

176

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Where Does Global Health Funding Come From and Where Does It Go?

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 **SOUTH
CENTRE**

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ABSTRACT

In theory, the World Health Organization (WHO) is the coordinating agency for global health. Influential private and public actors have claimed the relevance and central role of this United Nations (UN) agency. In practice, paradoxically, the money budgeted for health goes largely to other institutions and not to the WHO. New institutions and mechanisms have been created to which funds are channeled (GAVI, The Global Fund, Act-A, CEPI, COVAX, etc.). These institutions or mechanisms are, in most cases, public-private partnerships where the pharmaceutical industry is usually present. Official Development Assistance is important but represents only 1 per cent of what developing countries' expenditure on health. How much is spent to promote global health and where this money goes is the subject of this paper. After the experience with COVID-19, a fundamental question that must be addressed is how the global public interest can be preserved by creating common public goods and protecting human rights in the prevention, preparedness, and response to present and future pandemics.

En teoría la OMS es la agencia coordinadora de la salud mundial, y los grandes actores, privados y públicos, reivindican la relevancia y el rol central de esta agencia de Naciones Unidas. En la práctica, paradójicamente, los dineros para la salud van en gran parte a otras instituciones y no a la OMS o incluso se crean nuevas instituciones o mecanismos donde se canalizan los nuevos fondos (GAVI, Fondo Mundial, Act-A, CEPI, COVAX etc.). Estas instituciones o mecanismos son, en la mayoría de los casos, partenariados público-privados donde está presente la industria farmacéutica. La Ayuda Oficial para el Desarrollo es importante pero sólo representa el 1% de lo que invierten los países en desarrollo en salud. En qué se gasta para promover la salud global y a dónde va este dinero es el objeto de este documento. Una de las preguntas que debemos hacernos tras la experiencia con COVID-19 es cómo vamos a preservar el interés público global mediante la creación de bienes públicos comunes y la protección de los derechos humanos en las actividades de prevención, preparación y respuesta a las pandemias presentes y futuras.

En théorie, l'Organisation mondiale de la santé (OMS) est l'agence de coordination de la santé mondiale. Des acteurs privés et publics influents ont revendiqué la pertinence et le rôle central de cette agence des Nations unies (ONU). Dans la pratique, paradoxalement, l'argent prévu pour la santé est largement alloué à d'autres institutions et non à l'OMS. De nouvelles institutions et de nouveaux mécanismes ont été créés vers lesquels les fonds sont canalisés (GAVI, The Global Fund, Act-A, CEPI, COVAX, etc.). Ces institutions ou mécanismes sont, dans la plupart des cas, des partenariats public-privé dans lesquels l'industrie pharmaceutique est généralement présente. L'aide publique au développement est importante, mais elle ne représente que 1 % des dépenses de santé des pays en développement. Le présent document s'intéresse à la somme dépensée pour promouvoir la santé mondiale et où va cet argent. Une question fondamentale doit être posée après l'expérience du COVID-19 : comment pouvons-nous préserver l'intérêt public mondial en créant des biens publics communs tout en protégeant les droits de l'homme dans le cadre de la prévention, de la préparation et de la riposte aux pandémies actuelles et futures ?

TABLE OF CONTENTS

INTRODUCTION	1
1. BACKGROUND	3
2. ORIGINAL WHO FUNDING MODEL (1948-1998)	3
3. HOW WHO REGIONAL OFFICES ARE FUNDED	5
3.1 <i>The Unique Case of the Regional Office for the Americas: Blended Funding</i>	5
4. KOFI ANNAN'S GLOBAL COMPACT IN THE UNITED NATIONS	5
5. PROGRESSIVE PRIVATIZATION OF WHO: INFLOW OF PRIVATE, PHILANTHROPIC AND VOLUNTARY PUBLIC FUNDS OUTSIDE THE REGULAR BUDGET	8
6. OFFICIAL DEVELOPMENT ASSISTANCE (ODA) FOR HEALTH.....	10
7. THE CREATION OF PARALLEL HEALTH-RELATED AGENCIES	13
7.1 <i>UNAIDS 1996</i>	13
7.2 <i>From the Expanded Program on Immunization (EPI) to the GAVI</i>	13
7.3 <i>The Global Fund to Fight AIDS, Tuberculosis and Malaria</i>	14
7.4 <i>UNITAID</i>	15
7.5 <i>Medicines Patent Pool (MPP)</i>	16
7.6 <i>Coalition for Epidemic Preparedness Innovations (CEPI)</i>	16
7.7 <i>COVAX – 2021</i>	17
8. THE WHO FOUNDATION	18
9. THE WHO SUSTAINABLE FINANCING WORKING GROUP	20
9.1 <i>Decision Approved by the 75th WHA</i>	20
10. THE WORLD BANK'S FINANCIAL INTERMEDIARY FUND (FIF) FOR PANDEMIC PREVENTION, PREPAREDNESS, AND RESPONSE.....	22
10.1 <i>Objectives and Functions of the World Bank's FIF</i>	22
10.2 <i>Comments and Reactions to World Bank Reports on the FIF</i>	23
CONCLUSIONS	25

INTRODUCTION

At the beginning of the COVID-19 pandemic in 2020, many of us, including Mariana Mazzucato, thought that this was the opportunity to use the crisis “to understand how to build a different capitalism. This implies rethinking about the purpose of governments. Instead of merely correcting market failures when they arise, they should move on to actively shaping and creating markets that generate inclusive sustainable growth. They should also ensure that partnerships with companies that receive public funding are motivated by the public interest, not profit”.²

Mazzucato's optimism is tempered with her analysis that “the prominent role of business in public life has also led to a loss of confidence in what government alone can accomplish. This, in turn, has given rise to many problematic public-private partnerships, which prioritize corporate interests over public interests. For example, it is well documented that public-private partnerships in research and development often favor ‘bestsellers’ at the expense of drugs with less commercial appeal but which are very important to public health, such as antibiotics and vaccines...”³

Unfortunately, the handling of COVID-19 in 2021 and 2022 confirmed that Mazzucato's concerns were true despite her warning that stressed: “Large public funding for health care innovation requires governments to be at the helm of the process of making sure that prices are fair, patents are not abused, drug supply is guaranteed, and profits are reinvested in innovation rather than diverted to shareholders.”⁴ Today we know that prices were neither transparent nor fair, that the supply of vaccines was inequitable, and that the intellectual property exemption requested by developing countries at the World Trade Organization (WTO) came too late and did not meet expectations. Furthermore, we still have no evidence on whether companies that were given large public subsidies⁵ and made huge profits⁶ are reinvesting in innovation.

Already in 2020, some individuals argued “that for a response to the current health and economic crisis to be effective, it must be guided by the values of international solidarity, multilateralism, and equality.”⁷ What we know today is that this did not happen.

But the large public funding granted to vaccine producers is just one example of how “generous” some states can be at a specific time. This paper goes further and explores where the money that developed countries spend on global health comes from and where it goes.

² Mariana Mazzucato, *No desaprovechemos esta crisis. Lecciones de la COVID-19*, (ED. Galaxia Gutenberg, Barcelona, 2022).

³ Mariana Mazzucato op. cit.

⁴ Mariana Mazzucato op. cit.

⁵ See Katuska King Mantilla and César Carranza Barona, *COVID-19 Vaccines as Global Public Goods: Between Life and Profit*, Research Paper No. 154 (Geneva, South Centre, 9 May 2022). Available from <https://www.southcentre.int/research-paper-154-9-may-2022/>.

⁶ According to second-quarter financial data recently released by the companies themselves, it is estimated that “Moderna has billed more than \$6 billion in revenue so far, of which \$4.3 billion would be net profit, or a 69 per cent margin from vaccine sales. Moderna expects to achieve total vaccine sales of \$20 billion by the end of 2021.” (OXFAM, “A pesar de los beneficios de las grandes farmacéuticas gracias a las vacunas del COVID-19 los impuestos que pagan son bajos”, 15.09.21 <https://www.oxfamintermon.org/es/nota-de-prensa/beneficios-grandes-farmac%C3%A9uticas-vacuna-covid19-pagan-bajos-impuestos>).

⁷ Muhammad Zaheer Abbas, *Practical Implications of Vaccine Nationalism: A Short-Sighted and Risky Approach in Response to COVID-19*, Research Paper No. 124 (Geneva, South Centre, November 2020). Available from <https://www.southcentre.int/research-paper-124-november-2020/>.

