October 2023

Brot für die Welt | GPF Global Policy Forum | misereor ALLY FOR A JUST WORLD

A pandemic of voluntarism

The increasing fragmentation of the global health architecture through ever new multi-stakeholder initiatives

by Karolin Seitz

National and regional go-it-alone efforts characterized government action against the COVID-19 pandemic. The guidance of the World Health Organization (WHO), as the overarching and coordinating health body, to ensure equitable and efficient distribution of vaccines and other necessary medical products to contain the pandemic was not heeded. Several governments, philanthropic foundations, and the WHO launched the global multi-stakeholder initiative (MSI) Access to COVID-19 Tools Accelerator (ACTA) at short notice, with participation of pharmaceutical industry and other MSIs, as a key global mechanism to contain the pandemic. However, ACT-A fell far short of not only its distribution goals, but also its coordination aspirations. Rather, ACT-A contributed to further fragmentation of the global health architecture. åNow that the pandemic has been mitigated, various global health actors are working out proposals how to address future pandemics. These proposals include greater corporate involvement in multilateral processes and the creation of new global multi-stakeholder initiatives. Yet the problems associated with increasing fragmentation and multi-stakeholder initiatives have long been recognized. They include impeded coordination of activities, duplication of efforts, funding competition among initiatives and with WHO, undermining of WHO's expertise, isolated solutions, and difficulties of external monitoring and follow-up. Many of the initiatives failed to achieve their goals, not least because of their voluntary nature. Instead of continuing to rely on the principle of voluntary commitments, governments and companies need to be made more accountable. This briefing examines the state of the global health architecture and makes suggestions for strengthening it.

The uncoordinated COVID-19 response in a fragmented global health landscape

When the European Commission, the French government, and the Bill & Melinda Gates Foundation, together with WHO, announced the creation of the Access to COVID-19 Tools Accelerator (ACT-A) on April 24, 2020, the stated goal of the multi-stakeholder initiative was to coordinate the response to the COVID-19 pandemic among the many actors in the face of a highly fragmented global health architecture. At that time, there were already a multitude of mostly parallel and under-coordinated MSIs involving international organizations, the private sector, and civil society working together to address communicable diseases and health crises, including COVID-19.[1]

ACT-A comprises four areas ("pillars"): Diagnostics, Therapeutics, and Vaccines pillars, as well as the cross-cutting Health Systems pillar. Each pillar is led by 2-3 participating institutions. In addition, WHO is leading a cross-cutting Access and Allocation workstream. The COVAX facility, which forms the vaccine pillar of the initiative, has emerged as a central element of ACT-A. COVAX is jointly led by CEPI, Gavi, and WHO. UNICEF is responsible for logistics. The basic idea was to create a global initiative to support the development of COVID-19 vaccines through upfront agreements

1 For example, the Global Alliance on Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the Coalition for Epidemic Preparedness and Innovation (CEPI), the Medicines Pantent Pool (MPP), the Multilateral Leaders Task Force on COVID-19, the International Coordination Group on Vaccine Provision. See also https://covid19response.org/#overview

BRIEFING

with pharmaceutical companies, and to distribute the vaccines to all countries in the world, whether they can pay for them or not. COVAX was to be responsible for the joint procurement and equitable distribution of COVID vaccines, based on a Fair Allocation Framework developed by WHO.

ACT-A as a whole relied on a voluntary commitment both by governments, which were to procure vaccines via COVAX and at the same time finance the COVAX system for economically weaker countries, and by pharmaceutical companies, which were to supply vaccines to the world via COVAX at fair prices. The belief that "the pandemic is not over until it is over for everyone" should guide global solidarity and cooperation. However, of the 17.5 billion doses of vaccine agreed to be delivered worldwide by the end of 2021, COVAX accounted for only 16 percent (2.8 billion). Rich countries secured the rest bypassing COVAX through bilateral supply agreements. Pharmaceutical companies supplied these before fulfilling their commitments to COVAX.

With ACT-A, meanwhile, the center of global corona crisis management shifted from WHO to a multi-stakeholder initiative with its own complex governance and decision-making structure.[2] Here, WHO was only one of several partners alongside global multi-stakeholder partnerships.[3] However, ACT-A fell far short not only of its distribution targets but also of its coordination ambition, and came under criticism for its poor governance and lack of transparency. As a result, ACT-A contributed to further fragmentation of the global health architecture.

Boom in multi-stakeholder initiatives, weakening of the WHO, and further consequences of the fragmentation

ACT-A and COVAX were not the first MSIs to marginalize WHO in key decision-making. Since the late 1990s, central tasks of public health policy and their financing have increasingly been outsourced from the WHO to so-called multi-stakeholder initiatives and partnerships. The reasons given for this were, on the one hand, weaknesses in the functioning of WHO or in the sometimes cumbersome and slow system of the United Nations (UN) itself, while, on the other hand, MSIs were considered to be more effective and efficient, based on market-based solutions, privatization, and involving private actors, in line with neoliberal ideology.[4] Cumbersome multilateral coordination processes between states could be circumvented within MSIs. Particularly during the tenure of WHO Director-General Gro Harlem Brundtland, WHO became involved in an increasing number of private-public partnerships. By doing so, WHO expected not only to mobilize additional financial resources, but also to gain more political attention and relevance.

