



Making One Health work: Communication, co-ordination and governance

Stronger systems don't emerge during crises – they are built through sustained co-ordination, communication and governance long before the crisis arrives

One Health in context

For those working in global health, One Health is not primarily a technical agenda: it is a **governance challenge**. It relates to how institutions with different mandates, incentives and accountability lines communicate, build capacity, collaborate and co-ordinate to manage shared risk.

Many major health challenges – including maternal, newborn and child health outcomes, health security, antimicrobial resistance (AMR), climate and health, and non-communicable diseases – are shaped by risks that cut across human, animal, plant and environmental systems. Without **formal co-ordination mechanisms**, collaboration remains ad hoc and collapses under pressure. One Health provides a framework to institutionalize communication and co-ordination, making multisectoral action more routine than reactive. In practice, co-ordination can take different forms, depending on the context: dedicated One Health platforms, or issue-specific mechanisms that bring relevant sectors together, such as AMR co-ordination structures or National Action Plan for Health Security (NAPH) processes.

This framing aligns with the '4 Cs' that are commonly used in One Health learning and evaluation – communication, capacity building, collaboration and co-ordination – with governance providing the enabling conditions that allow these to function together in practice.

Why it matters

- Many failures to address cross-sectoral challenges stem from **poor co-ordination, not a lack of evidence**.
- Early warning signals often exist but **fail to trigger action across sectors**.
- Informal relationships are fragile; governance structures that enable co-ordination and collaboration endure.
- Multisectoral co-ordination is now embedded in international commitments on **health security and AMR**.
- These are areas where those working in global health already focus – even when this work is not labelled as "One Health".

Practical examples

- **'One Health Governance in Bangladesh: Translating Multisectoral Strategies into Coordinated Action'**. This case study documents Bangladesh's efforts to institutionalize One Health through national-level governance arrangements that bring together human, animal and ecosystem health actors. Rather than relying on crisis-driven collaboration, the approach focuses on formal co-ordination mechanisms, shared planning processes and sustained political engagement. The case study highlights both progress and persistent challenges, which include maintaining momentum, clarifying roles across ministries, and ensuring co-ordination translates into operational action.
- **'Toward the Institutionalization of a One Health Agenda: What the World can Learn from Bangladesh'**. Complementing the case study above, this analysis focuses explicitly on institutionalization: how One Health moves from strategy to durable governance practice. It shows that sustained co-ordination requires time, political commitment, and repeated negotiation across sectors. Progress in this case was uneven and non-linear, reinforcing the lesson that governance reform is a long-term process rather than a technical fix.
- **'Towards Institutionalization of One Health in Eastern and Southern Africa'**. This regional case study examines how countries have attempted to formalize One Health co-ordination through platforms, strategies and cross-sector mechanisms. It illustrates common governance bottlenecks: unclear mandates, weak resourcing, variable sub-national uptake, and dependence on external funding. The case study is valuable precisely because it shows why institutionalization is difficult, and why co-ordination often remains fragile when there is a lack of strong government ownership.

Common challenges in practice

- **Unclear authority.** No single institution is empowered to convene and make decisions.
- **Competing mandates** between ministries and agencies.
- **Co-ordination without teeth.** Meetings where information is shared but where action cannot be enforced.
- **Political and leadership turnover**, disrupting continuity.
- **Donor-driven fragmentation**, even where co-ordination is supported rhetorically.
- **Weak sub-national translation** of national co-ordination frameworks.

Factors needed to make these approaches work

- **Formal mandates.** Co-ordination platforms anchored in policy or government decisions are more resilient than informal or voluntary arrangements.
- **Problem-driven co-ordination.** Collaboration is stronger when it is built around concrete shared risks (e.g. zoonoses, AMR) rather than abstract One Health principles.
- **Dedicated co-ordination capacity.** Secretariats or focal points matter – co-ordination does not happen without dedicated resources.
- **Continued political backing.** Institutionalization depends on sustained leadership support, not one-off endorsements.
- **Realistic expectations.** Governance reform is iterative and contested; progress is measured in years, not project cycles.

Possible entry points for those working in global health

- **Engaging with and strengthening existing platforms.** Where One Health, zoonoses or AMR co-ordination mechanisms exist, those working in global health may contribute health perspectives and, in some contexts, help identify opportunities to broaden participation or build on existing structures.
- **Advocating for cross-sectoral approaches to shared risks.** In settings where co-ordination is limited, there may be opportunities to highlight how risks – such as AMR, food safety or climate-related health impacts – cut across sectors and where more joined-up approaches could be beneficial.
- **Supporting alignment of sectoral initiatives.** Programmes across health, agriculture or environment may benefit from being linked to existing co-ordination mechanisms, where these exist.
- **Encouraging shared interpretation of evidence.** Joint review of surveillance findings or risk assessments can help build shared situational awareness across sectors.
- **Recognizing sub-national dynamics.** Many co-ordination challenges emerge at provincial or district levels, where there are interactions between the operations of different actors.

Want to know more?

Contact CABI's One Health Hub Team | h.coskeran@cabi.org

Key resources:

- **'One Health Explainer'** – <https://www.cabi.org/cabi-publications/one-health-explainer/>
- **'One Health Governance in Bangladesh: Translating Multisectoral Strategies into Coordinated Action'** – https://virtual-learning-center.fao.org/pluginfile.php/262489/mod_page/content/12/Abu%20Sufian%20presentation%20.pdf (National governance and institutionalization case study). Available via the FAO One Health Virtual Learning Centre (requires joining the Community of Practice for access).
- **'Toward the Institutionalization of a One Health Agenda: What the World Can Learn from Bangladesh'** – <https://www.cabidigitallibrary.org/doi/10.1079/onehealthcases.2024.0018> (National case study / institutional learning case)
- **'Towards institutionalization of One Health in Eastern and Southern Africa'** – <https://doi.org/10.1079/onehealthcases.2024.0007> (Multi-country programme case study / learning case study)

This brief was produced under the auspices of the One Health Hub, managed by CABI with funding from UK International Development from the UK government. The views expressed do not necessarily reflect the UK government's official policies.