We will see how, despite the fact that in major crises (HIV/AIDS, Ebola, COVID-19) the rhetoric of strengthening the WHO prevails, in practice the money goes to other institutions or is even used to create new institutions to manage the health crisis of the moment. We will also analyze what the Official Development Assistance represents and how it is used in the field of health.

1. BACKGROUND

In April 1945, during the Conference for the Establishment of the United Nations (UN) held in San Francisco, representatives of Brazil and China proposed the creation of an international health organization and the convening of a conference to draft its constitution. A Preparatory Technical Committee met in Paris from 18 March to 5 April 1946, and developed proposals for a constitution in response to this initiative. The Conference on International Health convened in New York, from 19 June to 22 July 1946, drafted and adopted the Constitution of the World Health Organization, which was signed on 22 July 1946 by representatives of 51 UN members and 10 other nations.

The Constitution entered into force on 7 April 1948, when 26 of the 61 signatory governments ratified it.⁸

As Nirmalya Syam points out, the objectives of the WHO Constitution were very progressive and laid the groundwork for addressing public health problems from a socioeconomic and developmental point of view to strengthen health systems in countries lacking them; he explicitly recognized uneven development in public health.⁹ However, as Syam discusses in his paper, since the 1980s, this role of WHO has been increasingly undermined with the emergence of new institutions and funding mechanisms in global health.

2. ORIGINAL WHO FUNDING MODEL (1948-1998)

The original WHO funding model was based on assessed contributions from member countries. These contributions are the fees that countries pay to become members of the Organization. The amount to be paid by each Member State is calculated on the basis of the country's wealth and its population."¹⁰

The scale of regular assessed contributions that each of the 196 Members and Associate Members must annually pay to WHO is calculated by the United Nations¹¹ based primarily on the country's GDP and its number of inhabitants. The World Health Assembly, on the basis of assessed contributions, approves the budget every two years.

Regular contributions are a key source of funding for the Organization, providing predictable funding, helping to minimize dependence on donors, and allowing resources to be aligned with the Program Budget.

Initially, since its creation in 1948, WHO relied on regular assessed contributions from its Member States to finance its regular budget. A budget based mainly on regular contributions

⁸ History of WHO, <https://www.who.int/about/history>.

⁹ Nirmalya Syam, *Leading and Coordinating Global Health: Strengthening the World Health Organization*, Research Paper No. 174 (Geneva, South Centre, February 13, 2023). Available from <https://www.southcentre.int/research-paper-174-13-february-2023/>.

¹⁰ WHO, "Cómo se financia la OMS", available from <https://www.who.int/es/about/funding>.

¹¹ This is explained by the fact that WHO is a Specialized Agency of the United Nations.

from the Member States allowed, in principle, for an independent and democratically decided priority setting with the participation of the Member States.

However, regularly assessed contributions have declined dramatically as an overall percentage of the Program Budget over the past 30 years and currently represent only 16 per cent of the Organization's funding.¹²

In the late 1980s (during the administration of H. Nakajima, 1988-1998), the WHO World Health Assembly,^{13 14} at the initiative of the United States and other industrialized countries, agreed on the practice of "zero real growth" of the regular budget. This policy remained in place for several decades until the 2022 World Health Assembly. The Organization was thus forced to increasingly resort to raising additional voluntary contributions, known as extrabudgetary funds (EBFs). Between 1998 and 2003 (during the Gro Harlem Brundtland administration), the real value of EBFs exceeded the regular budget, which had never happened before. All WHO programs, except the Assembly and the Executive Board, received EBFs.¹⁵

Article 57 of the WHO Constitution of 1948 states that "the Health Assembly, or the Board acting for and on its behalf, may accept and administer gifts and bequests made to the Organization, provided that the conditions to which they are subject are acceptable to the Health Assembly or the Board and are consistent with the purpose and policy of the Organization."¹⁶ This very general article does not specify the origin of donations, nor does it limit their amounts. Presently, this has allowed the Organization to face the mentioned budgetary deficit (the Organization's regular public contributions are only 16 per cent of the total). Can we still talk about a public international agency for the stewardship of global health?

Since Article 57 places no limit on the amount that an individual donor may contribute, there is the risk that an entity, even a philanthropic one, may become a major donor to the Organization. This is the case of the Bill & Melinda Gates Foundation, which is currently the second largest contributor to the Organization's budget.

¹² WHO, A healthy return, Investment case for a sustainably financed WHO, <https://www.who.int/about/funding/invest-in-who/investment-case-2.0>.

¹³ Mathilde Krim, "Jonathan Mann 1947-1998", *Nature Medicine*, vol. 4 (October 1998), p. 1101. DOI <https://doi.org/10.1038/2592>.

¹⁴ See also Michael Merson and Stephen Inrig, "End of the Global Programme on AIDS and the Launch of UNAIDS", in *The AIDS Pandemic: Searching for a Global Response*. (Springer, 2018). Available from https://doi.org/10.1007/978-3-319-47133-4_16.

¹⁵ J P Vaughan, S Mogedal, S Kruse, K Lee, G Walt, K de Wilde, "Financing the World Health Organization: Global Importance of Extrabudgetary Funds", *Health Policy* 1996 Mar;35(3):229-45. doi: 10.1016/0168-8510(95)00786-5. <https://pubmed.ncbi.nlm.nih.gov/10157400/>.

¹⁶ Article 57 of the WHO Constitution.

3. HOW WHO REGIONAL OFFICES ARE FUNDED

The six WHO regional offices —located in Brazzaville, Cairo, Copenhagen, Manila, New Delhi, and Washington— receive a share of the WHO global budget each biennium according to parameters that are periodically reviewed.

3.1 The Unique Case of the Regional Office for the Americas: Blended Funding

The WHO regional office for the Americas (the Pan American Health Organization, PAHO) has particular and somewhat problematic bylaws. This regional office was integrated into PAHO which, created in 1902, already existed as a regional organization at the time of the WHO's creation in 1948.

The budget of this regional office for the Americas has two sources: funds transferred from the WHO headquarters in Geneva and contributions from each country in the region. Thus, the countries of the Americas have to make a double contribution: one contribution to WHO in Geneva and another directly to PAHO in Washington.

One has to wonder why the countries of the Americas region pay a double financial contribution. We may also ask to what extent the weight of the United States' contribution to PAHO influences the regional implementation of the recommendations and measures decided upon by all the member countries in Geneva.

4. KOFI ANNAN'S GLOBAL COMPACT IN THE UNITED NATIONS

In the UN system, public-private partnerships (PPPs) began in the late 1990s with the reform of the UN system launched by the Secretary-General, Kofi Annan. In response to Resolution 55/215 "Towards a Global Partnership,"¹⁷ the United Nations General Assembly requested the Secretary-General to "seek the views of all Member States on ways and means of enhancing cooperation between the United Nations and all relevant partners, in particular the private sector, on how to increase cooperation with the United Nations." The introduction to the Secretary-General's report states that "over the past decade (...) there has been an increase in the number of non-State actors interacting with the United Nations (...), for example through consultations in governing bodies, procurement contracts, and philanthropic fundraising activities."¹⁸ It further reasserts that "the number, diversity, and influence of non-state actors has grown dramatically over the past ten years" and concludes that "special efforts are needed to ensure that cooperation with the business community and other non-State actors adequately

¹⁷ UN General Assembly, 55th Session, Agenda Item 173, A/RES/55/215, 6 March 2001.

¹⁸ UN General Assembly, 55th Session, Provisional Agenda Item No. 50: Cooperation between the United Nations and all relevant partners, in particular the private sector, Report of the Secretary-General, 28 August 2001.

reflects the composition of the Organization and pays special attention to the needs and priorities of developing countries.”¹⁹

In accordance with the objective of this Global Compact, private sector companies would align their operations and strategies with universally accepted principles in the areas of human rights, labor, environment, and anti-corruption. “The Global Compact calls on companies to adopt universal principles and partner with the United Nations. It has become a key platform for the UN to engage effectively with enlightened global business.”^{20,21} This Global Compact calls on companies to adopt, support, and enact, within their sphere of influence, the 10 principles on human rights, labor standards, environment, and anti-corruption (see Box 1).