Since then, new MSIs and actors have been added to the global health landscape and have gained influence. Steven Hoffman and Clarke Cole of the Institute for Global Health Research at York University counted over 203 actors in global health as early as 2018, including 17 global, mostly disease-focused (vertical) public-private initiatives and partnerships.[5] The Bill & Melinda Gates Foundation (BMGF) is behind many MSIs, having initiated them. It is not only a financial supporter, but also plays a major role in determining their fate through its own seat on the initiatives' board of directors.

But as Dr. Djamila Cabral, WHO representative in Angola, describes, such one-sided and single-diseases-focused approaches often lead to duplication of effort:

"Funding focused on specific diseases tends to duplicate efforts and creates fragmentation. With more direct support, WHO can leverage the resources essential to reach the most vulnerable people and contribute to realizing the Organization's mandate."[6]

The many new players in global health have not only undermined the authority of WHO, but also compete with it financially – including with regard to its activities to combat the COVID-19 pandemic. As of December 2022, WHO still lacked USD 436.5 million to fully implement its COVID-19 Strategic Preparedness and Response Plan.[7] At the same time, increasing competition for scarcer funding is also evident among the various MSIs. ACT-A, for example, was severely underfunded, too,

2 See Martens (2022).

3 GAVI, CEPI, the Foundation for Innovative New Diagnostics (FIND), GFATM, Unitaid, other multilateral organizations (UNICEF, PanAmerican Health Organization, and the World Bank), and some of the largest private foundations (Wellcome Trust and Bill & Melinda Gates Foundation).

4 Pantzerhielm/Holzscheiter/Bahr (2019) und Spicer/ Agyepong et al. (2020)

5 Brown/Cueto/Fee (2006) und Hoffman/Cole (2018)

6 WHO (2022), p. 22

7 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donors-and-partners/funding

and long-established MSIs such as GAVI and the GFATM are facing diminishing funding as well. As the number of MSIs increases, this situation will continue to worsen.

The WHO has had a chronic funding problem for years. While member states have approached the organization with an increasing number of tasks in recent decades, they have at the same time provided it with hardly any additional resources for this purpose. Since 1993, compulsory national contributions to the WHO have essentially been frozen.[8] WHO depends in large part on voluntary funding from a few large member states of the global North, such as the United States, Germany, the United Kingdom, the EU, Canada, and private foundations, most notably the Bill & Melinda Gates Foundation. Only about 16 percent of the 2020–2021 biennial budget was covered by predictable and flexible mandatory contributions from member countries.[9] Much of the voluntary funding is earmarked, which allows donors to dictate to WHO what it must use it for. As a result, WHO is often more of an implementation and service organization than a governance organization.[10] Consequently, a lot of money has gone to just a few programs, while other programs, such as rapid response capacity or WHO's work on non-communicable diseases, have remained underfunded.[11] Although WHO received more funding than originally planned for in 2020–2021, the funding gap for organizational budget positions at the output level was about USD 600 million. WHO also started a USD 2.7 billion funding appeal in early 2022 to support people worldwide in special crisis situations.[12] However, the need was not met. In the end, the organization received only about USD 1.7 billion in donations for emergency relief.[13] In May 2023, the 76th World Health Assembly (WHA) approved a 20 percent increase in mandatory contributions for WHO's 2024–2025 biennial budget. This is an important first step toward more sustainable and independent financing of the organization, but it will not be enough to fully fund the WHO's diverse tasks.

However, the fragmentation of the health landscape is not only accompanied by a weakening of the WHO. Whether donor countries, development banks, MSIs, private foundations, or NGOs, each actor has its own interests, sets different priorities, uses different methods and financing instruments, and demands different reporting from recipient countries and organizations. The consequences are increased transaction costs, more difficult coordination, conflicting or duplicated activities, and areas of responsibility that remain underfunded. In addition, there is the difficulty of externally monitoring and accompanying all the initiatives with all their own structures – by NGOs, but especially by governments themselves. The COVID-19 pandemic has reversed progress toward achieving the health-related Sustainable Development Goals. But even before the Corona crisis, progress was slow. Dr. Tedros Adhannom Ghebreyesus, WHO Director-General, attributed the failure in part to fragmentation in the global health architecture:

"(…) the reality is, we're off track to achieve these ambitious goals by 2030. Fragmentation, duplication and inefficiency are undermining progress." [14]

Risks of multi-stakeholder initiatives

Previous experience with global multi-stakeholder initiatives, even beyond the health sector, shows that they are accompanied by a whole range of challenges and risks: [15]

1. **Growing influence of business interests:** Critics warn that under the umbrella of partnership initiatives, the influence of transnational corporations and their stakeholders on the discourse, agenda setting, and policy decisions of governments is growing. They gain co-decision-making power over the use of public funds, too.
2. **Conflicts of interest:** In many MSIs, implementing institutions and recipients of financial support are often also members of the bodies that determine the allocation of funds. Even in non-financial but coordinating

8 WHO Doc. EB/WGSF/7/INF./1, p. 1, online: https://apps.who.int/gb/wgsf/pdf_files/wgsf7/WGSF_7_INF1-en.pdf
9 WHO (2022), S. 7
10 Handrieder (2020)
11 Gostin/Chirwa et al. (2023), p. 3 and WHO Doc. EB/WGSF/7/INF./1, online: https://apps.who.int/gb/wgsf/pdf_files/wgsf7/WGSF_7_INF1-en.pdf
12 https://www.who.int/emergencies/funding/outbreak-and-crisis-response-appeal
13 WHO (2023a)
14 WHO (2018)
15 See Martens/Seitz (2017)

MSIs, for example, companies are given co-decision-making power over the regulation/management of their own sometimes problematic business and political practices.

