5. The World Health Organization

The WHO within the global health architecture

The World Health Organization (WHO) was founded in 1948 as a specialized agency of the United Nations system to act as the “directing and coordinating authority on international health work.”\textsuperscript{114} The World Health Assembly (WHA) is the supreme decision-making body of WHO, convening all 194 Member States on an annual basis to set the policy framework and approve the programme budget of the organization. The WHA is supported by the Executive Board, a group of 34 health experts designated by Member States. The Secretariat, made up of around 8,500 people in 147 countries, enables WHO to carry out its mandate: to provide leadership on global health matters; shape the health research agenda; establishing international health-related standards, methods and guidelines; articulate ethical and evidence-based policy options; provide technical support to member countries; and monitor the global health situation and assess health trends. In addition to its important functions in the governance of world health, WHO has been an important contributor towards building consensus around contentious health issues and placing health services on the political agenda, as exemplified by its “Health for All” agenda\textsuperscript{115} and its central role in combating HIV/AIDS, Tuberculosis and Malaria.

Over recent decades WHO has lost political importance relative to new actors in the global health arena. From being the foremost—and virtually single—authority on global health in the first decades of its existence, WHO now stands amongst a growing number of public and private actors, initiatives and international partnerships in health, including the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the Global Vaccines Alliance (GAVI), UNAIDS and the Bill and Melinda Gates Foundation. At the same time, other international organizations such as UNICEF and the World Bank have expanded their role in health and dispose of significant resources for programme implementation.

Further, WHO’s ability to fulfill its role as the global health authority is being increasingly undermined by an ongoing budget crisis: the share of assessed contributions to its budget is shrinking. Consequently the organization increasingly relies on inflexible specified voluntary funds, earmarked for activities or programmes that funders wish to prioritize. The latter funds come from both WHO Member States and other public sources, as well as increasingly from an array of private contributors, including corporate philanthropy and companies.

\textsuperscript{114} Cf. WHO (2014a).

\textsuperscript{115} For an outline of WHO’s ‘Health for All’ strategy, see: http://undp.by/en/who/healthforall/.
In recent years WHO has faced a serious lack of resources, which stands in stark contrast to the enormous and growing funding needs in global public health. WHO’s overall budget grew between 1998–1999 and 2010–2011, but has declined since (see Figure 7). Only the proposed programme budget 2016–2017 indicates a slight upward trend again.

As in the case of other UN specialized agencies, assessed contributions are required contributions to the regular budget of WHO from Member States, whereas voluntary contributions, in the form of either donations or grants, come from public or private, or a blend of public and private sources.

Assessed contributions from WHO Member States as a proportion of WHO’s total revenues have declined, most notably since 1998. Until then the Member States had insisted that at least 51 per cent of the organization’s budget should be financed through assessed contributions, including all programmes related to the normative work of WHO.116 By 2014 however, assessed contributions represent just 23 per cent of WHO’s total budget (see Figure 8).117

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The increasing imbalance of voluntary in relation to assessed contributions has resulted in WHO having less flexibility in its budget allocations. This has been exacerbated as specified funds dominate voluntary contributions.\(^{118}\) These specified funds are earmarked for particular projects or programmes, and often have further donor conditions attached. They can also be highly volatile from year to year. As a result, WHO’s agenda has become shaped increasingly by the priorities of donors, public and private.

**Latest shifts in funding priorities**

WHO’s approved Programme Budget for 2014–2015 was US$ 3,977 billion—an amount the organization considers to be a “realistic budget based on previous income and expenditure patterns.”\(^{119}\) According to WHO, the allocation of budgetary funds has been determined through various priority-setting criteria and by the categories of work established by WHO together with its Member States. Ostensibly, it aligns with the strategic vision of the programme of work, adopted by the World Health Assembly in May 2013, which has seen some important changes to the organization’s focus areas. Table 15 shows the shift in WHO’s priorities between 2012–2013 and 2014–2015.\(^{120}\)

In order to free up funds for its growing focus on non-communicable diseases (NCDs) and to implement its Global Action Plan for the Prevention

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\(^{118}\) Cf. WHO (2011a), p. 15.


\(^{120}\) Ibid., p. 8.
and Control of NCDs 2013–2020, WHO proposed in its 2014–2015 budget to slash funding for communicable diseases and, in particular, outbreak and crisis response. The proposal for the latter category reduced funding by more than 50 per cent from US$469 million in 2012–2013 to US$228 million in 2014–2015. However, such a substantial funding cut does not appear to be congruent with the organization’s ready acknowledgement that public health emergencies “are acute external events that are unpredictable and call for an urgent and sometimes massive response by WHO.”121 WHO has also lost around a third of its emergency health experts since 2009, when the crisis response department started running into funding shortages in the wake of the global financial crisis, and staff had to be laid off.