Box 1.

Principles of the United Nations Global Compact Initiative²²

Human Rights

- Principle 1: Businesses should support and respect the protection of internationally proclaimed human rights; and
- Principle 2: Businesses should ensure that they are not complicit in human rights abuses.

Labor Rights

- Principle 3: Businesses should uphold the freedom of association and the effective recognition of the right to collective bargaining;
- Principle 4: the elimination of all forms of forced and compulsory labor;
- Principle 5: the effective abolition of child labor; and
- Principle 6: the elimination of discrimination in respect of employment and occupation.

Environment Rights

- Principle 7: Businesses should support a precautionary approach to environmental challenges;
- Principle 8: Business should undertake initiatives to promote greater environmental responsibility; and
- Principle 9: They should encourage the development and diffusion of environmentally friendly technologies.

Anti-corruption

- Principle 10: Businesses should work against corruption in all its forms, including extortion and bribery.

During Margaret Chan's tenure as WHO Director General (2007-2017), the issue of the role of non-State actors was widely debated during the failed reform attempted by this administration.

¹⁹ Richter, J., "Public-Private Partnerships for Health: A Trend with no Alternatives?", *Development* (2004) 47(2) 43-48. doi:10.1057/palgrave.development.1100043.

²⁰ UN Secretary-General Ban Ki-moon, www.unglobalcompact.org.

²¹ The UN Global Compact included the participation of the following major UN agencies:

Office of the United Nations High Commissioner for Human Rights
United Nations Environment Programme
International Labor Organization
United Nations Development Programme
United Nations Industrial Development Organization
United Nations Office on Drugs and Crime
UN-Women: United Nations Entity for Gender Equality and the Empowerment of Women

See: <http://www.unglobalcompact.org/AboutTheGC/>.

²² <http://www.unglobalcompact.org/AboutTheGC/TheTenPrinciples/index.html>.

Even if some things were achieved in the reform, the issue of the role of private actors was not clearly defined.

WHO does not participate in the United Nations Global Compact. As one of the UN agencies with the largest number of PPPs, it is paradoxical that it is not one of the agencies that have signed this one. It is also paradoxical that none of the 10 principles on which the initiative's "core values" are based refers to public health or the right of access to health care.

5. PROGRESSIVE PRIVATIZATION OF WHO: INFLOW OF PRIVATE, PHILANTHROPIC AND VOLUNTARY PUBLIC FUNDS OUTSIDE THE REGULAR BUDGET

Until 1998, the World Health Organization (WHO) remained relatively uninfluenced by the private sector. Member States insisted that the regular public budget should represent at least 50 per cent of the Organization's budget and that all regulatory programs should be financed entirely from the regular budget from Member States' contributions.²³

In the context of WHO, the Special Program for Research and Training in Tropical Diseases (TDR) can be considered a precursor to the PDPs. TDR was created by WHO in 1975 and it was co-sponsored by the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), and the World Bank. Its objective was to promote and intensify research on tropical diseases, taking into account that these activities should be carried out mainly in endemic countries; define research priorities; expand cooperation with national institutions and other governmental and non-governmental organizations in coordinating research in this field; and, mobilize extra-budgetary resources to further these objectives.²⁴ TDR was created primarily as a partnership among public donors, co-sponsors, and endemic country governments represented in an independent board-type structure. Its research priorities were defined by a scientific committee of experts that oversaw the selection of research projects for funding and evaluated the progress of several scientific working groups and technical staff, with representation from endemic countries.²⁵

Some of TDR's practices during the 1970s and 1980s set a precedent that Product Development Partnerships (PDPs) would later follow. For example, TDR created an international network of academic centers to test pharmaceutical companies' products for their usefulness against tropical diseases. The TDR was certainly a precursor to PDPs and perhaps the beginning of the problems we see today.

In her first address to the World Health Assembly (WHA), the Director-General, Brundtland, stated that in order to fulfill the mandate she had been given: "We must reach out to the private sector (...). The private sector has an important role to play in both technology development and service delivery. We need open and constructive relations with the private sector (...). I invite the industry to engage in a dialog on the key issues we face."²⁶

WHO's lack of credibility during the last years of Director-General Nakajima's administration, as well as the Organization's financial problems due to the refusal of developed countries to increase its regular budget, led the Brundtland administration to seek the help of the private sector to solve these two problems. This included the incorporation into WHO of high-level individuals who had worked for transnational pharmaceutical companies.²⁷

²³ G. Velásquez, *Public-Private Partnerships in Global Health. Putting Business Before Health?* Research Paper No. 49 (Geneva, South Centre, January 2014).

²⁴ WHA 27.52. In May 1974, The WHA adopted Resolution WHA 27.52, a brief document that called for intensification of research on tropical diseases.

²⁵ See UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, *Making a Difference - 30 Years of Research and Capacity Building in Tropical Diseases* (2007).

²⁶ Gro Harlem Brundtland, Speech to the Fifty-First World Health Assembly, doc. A51/DIV/6, 13 May 1998, pp. 4-5.

²⁷ This was the case with Michael Scholtz, former Marketing Director of Smith Kline Beecham Biologicals, appointed by Brundtland as Assistant to the General Director (AGD) for medicines.

Brundtland's invitation to the private sector was heavily influenced by what Buse and Walt called "the growing disillusionment with the UN and its agencies. Concerns about UN effectiveness, including growing evidence of overlapping mandates and interagency competition, led directly to the establishment of partnerships to address specific and limited issues."²⁸

During the five years of the WHO Brundtland administration, PPPs and PDPs increased in many of WHO's areas of work and in other international public health initiatives. Partnerships related mainly to innovation and access to medicines created their own "advisory bodies" that, in some cases, might not have been on the same lines as WHO's governing bodies, which are the Executive Board and the World Health Assembly.

Brundtland's appeal to the private sector was very "productive." At her arrival, the WHO program budget for 1998-1999 was \$1.8 billion and in 2003, at the end of her term, the WHO program budget rose to \$2.8 billion, thanks entirely to voluntary contributions (public as well as private contributions). This trend continued and increased during successive WHO administrations.²⁹

WHO has a good number of PPPs, particularly, but not only, in the area of drugs in diseases such as Trachoma (Pfizer), Lymphatic Filariasis (Smith Kline Beecham), Sleeping Sickness (Hoechst Hoest), and Onchocerciasis (Merck), to name a few.³⁰

²⁸ Buse, K. & Walt, G. (2000). Global Public-Private Partnerships: Part I: A New Development in Health? *Bulletin of the World Health Organization*, 78 (4), 549-561. World Health Organization.

²⁹ Buse & Walt op. cit.

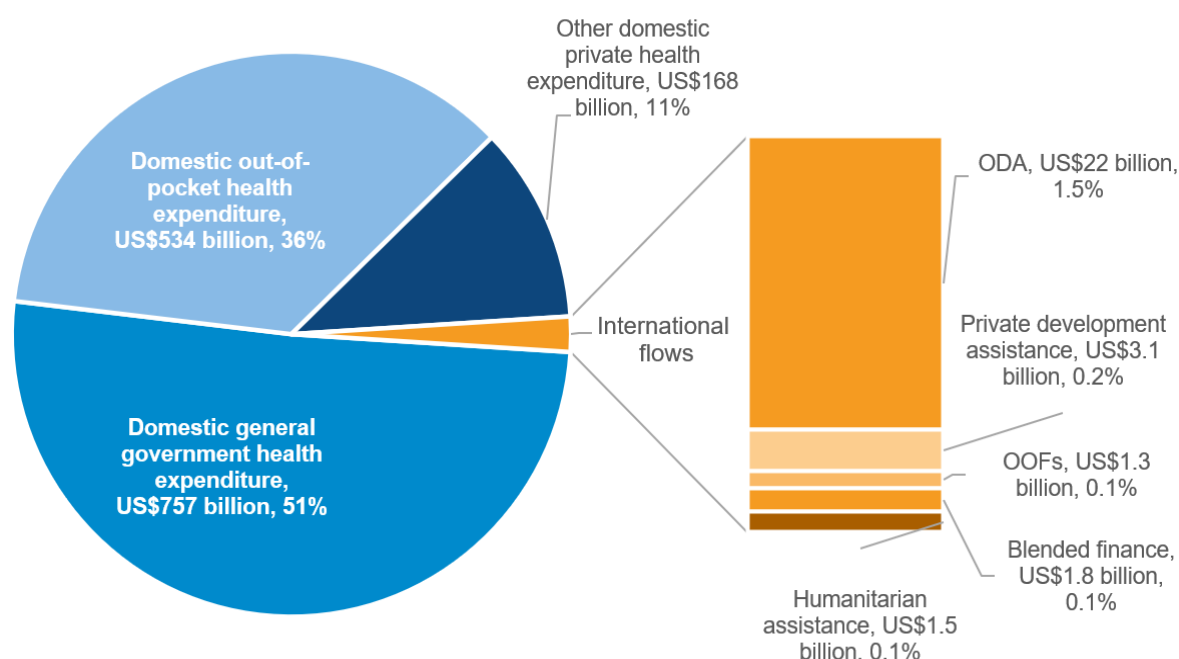
³⁰ HARVARD SERIES ON POPULATION AND INTERNATIONAL HEALTH, Harvard Center for Population and Development Studies, 9 Bow Street Cambridge, Massachusetts 02138 USA April 2002. Distributed by Harvard University Press, *Public-Private Partnerships for Public Health*, edited by Michael R. Reich, https://cdn1.sph.harvard.edu/wp-content/uploads/sites/480/2012/09/Partnerships_book.pdf.