3. **Depoliticization of debates:** In this context, global challenges in global health, among others, are often depoliticized by ignoring and displacing the underlying structural causes, the different interests of the actors involved (profit vs. public welfare-oriented interests), and regulatory solutions, such as the removal of intellectual property rights on vaccines, medicines, and other medical commodities to contain the COVID-19 pandemic. Instead, the principle of voluntary commitment, the charity approach, medical technology and market-based solutions continue to be upheld.
4. **Institutional fragmentation and weakening of the UN:** Many global partnerships have started with the claim to promote coordination and coherence in their respective areas of responsibility. Instead, however, they have tended to contribute to further fragmentation of the global institutional structure. Moreover, they weaken UN institutions by competing with them for financial and human resources as well as competencies. In the MSIs, the UN and governments are only one partner among many and no longer have a coordinating role.[16]
5. **Insufficient funding:** One main argument for many multi-stakeholder initiatives is that additional funding could be mobilized by involving private actors. However, practice to date shows that this is only the case to a limited extent. In particular, hopes for additional funding from the private sector have not yet been fulfilled, with a few exceptions (including the Gates Foundation).
6. **Lack of transparency and accountability:** Many MSIs lack valid monitoring mechanisms. As a result, the actual fulfillment of pledges and their effects are difficult to track. It can be assumed that some partnerships were deliberately set up outside the UN's intergovernmental structures for this very reason, in order to avoid all too rigid supervision and control.
7. **Donor dominance:** Many MSIs are aligned with the priorities of donors, whether private or public, while alignment with the needs of the recipient (countries), such as strengthening public health systems and local production capacities for medicines, is often poor.[17] The involvement of civil society actors is also often insufficient.

Initiatives against fragmentation

The problem of fragmentation in the global healthcare architecture has been known for years. Regular efforts have therefore been made at various levels to counter it. These include, for example, the International Health Partnership+ (IHP+, transformed to UHC2030 in 2016) and the Health Systems Funding Platform (2012). In some cases, however, the measures that were intended to lead to harmonization and interorganizational alignment exacerbated fragmentation.[18] A telling example is the Joint United Nations Programme on HIV/AIDS (UNAIDS), which evolved from a coordinating mechanism for all UN agencies and programs dealing with HIV/AIDS to a stand-alone institution in 1994, and eventually to a competitor with other UN agencies.[19]

One of the more recent attempts to counter fragmentation stems from the initiative of then German Chancellor Angela Merkel, Ghanaian President Nana Addo Dankwa Akufo-Addo, and former Norwegian Prime Minister Erna Solberg. The Global Action Plan for healthy lives and well-being for all (GAP) was launched in 2019 by WHO Director-General Tedros Adhanom Ghebreyesus. It aimed to support countries in implementing health-related SDG3 through improved coordination among different actors. Thirteen intergovernmental health and development organizations and MSIs were involved.[20]

WHO's own 2023 progress report presents a mixed outcome of the GAP. While there have been some successes, particularly with regard to new coordination structures, the authors make clear that the

16 Hanrieder (2020)
17 Syam (2023)
18 Pantzerhielm/Holzscheiter/Bahr (2019) and Holzscheiter (2015)
19 Shridar (2012) and Holzscheiter (2015), p. 8/9
20 The SDG3 GAP members are GAVI, Global Financing Facility, International Labor Organization (ILO), Globale Fonds UNAIDS, UNDP, UNFPA, UNICF, Unitaid, UN Women, The World Bank, WFP, and WHO. See also https://www.who.int/initiatives/sdg3-global-action-plan

commitments made by the various GAP members to improve coordination have been moderately well implemented at the country level.[21] One reason for this, they say, is a lack of mechanisms for states to hold GAP members accountable.[22] In addition, the GAP initiative has shown major weaknesses since its inception when it comes to engaging civil society actors. According to the WHO evaluation, the IHP+ initiative faced exactly the same problems.

The civil society alliance "**Watch the GAP!**" attests to the total failure of the GAP in view of the uncoordinated solo efforts of the its members during the COVID-19 pandemic:

"COVID-19 could have been the (early) test case for the GAP – not in the sense of it already being fully implemented, but of demonstrating a stronger spirit of cooperation and alignment. The GAP agencies have failed this test."

