and adoption of resolutions takes place at the World Health Assembly (WHO, 2020; WHO, 2023a).

The pathway illustrated in infographic 1 below shows how these governance rules operate in practice, from initial Member State sponsorship through Executive Board review to adoption by the World Health Assembly.

**1**

**Early Stage: Concept and Coalition Building:** Any WHO Member State may draft and sponsor a resolution, often drawing on technical input from WHO departments, researchers, and civil-society partners. Successful initiatives typically secure co-sponsorship across multiple regions. Draft concepts are

commonly developed with informal technical input from relevant WHO departments, including those working on social determinants of health, violence prevention, injury surveillance, and governance processes. Civil-society organisations may engage through WHO's Civil Society Commission, regional offices, and permanent missions in Geneva.

**2**

**Regional Committee Review (August–October):** Each of the six WHO Regional Committees—Africa (AFRO), the Americas (PAHO/AMRO), South-East Asia (SEARO), Europe (EURO), Eastern Mediterranean (EMRO), and Western Pacific (WPRO)—reviews proposed agenda items and draft texts. Regional endorsement builds cross-regional legitimacy and significantly increases the likelihood of advancement to the Executive Board stage.

**3**

**Executive Board (EB) Consideration – January Session:** The 34-member Executive Board (EB) reviews and approves items to be included in the WHA agenda. The EB session held in January each year is decisive. The EB examines draft resolutions for technical soundness, financial implications, and consistency with WHO's General Programme of Work (GPW). An October preparatory session may preview proposals. The Secretariat supporting this process is the Department of Governing Bodies (GBS) within WHO's Governance and Multilateral Affairs Division.

**4**

**Intergovernmental Negotiation and Revision (February–April):** Following Executive Board recommendation, Member States engage in informal consultations facilitated by sponsoring missions and WHO's Legal Office. Negotiations address operative language, financing implications, and linkages to existing resolutions. Drafts are refined through informal consultations and prepared for consideration by WHA Committee A.

**5**

**Formal Tabling at the World Health Assembly (May Session):** The WHA convenes annually in May. The resolution is introduced in Committee A (responsible for programme and policy matters), debated, amended, and adopted—usually by consensus. If consensus cannot be achieved, the WHA may vote, though this is rare. Once adopted, it becomes a formal expression of the Assembly's will.

**6**

**Adoption and Implementation:** Following adoption, the WHO Secretariat integrates the resolution's mandates into its Programme Budget and issues a Director-General's report to track progress. Relevant departments lead implementation, with oversight by the Executive Board. Follow-up reports are typically presented two to three years later.

**7**

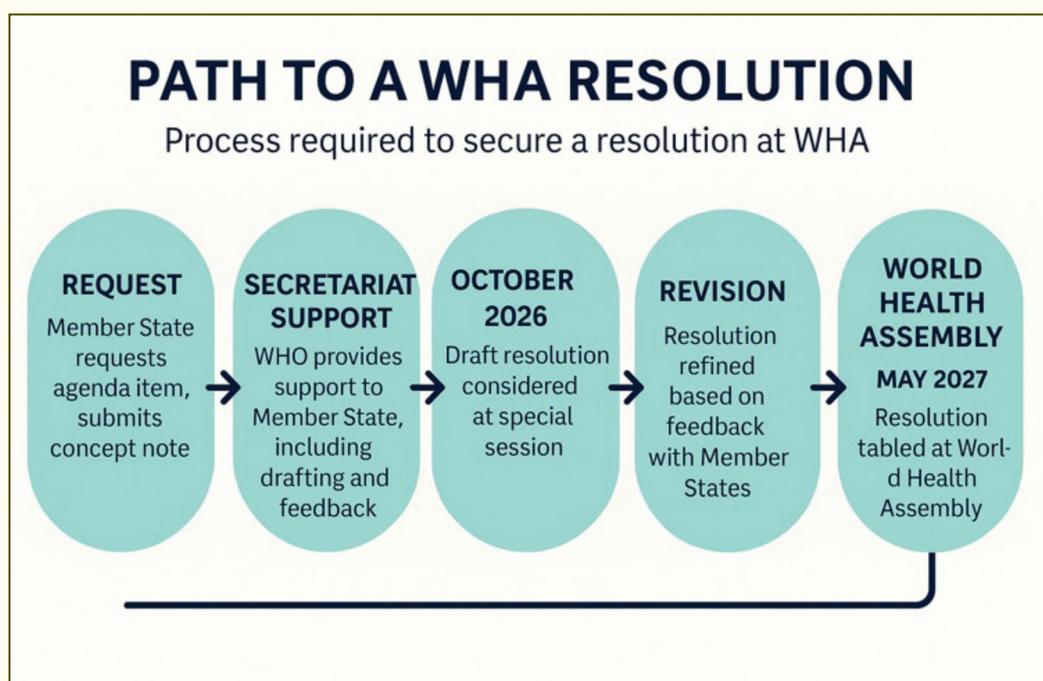
**Post-Adoption Steps:** Implementation involves coordination between WHO headquarters, regional offices, and Member States. Civil society organisations continue to play a monitoring role, ensuring accountability for the resolution's commitments.