6. OFFICIAL DEVELOPMENT ASSISTANCE (ODA) FOR HEALTH

In the last year for which data is available (2018), funding resources for health in ODA recipient countries accounted for 1.5 per cent of the total funding resources for health available in developing countries (see Figure 1).³¹ In other words, 98.5 per cent of such expenditures are funded with domestic resources of these countries.³²

Figure 1

Domestic and international resource flows to health, 2017/2018



Source: Development Initiatives, based on Organisation for Economic Cooperation and Development (OECD) Creditor Reporting System (CRS).

Health aid to developing countries reported by the Organization for Economic Cooperation and Development (OECD) includes, in addition to the classic bilateral cooperation agencies, the United States Agency for International Development (US-AID), the United Kingdom agency (DFID), the Swedish agency (SIDA), the German agency (GIZ), the funds that go to the Global Fund, the Global Alliance for Vaccines (GAVI), and the International Development Association (IDA).

According to OECD data,³³

- 1) Only 1.5 per cent of all that developing countries spend on health comes from international aid.
- 2) Half of international health aid goes to purchasing medicines³⁴ from industries that are mainly in donor countries.

³¹ OECD, "Aid Spent on Health: ODA Data on Donors, Sectors, Recipients, Factsheet", 24 July 2020, <https://devinit.org/resources/aid-spent-health-oda-data-donors-sectors-recipients/>.

³² OECD, op. cit.

³³ OECD, op. cit.

³⁴ OECD, op. cit.

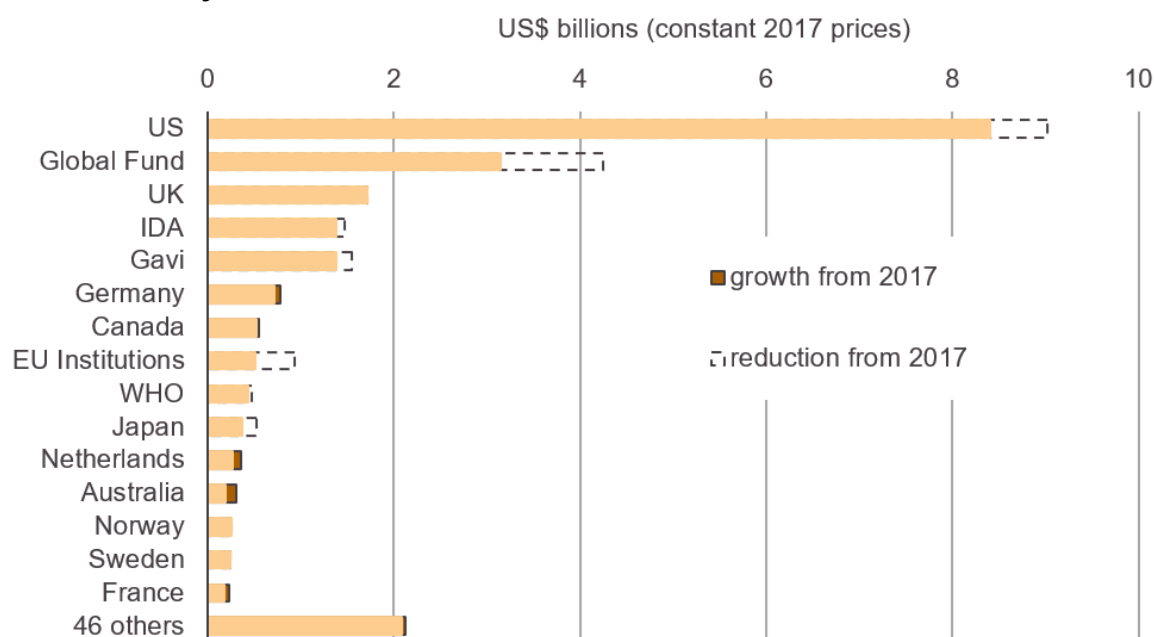
ODA aid to the health sector peaked in 2017 at \$24.4 billion, but declined by 9 per cent to \$22.2 billion in 2018.

The top three donors —the United States, the Global Fund, and the United Kingdom—accounted for 60 per cent of health aid in 2018, while the top 15 donors corresponded to 90 per cent of total aid.

More than half of aid from developed countries went to HIV/AIDS, malaria, and tuberculosis, and more than half of health aid went to sub-Saharan Africa in 2018. Health aid has declined for several of the largest donors between 2017 and 2018. See Figure 2.

Figure 2

ODA to health by donor, 2017 to 2018



Source: Development Initiatives, based on Organisation for Economic Cooperation and Development (OECD) Creditor Reporting System (CRS). International Development Association.

A report published by the World Bank and WHO,³⁵ prior to the COVID-19 pandemic, had already pointed out that half the world lacked access to essential health services, 100 million people became extremely poor due to health costs, and many of households were pushed into poverty because they had to pay for health care out of their own pockets.

The report made clear that health financing efforts must be urgently stepped up, while noting that several major health donors, including the Global Fund, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and the GAVI were shifting responsibility for program funding and implementation to national governments in developing countries.³⁶

³⁵ World Bank and WHO: "Half the world lacks access to essential health services, 100 million still pushed into extreme poverty because of health expenses", December 2017, <https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses>.

³⁶ McDonough, A., Rodriguez, D.C., "How Donors Support Civil Society as Government Accountability Advocates: A Review of Strategies and Implications for Transition of Donor Funding in Global Health", *Global Health* 16, 110 (2020). <https://doi.org/10.1186/s12992-020-00628-6>.

In order to make the limited aid received by developing countries efficient, it should be ensured that the prices of the drugs supplied bear a reasonable relationship to the costs of their development and production. Mass vaccination for COVID-19 and the failure of COVAX led many developing countries to spend astronomical sums³⁷ on vaccines purchased directly from the pharmaceutical industries. Analysis of the production costs of the leading mRNA-type vaccines produced by Pfizer/BioNTech and Moderna —developed with \$8.3 billion of public funding— suggests that these vaccines could be manufactured for as little as \$1.20 per dose. However, COVAX paid on average five times as much. COVAX failed, on the other hand, to get enough doses and at the required speed, because rich nations hoarded the vaccines by paying excessive prices.³⁸ We should ask ourselves whether it is reasonable to use development aid to buy products at five times their cost.

³⁷ According to OXFAM, Moderna and Pfizer/BioNTech companies are overcharging governments \$41 billion. <https://www.oxfamintermon.org/es/nota-de-prensa/monopolio-vacunas-multiplica-menos-cinco-coste-vacuna-covid19>.

³⁸ OXFAM, “Vaccine Monopolies Make Cost of Vaccinating the World Against Covid at least 5 Times More Expensive Than It Could Be”, <https://www.oxfam.org/en/press-releases/vaccine-monopolies-make-cost-vaccinating-world-against-covid-least-5-times-more>.