The Ebola crisis has shone a spotlight on the inadequacy of WHO’s current emergency response budget and its weakened capacities in this area. With the severely diminished funding available for outbreak and crisis

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121 Ibid., p. 79.
response, and the dwindling number of staff with the requisite expertise, the organization was unable to respond with the necessary speed, scale and competence—which it had previously demonstrated during the severe acute respiratory system (SARS) outbreak in 2003. Indeed, the ability of WHO to rapidly identify and curb the spread of SARS led, through the adoption of revised International Health Regulations in 2005, to the extension of WHO’s institutional responsibilities in the event of a public health emergency of international concern (PHEIC).122

The inadequacy of, and uncertainty around, WHO’s budgeting process for health emergencies had been recognized before the Ebola crisis. In 2011, the WHO Review Committee on the Functioning of International Health Regulations recommended the introduction of a Global Health Emergency Workforce, backed by a US$ 100 million contingency fund for surge capacity to be mobilized for a declared international public health emergency.123 Such provisions would have supported the rapid response needed to address the Ebola epidemic. However, the lack of financial commitment from member governments, particularly those in high-income countries, meant that the Committee’s recommendations were not acted on by WHO until the crisis hit with full force.124 Only at the 2015 WHA did WHO Member States adopt reform measures for the emergency and response programme and set up the US$ 100 million contingency fund which had been proposed in 2011.125

The failure of WHO Member State support has been compounded by recent trends whereby voluntary contributions represent a major and growing share of WHO’s budget. With a large proportion of voluntary funds outside the drastically shrunken emergency response budget and off-limits for an Ebola response, WHO was unable to mobilize sufficient public and private resources quickly enough to contain the disease.

**Private funding for the WHO**

As a consequence of changes in the funding patterns of its traditional donors, WHO has sought to “attract new donors and explore new sources of funding.”126 Efforts to this end have been marked by moves towards soliciting greater funding from the corporate sector and foundations, and further expansion of multi-stakeholder dialogues and initiatives in various areas of health. Recent figures from WHO suggest contributions from foundations and the private sector make up 19 per cent and 1 per cent respectively of total voluntary contributions.127 Table 16 shows that there are ten “non-state” contributors among the top 20 contributors of

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voluntary (non-assessed) funding to WHO, and Table 17 lists the top 20 private voluntary contributors for 2014. In addition to GlaxoSmithKline (GSK), Hoffmann-La Roche, Novartis which are included in the top 20, many other global pharmaceutical companies contribute to WHO, including Bayer, Merck, and Pfizer.

Table 16

WHO’s top 20 voluntary (state and non-state) contributors 2014 (in US$)

<table>
<thead>
<tr>
<th>#</th>
<th>Contributor</th>
<th>Core voluntary-contributions account</th>
<th>Other voluntary contributions —core</th>
<th>Voluntary contributions—specified</th>
<th>Special Programme of Research, Development and Training in Human Reproduction</th>
<th>Special Programme for Research and Training in Tropical Diseases</th>
<th>Stop TB Partnership</th>
<th>Total revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>USA</td>
<td>299,443,006</td>
<td>844,350</td>
<td>608,076</td>
<td>(223,627)</td>
<td>300,671,805</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>BMGF</td>
<td>253,658,387</td>
<td>1,924,568</td>
<td>938,282</td>
<td>256,521,237</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>United Kingdom</td>
<td>24,248,577</td>
<td>121,084,960</td>
<td>3,664,123</td>
<td>3,816,793</td>
<td>2,314,815</td>
<td>155,129,268</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>GAVI Alliance</td>
<td>127,754,707</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Rotary International</td>
<td>66,516,459</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>European Commission</td>
<td>56,683,493</td>
<td></td>
<td>1,955,769</td>
<td></td>
<td></td>
<td>58,639,262</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>UNDP</td>
<td>55,893,741</td>
<td></td>
<td>564,902</td>
<td></td>
<td></td>
<td>56,458,643</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>UNOCHA</td>
<td>53,307,400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53,307,400</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Norway</td>
<td>9,168,256</td>
<td>35,683,695</td>
<td>2,756,637</td>
<td>2,200,381</td>
<td></td>
<td>49,808,970</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Australia</td>
<td>18,552,876</td>
<td>31,243,059</td>
<td></td>
<td></td>
<td></td>
<td>49,795,934</td>
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<tr>
<td>11</td>
<td>Sweden</td>
<td>24,422,735</td>
<td>749,353</td>
<td>13,565,944</td>
<td>4,588,514</td>
<td>5,180,580</td>
<td>48,507,127</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Germany</td>
<td>46,703,498</td>
<td></td>
<td>814,111</td>
<td></td>
<td></td>
<td>47,517,610</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>UN CERF</td>
<td>43,130,386</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43,130,386</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>African Development Bank Group</td>
<td>31,460,986</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31,460,986</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Japan</td>
<td>30,444,627</td>
<td>270,000</td>
<td></td>
<td></td>
<td></td>
<td>30,714,627</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>UNFIP</td>
<td>26,403,792</td>
<td>705,472</td>
<td></td>
<td></td>
<td></td>
<td>27,109,264</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>GFATM</td>
<td>25,055,335</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25,055,335</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Netherlands</td>
<td>5,980,978</td>
<td>13,005,376</td>
<td>5,650,000</td>
<td></td>
<td></td>
<td>24,636,354</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>National Philanthropic Trust</td>
<td>22,700,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22,700,000</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Republic of Korea</td>
<td>3,589,496</td>
<td>16,843,428</td>
<td></td>
<td></td>
<td></td>
<td>20,432,924</td>
<td></td>
</tr>
</tbody>
</table>