The failure of the ACT-A multi-stakeholder initiative

The Access to COVID-19 Tools Accelerator (ACT-A) with its four pillars (Vaccines, Diagnostics, Therapeutics, Health Systems, and Access and Allocation), its Vaccine Facility COVAX, its Health Systems and Response Connector (HSRC), and its COVID-19 Vaccine Delivery Partnership (CoVDP) represented a renewed effort to coordinate the COVID-19 responses of the various multilateral organizations, MSIs, and private foundations, many of which are GAP members. Katerini Storeng et al. of the University of Oslo attest to ACT-A's quality as a so-called "super public-private partnership" because of its coordinating role across multiple MSIs.[23] However, ACT-A fell far short of its coordination claim.

An external evaluation of ACT-A of 2022 commissioned by WHO acknowledges the initiative's success in raising additional funds, but criticizes a long list of shortcomings.[24] These include an overly top-down approach in which low- and middle-income countries and civil society groups were not adequately involved.

However, the external evaluators, civil society groups and academics are particularly critical of the governance of the initiative, which allowed large (private) donors and companies too much influence and ultimately decision-making power over the use of the billions collected (largely public), while governments played a diminishing role.[25] The external evaluators criticize a lack of coordination among members and with regional platforms; lack of clarity about who is accountable to whom; lack of transparency in decision-making, resource allocation, and reporting; an informal and overall overly complex structure.[26] The MSIs involved (e. g. GAVI and the GFATM) often acted as both co-decision-makers on distribution and recipients of funds, raising questions about conflicts of interest. In addition, the various pillars of ACT-A competed for funding. The COVAX vaccine facility was the most successful, while the health system strengthening pillar remained severely underfunded. In total, ACT-A raised USD 24.2 billion in donations.[27]

According to Doctors Without Borders, the failure of ACT-A and COVAX demonstrated the fundamental problems of the public-private partnership (or MSI) model, which often involves market-based approaches to solutions.[28] The Advance Market Commitment (AMC) approach used by COVAX, in which pharmaceutical companies are subsidized to produce drugs for specific diseases that are particularly prevalent in low- and middle-income countries, was doomed from the start. The assumption that demand for drugs or vaccines might be insufficient or too uncertain and therefore not attractive to manufacturers did not hold true in the case of COVID-19. The problem with COVID-19 vaccines was excess demand, not incentivizing vaccine manufacturers.

Unlike other UN organizations, the WHO has a framework of rules for cooperation with so-called non-state actors (Framework of Engagement with Non-State Actors, FENSA). However, FENSA has some weaknesses.[29] It is unclear in what way regulations from FENSA, such as risk analyses prior to partnerships with the private sector, were followed in the context of MSI during the COVID-19

21 WHO (2023b)
22 Ibid., p. 16
23 Storeng/de Bengy Puyvallée/Stein (2021), p. 12
24 Open Consultants (2022)
25 See Moon/Amstrong et al. (2022) and https://www.politico.com/news/2022/09/14/global-covid-pandemic-response-bill-gates-partners-00053969
26 Open Consultants (2022), p. 33
27 https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker
28 https://msfaccess.org/covax-broken-promise-world
29 https://www.twn.my/title2/health.info/2019/hi190406.htm and Seitz (2016)

crisis. This is because FENSA (paragraph 73) grants WHO flexibility during crisis situations. The WHO Director-General must report on this for such an eventuality, which has not been done so far.[30] Therefore, urgent improvements to FENSA and strict enforcement are needed.

Pandemic Fund, Global Health Threats Council and Medical Counter Measures Platform – No Lessons for the Future?

In light of the many national go-it-alone efforts during the corona pandemic, the WHO Director-General launched a renewed attempt for coordination in 2022. In his report "**Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience**" presented during the 75th WHA, he makes ten proposals to strengthen the global health architecture with regard to future pandemics and to counteract the fragmentation of initiatives.

However, the proposals contain several contradictions.[31] On the one hand, the WHO Director-General calls for strengthening the WHO, but at the same time he calls for promoting multi-stakeholder initiatives and providing funding under the Pandemic Fund (**Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response**, or PPPR), which was established under the World Bank in September 2022. The goal of the Pandemic Fund is to mobilize additional resources for long-term investment and technical assistance for pandemic prevention, preparedness, and response at the country, regional, and global levels, with a particular focus on low- and middle-income countries.

WHO, along with 12 other organizations including the World Bank, FAO, UNICEF, GAVI, and the GFATM, are among the implementing organizations and are eligible to apply for resources from the Fund.[32]

At the country level, the Fund specifically aims to strengthen disease surveillance, laboratory systems, emergency communications, pandemic coordination, pandemic management, and health worker capacity. At the regional and global levels, the Fund will support, among other things, reporting and information sharing, harmonization, regulations, and the coordinated development, procurement, distribution, and delivery of medical countermeasures and supplies. Where appropriate, the Fund will support the development of medicines and vaccines, too.[33]

Since its inception in September 2022 through February 2023, funding commitments of USD 1.6 billion had been made. This still leaves the Fund far short of its goal of raising USD 10.5 billion annually and providing long-term and predictable funding.[34]

During the COVID-19 pandemic, public funding for health was increased by countries worldwide. But now national budgets for health spending and Official Development Assistance (ODA) are under massive pressure as a consequence of inflation and high debt burdens in many countries.[35] Many MSIs are also facing funding constraints because, unlike the WHO with its – albeit small – mandatory government contributions, they depend exclusively on voluntary funding commitments for a few years at a time.