7. THE CREATION OF PARALLEL HEALTH-RELATED AGENCIES

Since 1996, WHO Member States have discussed and developed various initiatives that have brought about the creation of independent health-related agencies outside the WHO framework. This policy led to the weakening of WHO as a global health agency.³⁹

7.1 UNAIDS 1996

There were two conflicting approaches regarding the management of the AIDS pandemic: a broad approach including social, economic, and human rights aspects, advocated by Jonathan Mann, Director of the Global Program on AIDS (GPA); and, a biomedical approach, advocated by Hiroshi Nakajima, Director-General of the WHO. This prompted Mann's decision to resign from his position in 1994.⁴⁰ The quick appointment of American Michael Merson to replace Jonathan Mann was not enough to assuage the GPA donors' distrust of WHO's handling of funds, and in 1996 the donors pulled from the WHO the WHO program that had the largest financial resources then and was addressing the biggest health problem of the time.

After two years of discussion and debate, UNAIDS was founded in 1994-1995 under the leadership of Peter Piot.⁴¹

This precedent could serve to argue today for the need to create an agency other than WHO to prevent and prepare for future pandemics. Already in some discussions on the Pandemic Treaty, some individuals argue that it should be negotiated outside WHO.⁴² However, this would be the wrong approach, since what is needed instead is to strengthen WHO as the global public health agency.⁴³

7.2 From the Expanded Program on Immunization (EPI) to the GAVI

The Expanded Program on Immunization (EPI) was created at WHO in 1974 to develop and expand immunization programs worldwide.⁴⁴

Ten years later, in 1984, WHO established a standardized vaccination schedule for the original EPI vaccines: Bacillus Calmette-Guérin (BCG), diphtheria-tetanus-pertussis (DTP), oral polio, and measles. Hepatitis B (Hep B), yellow fever in disease endemic countries, and *Hemophilus influenzae* meningitis (Hib) conjugate vaccine in countries with a high disease burden.⁴⁵

³⁹ See Velásquez G., *Vaccines, Medicines and COVID-19, How can WHO be Given a Stronger Voice?* Springer Briefs in Public Health, (Springer & South Centre, 2022, Open Access) https://doi.org/10.1007/978-3-030-89125-1_1.

⁴⁰ Merson M. And Inrig S., "The Resignation of Jonathan Mann", in *The AIDS Pandemic*. Springer, Cham., 2017. https://doi.org/10.1007/978-3-319-47133-4_7.

⁴¹ Velasquez G., *The World Health Organization Reforms in the Time of COVID-19*, Research Paper No. 121 (Geneva, South Centre, November 2020). Available from <https://www.southcentre.int/wp-content/uploads/2020/11/RP-121-rev2.pdf>.

⁴² Moon, S. and Kickbusch, I., "A Pandemic Treaty for a Fragmented Global Polity", *Lancet Public Health*, June 2021, <https://www.Sciencedirect.Com/Science/Article/Pii/S2468266721001031>.

⁴³ Velasquez op. cit.

⁴⁴ K Keja, C Chan, G Hayden, R H Henderson, "Expanded Programme on Immunization", *World Health Stat Q*, 1988;41(2):59-63. <https://pubmed.ncbi.nlm.nih.gov/3176515/>.

⁴⁵ Jamison D, Breman J, Measham A, Alleyne G, Claeson M, Evans D, Jha P, Mills A, Musgrove P., *Disease Control Priorities in Developing Countries*, Second Edition. 2006, The World Bank Group, (New York, Oxford University Press, 2006).

By the end of the 1990s, all WHO member countries had a national vaccination program, with a list of mandatory vaccines based on WHO recommendations. The governments of developing countries, with the active support of UNICEF, made significant progress: "By 1990, 108 countries (43 per cent of all children) had DTP3 coverage levels above 80 per cent, and less than 10 per cent of children lived in countries with less than 50 per cent coverage."⁴⁶ The EPI was undoubtedly one of WHO's most successful programs in partnership with UNICEF.

At the beginning of the Brundtland administration, which as mentioned since its installation called for private sector participation in health programs. Tore Godal, WHO Director⁴⁷ of TDR, withdrew the WHO vaccination program and was appointed Director of a new alliance named GAVI. Why is a program that was working well with the support of another UN agency and under the supervision of WHO members being taken away from WHO?

GAVI was created as a public-private partnership involving a number of governments, UNICEF, WHO, the World Bank, the Bill & Melinda Gates Foundation, the vaccine industry, public health institutions, and non-government organizations. Launched with an initial grant from the Bill & Melinda Gates Foundation, GAVI has also been funded by nine governments and other private contributors. Already in 2003, its overall commitments totaled \$1 billion,⁴⁸ a sum exceeding the entire regular WHO budget at that time.⁴⁹ GAVI currently has a 2021-2025 budget of US\$ 21.2 billion.⁵⁰

7.3 The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund is a public-private partnership that aims to mobilize and provide funding for the three diseases mentioned in its title. Created in 2002, this Fund is part of a new "generation" of actors in global health, combining the competencies of bilateral and multilateral agencies with the private sector and civil society.⁵¹

In the first two years of her mandate, Brundtland tried to convince developed countries to authorize an increase in the regular budget, which had been subject to the zero-growth rule since the late 1980s. Failing to secure an increase in the regular budget, the Brundtland administration explored ideas and mechanisms to raise additional funds for the Organization. This brought about the idea of creating a large global fund of voluntary contributions from a number of industrialized countries. It was not originally a separate WHO fund. It was an internal mechanism to strengthen WHO's own budget.

Kofi Annan and Brundtland proposed the idea of creating a global fund to the G8 summits held in Okinawa (Japan) in 2000 and in Genoa (Italy) in July 2001. In January 2002, the creation of the Global Fund was announced as an organization, which was autonomous and independent from WHO.⁵² According to information provided by the Global Fund itself:

⁴⁶ Anthony Burton and al., "WHO and UNICEF Estimates of National Infant Immunization Coverage: Methods and Processes".

⁴⁷ Tore Godal, a Norwegian, was one of the protagonists who convinced the former Prime Minister of Norway, Brundtland, to run for the WHO. After the election, Tore Godal imposed his wife, the Australian Anne Kern, as assistant to the Director-General and he managed to get the EPI to create the public-private partnership that was called the GAVI Alliance.

⁴⁸ OCHA Services, "Over \$1 Billion Committed To Immunize World's Poorest Children". <https://reliefweb.int/report/angola/over-1-billion-committed-immunize-worlds-poorest-children>.

⁴⁹ The WHO regular budget for the 2002-2003 biennium was US\$846.6 million.

⁵⁰ GAVI, <https://www.gavi.org/investing-gavi/funding/current-period-2021-2025>.

⁵¹ Johanna Hanefeld, "The Global Fund to Fight AIDS, Tuberculosis and Malaria: 10 years on", NIH, *Clin Med (Lond)*, 2014 Feb; 14(1): 54–57. doi: [10.7861/clinmedicine.14-1-54](https://doi.org/10.7861/clinmedicine.14-1-54).

⁵² The Global Fund website <https://www.theglobalfund.org/en/about-the-global-fund/history-of-the-global-fund/>.

"As a partnership of governments, civil society, technical agencies, the private sector and people affected by the diseases, the Global Fund brought together the world's resources to strategically invest in programs to end AIDS, tuberculosis, and malaria as public health threats. Since our inception, more than \$55.4 billion has been disbursed in the fight against HIV, tuberculosis, and malaria and in programs to strengthen health systems in more than 155 countries, including regional grants, making us one of the largest funders of global health."⁵³

7.4 UNITAID

Following an initiative proposed by Presidents Jacques Chirac and Luiz Ignacio Lula da Silva, UNITAID was created in September 2006 apart from the United Nations General Assembly, under the patronage of its Secretary-General, Kofi Annan, with representatives from the five founding countries (France, Brazil, Norway, Chile, and the United Kingdom).⁵⁴

At the Paris Conference held in February 2006 at the initiative of France and Brazil, a number of countries undertook to implement a solidarity contribution based on a tax on airline tickets. This money would be used to purchase drugs for HIV/AIDS, malaria, and tuberculosis. By mobilizing stable and predictable financial resources, UNITAID would also be an instrument for lowering prices and thus accelerating access to medicines in developing countries. UNITAID would be an independent structure hosted by WHO and would complement the existing organizations involved in the fight against these three major diseases.