### **Engagement of non-State actors and official relations with**

**WHO:** In addition to Member State leadership, WHO maintains a formal and regulated mechanism for engagement with non-State actors through *official relations*, governed by the Framework of Engagement with Non-State Actors (FENSA). Non-State actors in official relations include international professional associations, civil-society organisations, foundations, and academic networks with sustained global relevance and technical expertise.

Entities granted official-relations status enter into time-bound collaboration plans, typically covering three-year periods, and are subject to Executive Board review and annual reporting. While non-State actors do not have decision-making authority and cannot table or vote on resolutions, those in official relations may contribute technical expertise, participate in consultations and technical meetings, support implementation of WHO norms and guidelines, and engage transparently with WHO governing processes (WHO, 2016b; WHO, n.d.-b).

PERIOD	STAGE	KEY ACTORS
Mar–Aug 2026	Draft concept and secure sponsors	Health ministries, WHO Violence Unit, civil society
Aug–Oct 2026	Regional Committee endorsements	Regional Committees and Member States
Oct 2026	Executive Board preparatory session	EB members, Secretariat
Jan 2027	Executive Board approval	Executive Board (34 States)
Feb–Apr 2027	Informal negotiations and revision	Sponsoring missions, WHO Legal Office
May 2027	World Health Assembly adoption	All 194 Member States
2026–2028	Implementation and follow-up reports	WHO Secretariat, Member States, civil society



Infographic 1: Pathway to a WHA Resolution

# Post-Passage Actions and Timeline for a WHA Resolution

This document provides an overview of the mandatory steps taken by the World Health Organization (WHO) following the adoption of a World Health Assembly (WHA) resolution. It also includes evidence on the impact of past WHA resolutions and two infographics illustrating the process and timeline for post-passage actions.

**1**

## Mandatory Steps Following WHA Resolution Adoption

**0-3  
months-  
Formal  
Entry into  
Record:**

After adoption, the resolution is assigned a WHA number and entered into the Official Records of WHO. It is published online in all six UN languages and circulated to all Member States, regional offices, and relevant WHO departments. The Governing Bodies Secretariat (GBS) issues notifications, often accompanied by a Director-General circular.

**3-9  
months-  
Secretariat  
Planning and  
Integration:**

The Director-General assigns a lead technical department, which drafts an implementation plan or framework for action. The Programme, Budget and Administration Committee (PBAC) reviews financial implications, and integration into the Programme Budget follows.

**12-24  
months-  
First Report  
to Executive  
Board:**

The Director-General submits a report on progress in implementing the resolution, usually within 12-24 months, under the EB's regular agenda. The report details actions, outputs, and funding status.

**24–36  
months-  
Follow-up  
Reporting to  
WHA**

A consolidated report is presented to the WHA, summarising implementation progress across regions and proposing next steps. This may include new strategies or indicators for Member State reporting.

**3–5  
years-  
Follow-up  
Reporting to  
WHA Evaluation  
and Impact  
Review:**

WHO may establish global mechanisms or indicators to track ongoing implementation, with results reported every 2–4 years.

## Evidence of WHA Resolution Impact

Multiple WHO evaluations and independent analyses demonstrate that World Health Assembly (WHA) resolutions can produce durable policy, institutional, and normative effects—particularly when accompanied by implementation plans, reporting requirements, and sustained resources. Reviews of WHO governance and reform consistently find that resolutions are most influential when they catalyse normative guidance, mandate follow-up reporting, and are embedded within WHO’s General Programme of Work and programme budgets (World Health Organization [WHO], 2020; Irwin & Smith, 2019; Moser et al., 2022).

Illustrative examples include:

- **WHA49.25 (1996) and WHA56.24 (2003)**, which established violence as a public-health priority and led to the *World Report on Violence and Health*, the consolidation of WHO’s violence-prevention functions, and sustained Member State reporting on interpersonal violence and injury (WHO, 2002; WHO, 2003).
- **WHA69.5 (2016)** on strengthening the role of the health system in addressing violence, particularly against women and girls, and **WHA74.17 (2021)** on violence against children, which reinforced the integration of VAW and VAC within WHO normative guidance,

country programming, and accountability frameworks such as *INSPIRE* and *RESPECT*, and strengthened multisectoral prevention and response approaches across regions (WHO, 2016a; WHO, 2021a).