In such a tense context, the Pandemic Fund thus becomes another competitor to WHO for scarce public funds for global health. It remains to be seen whether the money raised for the Pandemic Fund is truly new and additional funding for global health, or whether it comes at the expense of contributions to WHO. According to the **Pandemic Action Network**, of the 22 funding pledges made by countries through July 2023, only three can so far be considered as actual additional funds to ODA. Three of the pledges made are clearly part of existing ODA. For the remaining funding pledges, no information has yet been provided in this regard.

The described functions of the Pandemic Fund make it clear that it will have a major impact on the various PPPR areas at the national, regional, and global levels. The Pandemic Fund must strictly adhere to WHO standards and guidance in all its activities and not develop parallel standards. In addition to funding, the Fund must not risk competing with WHO for its coordinating role and contribute to increased fragmentation.

30 https://www.twn.my/title2/health.info/2023/hi230203.htm
31 https://twn.my/title2/health.info/2023/hi230107.htm
32 https://www.worldbank.org/en/topic/pandemics/brief/factsheet-financial-intermediary-fund-for-pandemic-prevention-preparedness-and-respon
33 Ibid.
34 See a detailed critique of the FIF by Dentico/Aye/Meurs (2022), p. 6–12
35 World Bank (2023)

In the governance of the pandemic fund, WHO so far plays a subordinate role, since unlike the Bill & Melinda Gates Foundation, for example, it has no decision-making power over the allocation of funds, but only an observing, advisory and implementing role. The WHO Council on the Economics of Health for All, among others, called for a more significant role for WHO in the Fund:

"(…) as WHO represents 194 countries and plays a central role in supporting PPR globally, it is imperative that it also has a central role to play in all aspects of the FIF. This means WHO should not only be a technical advisor or operator, but also a decision-making member of the Governing Board." [36]

In addition, some countries called for the FIF to report to the WHA.[37]

The WHO Secretary-General's ten proposals also include a **Global Health Emergency Council.** A similar Global Health Threats Council, independent of WHO, had already been proposed by the **Independent Panel for Pandemic Preparedness and Response** (IPPPR). The panel concluded that WHO would not be competent enough to successfully manage future pandemics, and therefore, it had proposed a body completely independent of WHO and health ministers. The council would take the form of a MSI and be based at UN General Assembly in New York, with a membership of heads of government and high-level non-governmental representatives. However, civil society critics, including **Ilona Kickbusch** of the Graduate Institute of International and Development Studies Geneva, doubt the added value of such a council proposed by the IPPPR and fear that it would create another parallel structure in the global health architecture and further weaken the WHO. Finally, the proposed council would not only act independently of the WHO and other UN institutions, but would even be hierarchically above it. As an alternative, Kickbusch supports the WHO Secretary-General's proposal for a WHO-based forum for high-level representatives of governments and other relevant international organizations that would complement the World Health Assembly and the recently created EB Standing Committee on Health Emergency Prevention, Preparedness and Response (PPPR). During the January 2023 meeting of the WHO Executive Board, the WHO Secretary-General's proposal was met with skepticism by some member states, particularly because of the still unclear functioning and the risk of duplicating the work of other bodies.[38]

Another coordination attempt by the WHO Secretariat is the creation of a so-called "**Medical Counter Measures Platform**". Until new institutions are established under the future pandemic agreement or the revision of the **International Health Regulations** (IHR), the platform shall replace ACT-A and take over transitional coordination for access to medical products in health emergencies. It is envisioned that the platform will become operational in the fall of 2023, with support from some major donors.[39] Currently, there is still uncertainty about the governance form, funding, and functions of the platform. In addition, the question of its legitimacy has not yet been clarified. This is because, so far, there are no plans to involve the WHA in the decision on the establishment of the platform.[40] The Third World Network assesses the initiative as an attempt by WHO to circumvent the intergovernmental decision-making process:

"While the stage is set for the IHR [International Health Regulations] amendment and pandemic instrument negotiations are in progress this initiative of WHO is effectively an attempt to bypass the intergovernmental process." [41]

In mid-May 2023, the DEVEX news platform received a document stating that the Medical Counter Measures Platform would be chaired by a steering group of 25 members with representatives from member states, international and regional organizations, civil society organizations, and the private sector.[42] There are weaknesses in the platform's involvement of low- and middle-income countries,

36 https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/council-statement_19april2022.pdf?sfvrsn=6df1673f_3&download=true

37 https://genevahealthfiles.substack.com/p/the-fragmentation-in-emergencies?utm_source=post-email-title&publication_id=79396&post_id=72214725&isFreemail=true

38 https://healthpolicy-watch.news/new-10-point-who-proposal-for-reforming-global-emergency-response-gets-mixed-review/

39 In particular, the EU, USA, Norway, Canada, Japan, India, Rwanda, Botswana, South Africa, private foundations and MSIs, see https://genevahealthfiles.substack.com/p/a-new-medical-countermeasures-platform

40 https://genevahealthfiles.substack.com/p/medical-countermeasures-platform

41 https://genevahealthfiles.substack.com/p/a-new-medical-countermeasures-platform

42 https://www.devex.com/news/exclusive-who-s-pandemic-countermeasures-plan-takes-shape-105451

which were hardly included in the consultations on the platform's design.[43] At the moment, it looks as if the platform is a reincarnation of the ACT-A multi-stakeholder initiative. However, it is questionable whether lessons will be learned from the ACT-A experience with regard to the list of shortcomings.