In France, the tax on airline tickets was adopted by the law of December 22, 2005, which came into force on July 1, 2006. At the time of UNITAID's founding, it was estimated that France alone could provide \$220 million each year for the purchase of medicines, supporting the national pharmaceutical policies of beneficiary countries.⁵⁵

Fifteen years after its founding, UNITAID is today, as can be seen on its website: "a global health agency focused on finding innovative solutions to prevent, diagnose, and treat diseases in a quicker, cheaper and more effective manner, in low- and middle-income countries. Our work includes funding initiatives to address major diseases, such as HIV/AIDS, malaria, and tuberculosis, as well as HIV co-infections and co-morbidities, such as cervical cancer and hepatitis C, and cross-cutting areas, such as fever management."⁵⁶

This dynamic and innovative agency is still hosted by WHO, but it is independent and has its own governing bodies. Since its inception in 2006, UNITAID has received some \$3 billion in donor contributions. UNITAID's main donors are France, the United Kingdom, Norway, the Bill and Melinda Gates Foundation, Brazil, Spain, the Republic of Korea, and Chile.

A key source of revenue has been innovative funding, in particular the solidarity tax on airline tickets introduced by France, which was subsequently adopted by other countries (such as Cameroon, Chile, Congo, Guinea, Madagascar, Mali, Mauritius, Niger, and the Republic of Korea).⁵⁷ However, contrary to what the UNITAID's founders had thought, taxes on airline tickets were not adopted by the countries with the most air traffic.

⁵³ Ibid.

⁵⁴ C. Simon, G. De Lemos, « Unitaid : Un Financement innovant et solidaire pour lutter contre le Sida, le Paludisme et la Tuberculose », *Med Trop* 2006; 66: 583–584. <https://www.jle.com/fr/MedSanteTrop/2006/66.6/583-584>
[UNITAID un financement innovant et solidaire pour lutter contre le sida, le paludisme et la tuberculose \(De L.pdf\)](#).

⁵⁵ C. Simon, G. De Lemos op. cit.

⁵⁶ UNITAID WEB <https://unitaid.org/about-us/#en>.

⁵⁷ Op. cit. UNITAID WEB <https://unitaid.org/about-us/#en>.

7.5 Medicines Patent Pool (MPP)

At the initiative of UNITAID, during 2008 and 2009 and with the participation of WHO,⁵⁸ the World Trade Organization (WTO), the World Intellectual Property Organization (WIPO), a representative of the British Aid Agency (DFID), a representative of the Médecins Sans Frontières (MSF) campaign for access to medicines, and a representative of Knowledge Ecology International (KEI), a series of meetings was held with the intention of creating a patent pool to accelerate access to medicines in developing countries.

Both the UNITAID Secretariat, which originated the initiative, and the WHO were clear from the outset that the patent pool would promote voluntary and compulsory licenses. By this time, in 2008, World Health Assembly resolution 61.21 ("Global strategy and plan of action on public health, innovation and intellectual property") and others that followed had given a clear mandate to WHO to promote the "full" application of the flexibilities of the WTO-TRIPS agreement and particularly compulsory licensing. The WTO and WIPO representatives argued that it was not within the mandate of their organizations to promote or recommend compulsory licensing and, consequently, decided to no longer attend the meetings convened by UNITAID. MSF and KEI representatives aligned themselves with the position of UNITAID and WHO. After almost two years of deliberations, the British government representative reported that his government refused to approve the creation of a body to promote compulsory licensing.⁵⁹

The Medicines Patent Pool was finally created in 2010 by UNITAID with the aim of expanding access to affordable treatments in low- and middle-income countries through voluntary licensing. This institution could be useful as long as the promotion of the use of the right to compulsory licenses by the WHO, as mandated by several resolutions, remains clear and in force. This unfortunately did not happen in the following years when WHO diluted its mandate in the so-called "tripartite" collaboration (WHO, WTO, and WIPO).

According to a UNITAID financial report, UNITAID has invested nearly US\$60 million in the MPP since its inception.⁶⁰

7.6 Coalition for Epidemic Preparedness Innovations (CEPI)

According to information provided by CEPI, "CEPI is an innovative global partnership of public, private, philanthropic, and civil society organizations. We work together to accelerate the development of vaccines against emerging infectious diseases and to enable equitable access to these vaccines for people during outbreaks."⁶¹

In 2021-2022, CEPI adopted a \$3.5 billion plan to end the COVID-19 pandemic. "Compared with the trillions lost to COVID-19, at \$3.5 billion this plan is not only cost-effective, but also exactly what the world needs to ensure that our children will never again face the hardships and losses we have had to endure because of COVID-19," said CEPI Director Richard Hatchett.⁶²

These funds (almost the WHO's global budget for two years) were made available to this public-private consortium, outside the WHO, the international health reference agency, within a few months.

⁵⁸ In all the meetings that took place in 2008 and 2009, the author of this article was the WHO representative focused on the work for creating a patent pool for medicines.

⁵⁹ The author participated in these negotiations in his capacity as Director of the WHO Medicines Program.

⁶⁰ UNITAID, « L'IMPACT DE NOS PROJETS : LE MEDICINES PATENT POOL ». <https://unitaid.org/assets/L-impact-de-nos-projets-Medicines-Patent-Pool.pdf>.

⁶¹ CEPI, <https://cepi.net/about/whoweare/>.

⁶² CEPI, <https://100days.cepi.net/100-days/>.

7.7 COVAX – 2021

In June 2020, a global collaboration called the ACT Accelerator established a funding mechanism for universal access to COVID-19 vaccines (called COVAX). This mechanism was co-led by GAVI (the Alliance mentioned above),⁶³ the Coalition for Epidemic Preparedness Innovation (CEPI) (launched in Davos in 2017), and WHO.

The COVAX announcement generated a strong positive global response, especially from Southern countries concerned about equitable access to future vaccines. A year after its creation, the COVAX mechanism was challenged because industrialized countries and big pharma ignored the commitments made, and no one managed to prevent it.⁶⁴

At the beginning of the pandemic, COVAX set as a goal an equitable supply of vaccines for all countries. Unfortunately, it failed to reach even half of its 2021 target of supplying 2 billion doses.⁶⁵ An open letter to G20 leaders in October 2021 highlighted that 133 doses per 100 people had been provided in high-income countries, while four doses per 100 people had been provided in low- and middle-income countries. The WHO Director-General called this failure a "vaccine apartheid," speaking of "inequality in access to vaccines" to emphasize the extent of this moral failure, making an explicit comparison with the South African system of institutionalized racial segregation.⁶⁶

⁶³ GAVI, "The Bill & Melinda Gates Foundation", 2020. <https://www.gavi.org/fr/modele-de-fonctionnement/modele-de-partenariat-de-gavi/la-fondation-bill-melinda>.

⁶⁴ See Velasquez, G. *Vacunas, medicamentos y patentes: COVID 19 y la necesidad de una Organización internacional*, 2021, Ed. B de F, Buenos Aires.

⁶⁵ Taylor A., "COVAX Promised 2 Billion Vaccine Doses to Help the World's Neediest in 2021. It Won't Deliver Even Half That", The Washington Post, 10 Dec. 2021. <http://www.washingtonpost.com/world/2021/12/10/covax-doses-delivered/>.

⁶⁶ Grandi F, Vitorino A, Ghebreyesus TA, "An Appeal to G20 Leaders to Make Vaccines Accessible to People on the Move," World Health Organization, 29 Oct. 2021. <https://www.who.int/news/item/29-10-2021-an-appeal-to-g20-leaders-to-make-vaccines-accessible-to-people-on-the-move>.

8. THE WHO FOUNDATION

At the end of a lengthy keynote address at the 72nd World Health Assembly in May 2019, the Director-General reported: "... I am pleased to announce that the WHO Foundation will be established this year, which will enable us to generate funding from hitherto unexplored sources."⁶⁷ This announcement went unnoticed by most of the attendees. The creation of a WHO Foundation was never discussed by the governing bodies of the Organization; neither the Executive Board nor the Assembly had the opportunity to discuss this proposal.