- **WHA57.10 (2004)** on road safety, which helped catalyse legislative reform and national action in more than 100 countries and contributed to the establishment of sustained global coordination mechanisms, including the UN Road Safety Collaboration (WHO, 2015).
- **WHA56.1 (2003)**, which authorised negotiation of the WHO Framework Convention on Tobacco Control (FCTC), demonstrating how a WHA resolution can initiate binding international law and contribute to substantial long-term reductions in tobacco use through coordinated global and national action (WHO, 2003; WHO, 2021b).
- **WHA66.8 (2013)** on the *Comprehensive Mental Health Action Plan*, which advanced the integration of mental health into universal health coverage strategies in more than 80 countries and established routine WHA reporting on national progress (WHO, 2013; WHO, 2022).
- **WHA78.1 (2025)** on the *effects of nuclear war on public health*, which reaffirmed nuclear weapons as a legitimate and urgent public-health concern and requested WHO to update and report on the health consequences of nuclear war and nuclear weapons. This resolution illustrates WHO's continued engagement with issues at the intersection of geopolitics, security, and health, and its capacity to sustain normative leadership on politically sensitive global risks over time (WHO, 2025).

While WHA resolutions are non-binding, evidence from WHO evaluations and independent scholarship shows that their influence is greatest when political commitment, financing, and institutional capacity align, and when resolutions are supported by structured follow-up reporting and integration into WHO's General Programme of Work (WHO, 2020; Moser et al., 2022).



## Works cited

---

- Gostin, L. O., Sridhar, D., & Hougendobler, D. (2015). The normative authority of the World Health Organization. *Public Health*, 129(7), 854–863.
- Irwin, R., & Smith, R. (2019). *Rituals of global health: Negotiating the World Health Assembly*. *Global Public Health*, 14(2), 161–174.
- Meier, B. M., Taylor, A., Eccleston-Turner, M., Habibi, R., Sekalala, S., & Gostin, L. O. (2020). The World Health Organization in global health law. (4), 796–799.
- Moser, F., Clinton, C., & McNamara, K. (2022). Assessing the *World Health Organization: What does the reform literature say?* ***Social Science & Medicine*, 301**, 114961.
- United Nations. (2001). *Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects*. United Nations.
- United Nations. (2004). *Protocol against the illicit manufacturing of and trafficking in firearms, their parts and components and ammunition*. United Nations.
- United Nations. (2013). *Arms Trade Treaty*. United Nations.
- Office of the United Nations High Commissioner for Human Rights. (2023). *Impact of arms transfers on human rights*. United Nations.
- Peacock, D. (2025). *Understanding and countering gender-exploitative marketing of weapons and war*. Unpublished desk review prepared for multilateral consultation, Geneva.
- World Health Organization. (1981). *International code of marketing of breast-milk substitutes*. WHO.
- World Health Organization. (2002). *World report on violence and health*. WHO.
- World Health Organization. (2003). *WHA56.1: WHO framework convention on tobacco control*. WHO.
- World Health Organization. (2006). *Constitution of the World Health Organization* (47th ed.).
- World Health Organization. (2016a). *INSPIRE: Seven strategies for ending violence against children*.
- World Health Organization. (2016b). *Framework of engagement with non-State actors (FENSA)*.
- World Health Organization. (2019). *RESPECT women: Preventing violence against women*.
- World Health Organization. (2020). *Basic documents* (49th ed.).
- World Health Organization. (2021). *LIVE LIFE: An implementation guide for suicide prevention*.
- World Health Organization. (2023a). *Rules of procedure of the World Health Assembly*.
- World Health Organization. (n.d.-a). *Acute Care Action Network (ACAN)*.
- World Health Organization. (n.d.-b). *WHO Register of non-State actors*.

# Selected WHO Governance Documents for Further Reference

---

- WHO Constitution
- WHO Basic Documents (49th edition)
- Rules of Procedure of the World Health Assembly (WHA)
- Rules of Procedure of the Executive Board
- Framework of Engagement with Non-State Actors (FENSA)
- WHO General Programme of Work (GPW 13: 2019–2025)
- WHA49.25 – Prevention of violence: a public health priority (1996)

## Annex: Selected Analytical Literature on WHO Governance and Decision-Making (Non-WHO Sources)

---

This annex lists key peer-reviewed and scholarly analyses of the World Health Organization's governance, authority, and decision-making processes. These sources complement official WHO documents by examining how formal rules operate in practice, including the political, diplomatic, and institutional dynamics that shape agenda-setting and implementation.

- Gostin, L. O. (2015). The normative authority of the World Health Organization. Georgetown Law Faculty Publications.
- Kickbusch, I., & Liu, A. (2022). Global health diplomacy—Reconstructing power and governance. *The Lancet*, 399(10338), 2156–2166.
- Irwin, R., & Smith, R. (2019). Rituals of global health: Negotiating the World Health Assembly. *Global Public Health*, 14(2), 161–174.
- Moser, F., Clinton, C., & McNamara, K. (2022). Assessing the World Health Organization: What does the reform literature say? *Social Science & Medicine*, 301, 114961.



# Global Coalition for WHO Action on Firearm Violence

To join or request more  
information:

[info@whoaction.org](mailto:info@whoaction.org)  
[www.whoaction.org](http://www.whoaction.org)