Outlook: From voluntary commitments to binding international law!

Governments, WHO and other actors have recognized the problem of fragmentation in global health policy and its consequences for achieving healthy lives for all. However, as the example of the proposal to create a Global Health Threats Council, the Medical Countermeasures Platform, and the newly created Pandemic Fund at the World Bank show, new institutions continue to be created outside of WHO in the form of MSIs. Although governments emphasize the role of WHO as a coordinating authority and its strengthening, the Pandemic Fund has been located outside of WHO at the World Bank. The Global Health Threats Council is to be established independently of WHO, too. Both ultimately lead to a further loss of competencies of WHO and thus to an undermining of its authority as a multilateral decision-making body.

Unlike the World Bank, the G7, the G20 or global multi-stakeholder initiatives, WHO is a multilateral UN organization in which all UN member states are represented with one vote each and health policy measures can be discussed between states and decided multilaterally. Equal involvement creates ownership and accountability of all governments for the decisions and actions taken, ultimately increasing the effectiveness of global health policy in achieving a healthy life for all. There is no alternative international institution for these tasks. The decision of the WHA in May 2023 to increase the share of assessed contributions of countries to the WHO budget by 20 percent for 2023–2034 will further strengthen the ownership of all countries. However, the currently discussed replenishment mechanism (or "investment round") for voluntary contributions to WHO jeopardizes this positive development, as it would strengthen earmarked funding of WHO instead of untied contributions.[44] The WHO would thus again lose its hard-won financial independence from the priorities of major donors and, ultimately, its credibility and authority.

Moreover, despite the serious criticisms of ACT-A's management, governments and international organizations do not appear to have learned any lessons regarding the governance form of new decision-making bodies on measures against future pandemics. In particular, high-income governments are sticking to a multi-stakeholder model for the new Medical Counter Measures Platform, a Global Health Threats Council, and the governance of the Pandemic Fund.

Instead of continuing to rely on the principle of voluntary commitment, creating more and more new MSIs, and building parallel structures, governments and WHO should return to regulation as their core governance tool. They should fulfill their duty under international law to respect, protect and guarantee human rights through appropriate legislative measures. In the governance of global health, a "soft law" approach – based on voluntarism and non-binding incentives – has been the main approach adopted to date.[45] While legally binding international agreements exist, particularly in the area of trade and investment protection, in which states are taken to arbitration courts in the event of a breach of contract and sanctioned, for example, with a suspension of trade benefits, legally binding international agreements in the area of health with such sanction options in the event of violations do not yet exist. However, they are overdue. The International Health Regulations (IHR) are indeed binding and provide for the possibility of resorting to arbitration in the event of violations, too. But in fact, this dispute resolution mechanism is voluntary for states and thus ultimately a paper tiger, which has not been applied to date either.[46] From a civil society perspective, a more mandatory approach includes the following measures, which the German government should advocate at the various political levels:

» **A stronger binding commitment by governments at the international level in health crises:** Under the pandemic treaty, governments should make a **binding commitment to globally equitable access to essential medical products and sharing of**

43 https://genevahealthfiles.substack.com/p/medical-countermeasures-platform
44 https://twn.my/title2/health.info/2023/hi230503.htm
45 Gostin/Chriwa et al. (2023)
46 See Hoffman/Habibi et al. (2022) and Huang (2020).

data and technologies and know-how, and designate clear responsibilities. Ownership of products, such as patent rights, must be regulated for public health and made accessible to all, in particular those most in need. Especially in the case of global health crises, such as the COVID-19 pandemic, the removal of patent protection on medicines must be made possible. The Medical Counter Measures Platform and any follow-up mechanism created by the pandemic treaty for the distribution of medical products must have a binding character.

» **Mandatory regulation of companies rather than voluntary commitments under MSI for equitable access to medicines:** Governments should not leave it up to companies to whom they sell essential medicines and technologies, how much of them they produce, and whether they share the knowledge to produce them. Particularly where public money has been invested, companies should be required to be transparent about the costs of research, development, and production of medicines and technologies, and transparent about pricing. Public money must have conditions attached to it for universal access to these products, too. In addition, governments should work for the early adoption of an **ambitious agreement, binding under international human rights law** requires companies to respect human rights as well as environmental and climate protection in their business activities worldwide and provides access to justice for people affected by corporate human rights abuses.

» **Commit to health crisis prevention and universal health coverage:** In line with the One Health approach, governments should not only strengthen preparedness and response capacity to future health crises, but commit to their prevention, too. In the area of agricultural production and food systems, a fundamental transformation toward sustainable food production systems is essential for this.[47] Adequate funding for the WHO's climate program and the proposal by the governments of Kenya and Ghana for a UN resolution on climate and health would be an important step toward implementing the One Health approach. In addition, governments must do more to protect biodiversity.