However, in May 2020, the WHO welcomed the new foundation: "The World Health Organization (WHO) welcomes the establishment of the WHO Foundation, an independent grant-making entity, which will support the Organization's efforts to address the most pressing global health challenges."⁶⁸

This represents a fundamental, unprecedented change in the way the Organization is financed, which was not consulted and submitted for approval by the member countries. According to the Geneva Health Files, "new forms of financing are being defined that may alter governance in ways directly contrary to the very objectives of public health. These have been standardized and adopted without adequately consulting WHO Member States and despite concerns raised by civil society stakeholders."⁶⁹

The initiative for the creation of the WHO Foundation seems to have come from Thomas Zeltner, Chairman of the WHO Executive Board at the time, now founder and Chairman of the Board of Directors of the Foundation, as stated by the Director of WHO in his acknowledgments presented to Zeltner: "Today's announcement is the conclusion of more than two years of preparation and hard work by countless individuals and partner organizations. I would like to thank Professor Thomas Zeltner for leading this incredible adventure and founding the organization."⁷⁰

According to Zeltner, "We have to create a healthier, more equitable future for everyone. By investing in 8 billion lives and using a flexible, innovative, and collaborative approach, we aim to overcome today's health care challenges and ensure healthy lives in the future."⁷¹ It would be important to know what the "flexible approach" referred to by Thomas Zeltner is.

On the first page of the WHO Foundation's presentation the following is stated: "The World Health Organization (WHO) plays a singular role in leading the global health ecosystem, developing technical guidelines and tools to prevent and treat disease, and acting as an organizer at the country level with an unparalleled level of trust. The crises of the 21st century, including the COVID-19 crisis, have highlighted both the lack of equity in access to effective and affordable health care and the indispensable role of WHO. However, WHO lacks sufficient resources to fulfill its mandate. And, beyond funding, its vision cannot be achieved by the public sector alone. **The WHO Foundation was created as an independent Swiss foundation, affiliated with but independent of WHO**, to pool new resources from philanthropists, foundations, corporations, and individuals to support its mission, which is to promote health, keep the world safe, and serve the vulnerable"⁷² (emphasis added).

⁶⁷ Director-General's opening speech, World Health Assembly, May 2019.

⁶⁸ WHO, Press Release, May 27, 2020, the World Health Organization.

⁶⁹ Priti Patnaik, Geneva Global files, "A Hole in the Firewall: The WHO Foundation", Newsletter No. 50, April 2021

⁷⁰ WHO, Press Release, 27 May 2020, op. cit.

⁷¹ Prof. Dr. Thomas Zeltner, Founder and Chairman of the Board, WHO Foundation <https://who.foundation/>.

⁷² WHO Foundation <https://who.foundation/>.

The new WHO Foundation was created to raise funds for WHO that could have led to conflicts of interest, such as the recent \$2 million donation from Nestlé.

However, these donations should not come as a surprise. When Anil Soni was appointed to head the Foundation, he made clear the purpose for which this structure has been created:

“So, part of the reason we exist is because we will have a different set of operating parameters that will be more flexible in terms of engaging corporations. There will be some industries that are off-limits, because it's been important for the WHO to make clear that they keep a lack of engagement with the tobacco industry and with the arms industry, but those are typically the exceptions.

For other industries and corporations, we are going to be actively looking for partnership, and we will be doing so with ethical guidelines, which we will make public.⁷³

WHO Foundation is an independent grant-making foundation that is unique in the area of world health. WHO Foundation's role is to support the World Health Organization's (WHO's) mission both directly and by supporting WHO's network of partners on the ground. WHO Foundation is a force for new and better collective solutions. It brings together donors, world health professionals and the WHO network, to create partnerships that drive innovative actions to address the most pressing health challenges of today and tomorrow.⁷⁴

The main concern about this Foundation is the extent to which the mode of funding of a public international organization is changing. But we could also ask how these funds are going to reach the WHO. Will they be private or public contributions? What is the power of influence on the allocation of funds for WHO activities of an "independent foundation" that raises part of the public agency's budget?

⁷³ Anil Soni, quoted by Priti Patnaik, Geneva Global files, “A Hole in the Firewall: The WHO Foundation”, Newsletter No. 50, April 2021.

⁷⁴ WHO Foundation, <https://www.geneve-int.ch/whoswho/who-foundation>.

9. THE WHO SUSTAINABLE FINANCING WORKING GROUP

The problems of inadequate funding of WHO led to an important initiative: the creation of a WHO Sustainable Financing Working Group (SFWG). This group, created by the WHA, met seven times from April 2021 to April 2022. At their last meeting they agreed on the text of the recommendations and a draft decision to be presented to the 75th WHA in May 2022. The aim was to lay the foundation for funding to meet WHO's initial requirements, which were democratic and sustainable, by returning to a public, regular budget funded by Member States.

9.1 Decision Approved by the 75th WHA

The brief decision approved by the WHA on funding reads as follows:

"The Seventy-Fifth World Health Assembly, having considered the report of the Sustainable Financing Working Group, including its related recommendations,

Decided

"(1) to adopt the recommendations of the Sustainable Finance Working Group, which are set out in the annex to this decision; and

(2) to request the Director-General to establish measures to ensure the implementation of such recommendations."

Regarding the increase in the regular budget, annex e) in the recommendations states: "that the Seventy-Fifth World Health Assembly, recognizing the important role of contributions in the sustainable funding of the Organization, requests that the Secretariat develop budget proposals through the regular budget cycle to increase the contributions identified in order to contribute to the financial sustainability of WHO and to its aim of reaching a level of 50 per cent of the 2022-2023 base budget by the 2030-2031 biennium, while aiming to achieve it by the 2028-2029 biennium."⁷⁵

Thus, one of the consequences of the debate around COVID-19 within WHO was the decision to adopt at the WHA the recommendations of WHO's Sustainable Financing Working Group, led by the German delegate Bjorn Kummel. One of the recommendations is to develop budget proposals, as part of the regular budget cycle, to progressively increase contributions from the regular budget of the Organization until they represent 50 per cent of the Organization's budget in the 2028-2029 biennium (i.e., in 7 years' time). As already indicated, the WHO's regular, i.e., public, budget is currently only 16 per cent of the Organization's budget.⁷⁶

In a book by South Centre published by Springer in January 2022, it was already argued that "to progressively recover the public character of the organization, it would be necessary to define and implement mechanisms to control at least 51 per cent of the budget, for a period of, for example, 7 years. This means that regular mandatory contributions from Member States must represent at least 51 per cent of the organization's total budget."⁷⁷

⁷⁵ WHO EB/WGSF/7/4, 9 May 2022.

⁷⁶ WHO, "Meeting Report of the Working Group on Sustainable Financing", Doc. EB/WGSF/7/4, 9 May 2022.

⁷⁷ G. Velasquez, *Vaccines, Medicines, and COVID-19. How Can WHO Be Given a Stronger Voice* Springer Briefs in Public Health, (Springer & South Centre, 2022, Open Access) p. 105. https://doi.org/10.1007/978-3-030-89125-1_1.

This decision by the WHA, described as "historic" by several observers, to increase the Organization's regular budget which had been frozen and forced to zero growth since the early 1980s,⁷⁸ contrasts with the recent announcement to create a multi-billion US dollar fund at the World Bank for the prevention of pandemics,⁷⁹ which we will discuss in the following section.

⁷⁸ See Reddy, S, Mazhar S., Lencucha, "The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals", BMC part of Springer Nature, Open Access, November 2018: "In the early 1980s, the WHA introduced a 'zero real growth policy' for the regular budget. This policy froze membership dues in real dollar terms. Therefore, according to this, only inflation and exchange rates would influence membership dues adjustments. In 1993, the WHA voted for a tighter budgetary policy, moving the Organization from 'zero real growth' to 'zero nominal growth'".

⁷⁹ The World Bank, "World Bank Board Approves New Fund for Pandemic Prevention, Preparedness, and Response (PPR)", Press Release, 30 June 2022.

10. THE WORLD BANK'S FINANCIAL INTERMEDIARY FUND (FIF) FOR PANDEMIC PREVENTION, PREPAREDNESS, AND RESPONSE

Since the launch of the FIF for pandemic prevention, preparedness, and response by the World Bank and WHO on 30 June 2022, much has been written, commented, and speculated about this initiative. Factual information updated on 28 November 2022 is available on the World Bank's website. Some media had mentioned a World Bank \$50 billion fund.⁸⁰ However, that amount no longer appears in the Bank's quoted factual information.