Sources: WHO (2015a), pp. 4.
The voluntary contribution of the Bill & Melinda Gates Foundation positions it as WHO's second largest voluntary donor as well as second largest donor overall in 2014 (see Box 6).
The Bill & Melinda Gates Foundation

The Bill & Melinda Gates Foundation is becoming a major player in global health on a par with the WHO. In 2012 and 2013, the amount spent by the Gates Foundation alone on global health was more than half of WHO’s total biennial budget (Gates Foundation: US$ 1,980,868,000; WHO: US$ 3,959,000,000). Between 1998 and 2014, the Gates Foundation has donated US$ 2,098,376,995 by way of more than 200 grants to WHO, making the foundation the largest non-state funder of WHO over that period. Most of BMGF’s grants to WHO have been dedicated to the areas of Polio (US$1,143,150,251), Family Health (US$178,600,947) and Global Policy & Advocacy (US$146,044,131). However, BMGF grants are earmarked contributions and have influence on how WHO prioritizes its different programme activities. WHO Director-General Margaret Chan admitted as much, saying: “My budget [is] highly earmarked, so it is driven by what I call donor interests.”

The BMGF also contributes indirectly to the WHO budget through its funding of public-private partnership programmes such as the GAVI Vaccine Alliance, PATH, the UN Foundation/UN Fund for International Partnerships and the Global Fund, all of which donate substantial contributions to WHO. GAVI alone contributed US$222.94 million to WHO in the 2012–13 biennium. Considering that the BMGF is a founding partner of GAVI and its grants represent 18.8 per cent of all of GAVI’s donor contributions and pledges for the period 2011–15, the BMGF’s financing of GAVI (as well as the other partnerships mentioned) is another, if more indirect, channel of influence on WHO, its actions and priority-setting.

The BMGF is not only a funder but also a board member of several global health initiatives (e.g., the Global Fund, GAVI Alliance, Stop TB Partnership, Roll Back Malaria Partnership).

Concerns have been raised about BMGF’s dominance in setting the research and political agenda of global public health. A major focus of the Foundation is research on malaria treatment and vaccines that prevent infection or block transmission. To date, the BMGF has committed nearly US$2 billion in grants to combat malaria (as well as more than US$1.6 billion to the GFATM). Arata Kochi, the former head of WHO’s malaria programme, complained that the Gates Foundation was dominating research in malaria and risked stifling the diverse views held by others in the scientific community.

The Gates Foundation’s approach to global health is focused on finding technical solutions to global health problems with an emphasis on quick, measurable and visible outcomes, such as the development of new drugs and vaccines or the distribution of mosquito nets.
One of GAVI’s members reported that Bill Gates often told him in private conversations “that he is vehemently against health systems […] he basically said it is a complete waste of money, that there is no evidence that it works, so I will not see a dollar or cent of my money go to the strengthening of health systems.”

The Gates Foundation has never explicitly stated in public their scepticism about the effectiveness of efforts aiming to strengthen health care systems, however, through most of the time of the foundation’s activity, the issue had hardly been addressed, neither by public communication nor by funding. David McCoy, a medical doctor and scholar based at the University College London, stated in an interview that vertical financing of individual diseases and separate programmes, the method adopted by the Gates Foundation, can damage the general health system by leading national governments to shift their priorities. This could result in governments neglecting important general health infrastructures and activities, and the need to address the underlying roots of disease, such as poverty and malnutrition.

WHO observers are concerned about similar dynamics of priority–shifting and “externalizing” staff costs whereby WHO is left to administer what the BMFG determines, leading to the possible neglect other areas of global health that merit WHO’s attention.