» Taking preventive action means further **strengthening local public health systems** to ensure universal access to quality health services, especially for underserved and poor populations ("Leave No One Behind"), and focusing on intersectoral, horizontal approaches such as Primary Health Care. Governments must allocate their national health budgets accordingly. This can only succeed if **fundamental changes are made to the global financial architecture** that give governments greater domestic financial leeway. This includes, among other things, the creation of a UN tax convention for cooperation in international tax policy and the introduction of an international and independent state insolvency procedure to deal with debt crises.

» **Increase accountability and transparency of governments and intergovernmental organizations:** Only with a strong enforcement mechanism will the pandemic treaty and other health agreements be effective. Such mechanisms could include financial penalties for violating countries, exclusion from treaty bodies, and revocation of trade privileges, as is the case with the World Trade Organization. The dispute settlement mechanism for violations of the IHR should be strengthened and made binding on States Parties.[48] The treaty bodies of UN human rights treaties, with their regular reporting requirements for States Parties and review by independent technical committees, can serve as a model for robust accountability mechanisms for health agreements as well.[49] The Universal Health & Preparedness Review mechanism presented during the 75th WHA is already moving in the right direction. However, it should not be grounded on a voluntary basis, but should be mandatory for WHO member states.

» **Involving and strengthening the voice of civil society organizations**, especially local actors and groups from the Global South, is essential as they hold governments and influential actors in global health accountable for their (non-)actions. Such involvement and empowerment of civil society groups requires, among other things, transparency of intergovernmental processes and includes sufficient speaking time during, for example, the WHA or other processes, as well as involvement in planning,

47 See Seitz (2021).

48 See Hoffmann et al. (2022) and Huang (2020).

49 The specialized committees are empowered to make recommendations to governments (Concluding Observations) and to prepare General Comments. Some are allowed to conduct urgent procedures and early warning procedures, as well as their own investigations.

governance, implementation and review of multilateral agreements such as the future pandemic treaty, modeled on the WHO Framework Convention on Tobacco Control (FCTC).[50] In this process, civil society actors with a public interest must be given a different role than private sector interest groups. Instead, the implementation of the treaty and other international agreements must be protected from commercial interests.[51] **Involving parliaments and communities** is a mechanism to increase democratic scrutiny of the promises and actions of governments and global actors, too.

» **Increase accountability to public institutions and transparency of MSIs and other influential actors in global health:** This requires a comprehensive legal and institutional framework for multi-stakeholder partnerships to ensure that the risks and side effects of partnerships with private actors described above are avoided. This framework must include rules for dealing with and avoiding conflicts of interest, decision-making and management structures that are independent of private donors, independent evaluations of impacts, and well-equipped institutions to follow up on actors' commitments and enforce the framework. Conceivably, an intergovernmental body could be established to address UN-private sector relations and the design and monitoring of partnership initiatives on an ongoing basis.[52] Before UN agencies and programs or individual governments even enter into new partnership relationships, the potential impact should be systematically assessed. This should include a review of the added value that the initiatives bring to the achievement of the UN's goals, how to assess the relationship between the risks and side effects and the expected benefits, and what alternatives exist.

50 See https://g2h2.org/wp-content/uploads/2023/04/Civil-Society-in-PPPR-Governance-Research-Report-Final.pdf
51 See WHO FCTC, Article 15.3, online https://fctc.who.int/publications/i/item/9241591013
52 See in more detail Martens/Seitz (2017), p. 58, 59.

Literature

Brown, Theodore M. /Cueto, Marcos / Fee, Elizabeth (2006): The World Health Organization and the Transition From "International" to "Global" Public Health. American Journal of Public Health 96, 62–72, online at: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2004.050831

Dentico, Nicoletta / Aye, Baba /Meurs, Mariska (2022): Financial Justice for Pandemic Prevention, Preparedness and Response. G2H2 Report, online at: https://g2h2.org/wp-content/uploads/2022/11/G2H2-Report-2022.pdf

Gostin, Lawrence O. / Chirwa, Danwood Mzikenge et al. (2023): The WHO's 75th anniversary: WHO at a pivotal moment in history. BMJ Global Health 2023;8:e012344, online at: https://gh.bmj.com/content/8/4/e012344

Handrieder, Tine (2020): Priorities, Partners, Politics. The WHO's Mandate beyond the Crisis. Global Governance: A Review of Multilateralism and International Organizations, 26(4), 534–543, online at: https://brill.com/view/journals/gg/26/4/article-p534_2.xml

Hoffman, Steven J. / Cole, Clarke, B. (2018): Defining the global health system and systematically mapping its network of actors. Global Health. 2018 Apr 17;14(1):38, online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5904998/

Hoffman, Steven / Habibi, Roojin et al. (2022): Mending Dispute Resolution under the International Health Regulations. International Organizations Law Review, 19(1), 241–268, online at: https://brill.com/view/journals/iolr/19/1/article-p241_009.xml?language=en

Holzscheiter, Anna (2015): Restoring order in global health governance: Do metagovernance norms affect interorganizational convergence? CES Papers-Open Forum 2014–2015 #23, online at: https://aei.pitt.edu/67186/1/CES_OFWP_23.pdf