10.1 *Objectives and Functions of the World Bank's FIF*⁸¹

With the support of G20 members, on June 30, 2022, the World Bank's Board of Executive Directors approved the creation of this new Fund. The FIF was established by the World Bank Board of Governors at its inaugural meeting on 8-9 September 2022 and officially launched at a high-level event on the sidelines of the G20 Joint Finance and Health Ministers' Meeting held in Bali on 13 November 2022.

According to information published by the World Bank, the Fund will provide additional funding to strengthen pandemic prevention, preparedness, and response (PPR) capacities in low- and middle-income countries. Financial intermediation funds offer independently governed multi-contributor collaboration platforms.

The Fund's Governing Board includes equal representation from sovereign donors and governments of potential implementing countries (co-investors), as well as representatives from foundations and civil society organizations. The Fund will be administered by the World Bank, and WHO will provide technical support, participating as a non-voting observer.

Funding from the Fund could help strengthen and sustain capacity for PPR in areas such as zoonotic disease surveillance, laboratories, communication, emergency coordination and management, critical health care worker capabilities, and community engagement. Projects financed by the Fund can also help strengthen PPR at the regional and global levels.

The Fund has announced more than \$1.6 billion in pledges from Australia, Canada, China, the European Commission, France, Germany, India, Indonesia, Italy, Japan, the Netherlands, New Zealand, Norway, the Republic of Korea, Saudi Arabia, Singapore, South Africa, Spain, Switzerland, the United Arab Emirates, the United Kingdom, the United States, the Bill & Melinda Gates Foundation, the Rockefeller Foundation, and the Wellcome Trust.

"One Health" activities, which recognize that human and animal health are interdependent and linked to the health of the ecosystems they share, will be eligible for funding from the Fund. Activities related to Antimicrobial Resistance (AMR) will also be eligible for funding from the Fund, which accepts contributions from the private sector.

⁸⁰ UN News: COVID-19: Nueva iniciativa de 50.000 millones de dólares para acabar con la pandemia y asegurar la recuperación mundial, <https://news.un.org/es/story/2021/06/1492752>.

⁸¹ World Bank, FAQs: Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response, <https://www.worldbank.org/en/topic/pandemics/brief/factsheet-financial-intermediary-fund-for-pandemic-prevention-preparedness-and-response>.

10.2 Comments and Reactions to World Bank Reports on the FIF

One month after the announcement of the creation of the FIF, in July 2022, Emily Bass and Asia Russell presented their first comments on the new Fund: "This fund, enthusiastically backed by the United States is, in its current form, built to fail. Numerous groups, from the Africa Centres for Disease Control and Prevention to the World Health Organization's Council on the Economics of Health For All to a range of seasoned activist groups and coalitions, have identified potentially lethal flaws in the blueprint, including a problematic approach to governance, a narrowly scoped list of implementing entities, and an absence of real strategy for ensuring equity, access, and impact. As it stands, this latest global health coffer, officially known as the Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response (PPR), seems destined to flounder, if not fail."⁸²

Later, in October 2022, when the World Bank Governors met for the second time, under the leadership of Bank Director David Malpass, Bass and Russell again expressed in "Think Global Health" their serious concerns and reservations about the role of World Bank management and the U.S. Government in the creation and direction of the Pandemic Fund. Bass and Russell titled their article "Back From the Brink."⁸³

For many civil society organizations, the World Bank's closeness to the private sector raised doubts about the effectiveness of the new Fund if implementation were to be primarily in the hands of private actors:

"Development actors should prioritize public over private provision, especially for primary health care, as recently noted by the Lancet commission on Primary Health Care," said Marco Angelo, of Belgium-based CSO Wemos. He added, "Private provision negatively affects equitable access when it is not integrated in the public health financing system; when integrated, on the other hand, it can present many challenges."⁸⁴ In a collective letter from 33 civil society organizations in response to the World Bank's FIF proposal, the signatories stated: "The World Health Organization (WHO) and the World Bank have estimated that an additional \$10.5 billion⁸⁵ of external financing is needed for the next five years for investments at country, regional, and global levels to strengthen the capacity of low- and middle-income countries."⁸⁶ The 33 organizations presented a series of recommendations on governance, private sector participation, and financing, insisting that a Global Public Investment approach be adopted to make the FIF proposal truly inclusive.⁸⁷

It is important for any pandemic prevention, preparedness, and response funds to adopt a human rights-based approach.

⁸² Emily Bass and Asia Russell, "Fix It or Forget It", *Think Global Health*, 11 July 2022. <https://www.thinkglobalhealth.org/article/fix-it-or-forget-it>.

⁸³ Emily Bass and Asia Russell, "Back From the Brink", *Think Global Health*, 6 October 2022.

⁸⁴ Bretton Woods Project - CRITICAL VOICES ON THE WORLD BANK AND IMF, "World Bank's Commitment to Private Sector-Led Development Casts Doubt on the Effectiveness of the New Pandemic Preparedness Fund", <https://www.brettonwoodsproject.org/2022/07/world-banks-commitment-to-private-sector-led-development-casts-doubt-on-effectiveness-of-new-pandemic-preparedness-fund/>.

⁸⁵ This is the source of the amount quoted by some articles mentioned above, 10 billion per year, for 5 years would be 50 billion... A total that the World Bank and the WHO suggest that is needed. This is not near at all of the pledges that the Pandemic Fund has received so far, i.e., US\$1.6 billion.

⁸⁶ WEMOS, "Collective Civil Society Inputs in Response to the World Bank Group's White Paper: A Proposed Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response Hosted by the World Bank", https://149805364.v2.pressablecdn.com/wp-content/uploads/2022/06/FIF_consultation_input_Wemos_and_Eurodad_including_endorsements.pdf.

⁸⁷ Ibid.

Strengthening the public sector should be a priority objective. The COVID-19 pandemic has made it clearer than ever that a strong public health system is the most important tool for ensuring an effective and fair response to health emergencies, including pandemics.⁸⁸

Despite its ambitious goal, by the end of 2022 the FIF had only received funding pledges of US\$1.6 billion from the donors mentioned above.

⁸⁸ Ibid.

CONCLUSIONS

Development Aid represents a minor portion of the investment that developing countries use to sustain their health systems. All of these funds, on the other hand, are not channeled directly to developing countries, but circulate through public-private consortia and other entities such as the Global Fund, CEPI, COVAX, the WHO Foundation, and the World Bank's FIF. Approximately half of the aid goes to purchasing drugs and vaccines produced in a small group of countries included in the list of 15 donor countries.

CEPI's COVID-19 management, COVAX, and the recent creation of the WHO Foundation and the World Bank FIF show that industrialized countries prefer and are trying to impose global health management governed by public-private consortia that are designed by those countries. For its part, the WHO—which has been allowed to symbolically increase its public budget—will act as a non-voting observer and provide technical assistance to public-private consortia that make the decisions.

The narrative says that the WHO coordinates and governs, but in practice the WHO gives technical recommendations and oversees decision-making processes.

The role of the WHO Foundation, which was never approved by WHO's governing bodies, is ambiguous and the mechanisms for avoiding conflict of interest are not sufficiently clear.

Will the G8 and in its extension the G20 make the decisions and impose their vision of how global health will be managed?

The question that we could ask ourselves, to conclude, is how are we going to preserve the public interest, in defense of common public goods and the protection of human rights in the activities of prevention, preparedness, and response to present and future pandemics?

Recent international rhetoric, such as that mentioned in the 2022 World Health Assembly and in the G7 and G20 reports, is to strengthen the role of WHO as a lesson learned from the COVID-19 pandemic. In this sense, the decision of the WHA to progressively increase the regular public budget to 50 per cent of public contributions by 2028-2029 can be understood. The total increase in the Organization's regular public budget contributions would represent an additional US\$1.2 billion, which could be compared with some bewilderment with the billions that the entities and mechanisms mentioned in this document are spending or would like to manage.

We have seen how international solidarity failed to ensure access to vaccines, diagnoses, and treatment. The COVID-19 crisis has prompted the international community to reflect on the need for a binding international pandemic treaty. Before the pandemic even concluded, Russia started an absurd and costly war against Ukraine and NATO launched an arms race that risks diverting the urgent investment in health to the purchase of weapons. True preparedness for future pandemics clearly requires strengthening the public health sector, including WHO, and funding that is now dispersed across a multitude of entities and mechanisms that fragment rather than bring greater coherence to the global health system.

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