Huang, Jie (2020): Can Trade Dispute Resolution Mechanisms Enhance State Compliance with International Health Regulations? Insights from MARPOL 73/78, ASIL Insights, Volume: 24 Issue: 8, online at: https://www.asil.org/insights/volume/24/issue/8/can-trade-dispute-resolution-mechanisms-enhance-state-compliance

Martens, Jens (2022): Globale Impfgerechtigkeit. Schlüssel zur Lösung der COVID-19-Pandemie. Bonn: GPF, online unter: https://www.globalpolicy.org/sites/default/files/GPF_Globale_Impfgerechtigkeit.pdf

Martens, Jens/Seitz, Karolin (2017): Globale Partnerschaften. Wundermittel zur Umsetzung der 2030-Agena? Bonn: Global Policy Forum Europe, online at: https://www.globalpolicy.org/de/publication/globale-partnerschaften

Moon, Suerie / Amstrong, Jana et al. (2022): Governing the Access to COVID-19 Tools Accelerator: towards greater participation, transparency, and accountability. Lancet 2022; 399 (10323): 487–494, online unter: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02344-8/fulltext

Open Consultants (2022): External Evaluation of the Access To COVID-19 Tools Accelerator (ACT-A), online at: https://www.who.int/publications/m/item/external-evaluation-of-the-access-to-covid-19-tools-accelerator-(act-a)

Pantzerhielm, Laura / Holzscheiter, Anna / Bahr, Thurid (2019): Governing effectively in a complex world? How metagovernance norms and changing repertoires of knowledge shape international organisation discourses on institutional order in global health. Cambridge Review of International Affairs, 35:4, 592–617, online at: https://www.tandfonline.com/doi/full/10.1080/09557571.2019.1678112

Seitz, Karolin (2016): FENSA – a fence against undue corporate influence? Brot für die Welt/GPF/Misereor, online at: https://www.globalpolicy.org/en/publication/fensa-fence-against-undue-corporate-influence

Seitz, Karolin (2021): Ways out of the global health crisis. Healthy people, healthy animals and a healthy environment worldwide with the One Health approach. Brot für die Welt/GPF/Misereor, online at: https://www.globalpolicy.org/en/publication/ways-out-global-health-crisis

Shridar, Devi (2012): Coordinating the UN System: Lessons from UNAIDS: A commentary on Mackey, Social Science & Medicine 76, (2012): 21–23, online at: https://www.sciencedirect.com/science/article/abs/pii/S0277953612007071

Spicer, Neil / Agyepong, Irene et al. (2020): 'It's far too complicated': why fragmentation persists in global health. Global Health 16, 60 (2020), online at: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00592-1

Storeng, Katerini / de Bengy Puyvallée, Antoine / Stein, Felix (2021): COVAX and the rise of the 'super public private partnership' for global health. Global Public Health, Volume 0, Issue ahead-of-print, online at: https://www.tandfonline.com/doi/epdf/10.1080/17441692.2021.1987502?needAccess=true&role=button

Syam, Nirmalya (2023): Leading and Coordinating Global Health: Strengthening the World Health Organization. Research Paper 174. South Centre, online at: https://www.southcentre.int/wp-content/uploads/2023/02/RP174_Leading-and-Coordinating-Global-Health-Strengthening-the-World-Health-Organization_EN.pdf

World Bank (2023): From Double Shock to Double Recovery, online at: https://www.worldbank.org/en/topic/health/publication/from-double-shock-to-double-recovery-health-financing-in-the-time-of-covid-19

WHO (2018): Towards a Global Action Plan for Healthy Lives and Well-Being for All, online at: https://www.who.int/publications/i/item/WHO-DCO-2018.3

WHO (2022): A healthy return: investment case for a sustainably financed WHO, (S.22), online at: https://www.who.int/about/funding/invest-in-who/investment-case-2.0

WHO (2023a): WHO's Health Emergency Appeal (Annex 2), online at: https://www.who.int/emergencies/funding/outbreak-and-crisis-response-appeal/impact-in-2022

WHO (2023b): 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All, online at: https://www.who.int/initiatives/sdg3-global-action-plan/progress-and-impact/progress-reports/2023

Imprint

A pandemic of voluntarism

The increasing fragmentation of the global health architecture through ever new multi-stakeholder initiatives

Publishers:

Bischöfliches Hilfswerk MISEREOR e. V.
Mozartstraße 9, 52064 Aachen,
Germany
info@misereor.de
www.misereor.de
Contact: Klaus Schilder

Brot für die Welt
Evangelisches Werk
für Diakonie und Entwicklung e. V.
Caroline-Michaelis-Straße 1, 10115 Berlin,
Germany
info@brot-fuer-die-welt.de
www.brot-fuer-die-welt.de
Contact: Mareike Haase

Global Policy Forum Europe e.V.
Königstraße 37a, 53115 Bonn,
Germany
europe@globalpolicy.org
www.globalpolicy.org
Contact: Jens Martens

Author: Karolin Seitz

Editorial assistance: Mike Gardner, Mareike Haase, Klaus Schilder, Ellen Schmitt, Julia Stoffner

Layout: www.kalinski.media

Aachen / Berlin / Bonn, October 2023