In terms of transparency the Foundation performs well—better than some UN organizations. The Gates Foundation is the first non-governmental agency to report its aid activities to the Development Assistance Committee (DAC) of the OECD. It is also a member of the International Aid Transparency Initiative (IATI). In an assessment of the quality of ODA, the Global Economy and Development programme at the Brookings Institution and the Center for Global Development rank the BMGF high on focusing its efforts on those countries that have good operational strategies. According to their report, the foundation has done well in reaching the poorest people and giving assistance to countries with good monitoring and evaluation frameworks, while lacking on coordination and collaboration with other donors and increasing the burden on partner countries.

### Table 18

<table>
<thead>
<tr>
<th>Year</th>
<th>Awarded grants in US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>41,452,186</td>
</tr>
<tr>
<td>2011</td>
<td>69,723,900</td>
</tr>
<tr>
<td>2012</td>
<td>164,726,386</td>
</tr>
<tr>
<td>2013</td>
<td>343,100,855</td>
</tr>
<tr>
<td>2014</td>
<td>173,008,473</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,098,376,995</strong></td>
</tr>
</tbody>
</table>


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Corporate interest in the policies and programmes of the WHO is not a new phenomenon. The repercussions of corporate influence on WHO could be observed, for instance, during the management of the swine flu outbreak in 2009–2010. It was revealed shortly after WHO had declared the virus a pandemic that some of the experts advising the emergency committee behind this decision had “declarable financial and research ties” with drug companies that were producing antivirals and influenza vaccines. The pandemic proved to be a trigger point for pharmaceutical companies to establish vaccine contracts with governments, many of which subsequently lay dormant due to overestimations of the severity of the virus by the emergency committee. This did not come without significant costs for countries already facing tight health budgets, and raised serious concerns about potential conflicts of interest. It took WHO more than one year after the declaration to reveal the names behind the decision-making processes of the committee, with the organization citing the “need for secrecy to protect against the influence of outside interest on decision-making.” After a large number of reviews and inquiries following allegations of industry influence, the question remains whether the interests of pharmaceutical companies in lucrative vaccine deals or concerns for public health were being prioritized in WHO decisions at the time of the A/H1N1 outbreak.

A further example where WHO ties with private actors have been tight has been in its association with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), a body with strong pharmaceutical industry presence. IMPACT’s relationship with WHO is ambiguous, having been described as everything from a ‘WHO-hosted partnership’ to a completely separate entity. This ambiguity made it possible for a document prepared by GlaxoSmithKline, “Anti-counterfeit Technologies for the Protection on Medicines,” to be introduced into WHO’s policy process—a move made even easier by the fact that the chair of IMPACT’s Technology Working Group was also the director of the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), of which GlaxoSmithKline is a member. The document itself proposes a variety of high-tech protections, which seem useful for high-value branded medicines. The relationship between WHO and IMPACT clearly highlights the need for consistent rules and regulations for WHO’s relationships with non-state and private actors in order not to compromise the organization’s credibility and independence.

141 Cf. IMPACT (2008).
142 Cf. Third World Network (2010).
Towards a Framework of Engagement with non-State Actors

In light of the growing role of corporate philanthropy and private companies in the WHO decision-making process, many governments and civil society organizations have called for a comprehensive and effective follow up of the public interest safeguards promised by Gro Harlem Brundtland in 1998 and the WHO “Guidelines on working with the private sector to achieve health outcomes” from the year 2000.\(^\text{143}\) WHO Director-General Margaret Chan reaffirmed the importance of such safeguards in a speech at the 8th Global Conference on Health Promotion in June 2013: “In the view of WHO, the formulation of health policies must be protected from distortion by commercial or vested interests.”\(^\text{144}\)

As part of the current WHO reform process that started in 2011, governments have requested the Director-General to develop a Framework of Engagement with non-State Actors (FENSA), and separate policies on engagement with different groups of non-State actors (NSAs). The WHO Secretariat has been working on a draft framework since 2012 and presented reports in May and December 2014.\(^\text{145}\) In response to the first draft, several WHO Member States raised serious concerns\(^\text{146}\) for consideration in the final framework. These include:

» **Conflicts of interest** and their management were identified as the most critical aspects of the framework of engagement. There were several calls for a stronger approach or policy on conflict of interest as integral part of the framework of engagement.

» Further clarity was requested on the process and modalities of **conducting due diligence**, the criteria applied, and the link between due diligence and conflict of interest.

» WHO is expected to accept **financial resources from private sector** entities only if potential conflicts of interest are ruled out and if this engagement does not compromise WHO’s integrity and reputation.

» The **secondment of non-State actors’ representatives** to WHO were questioned. The key concern in this regard is to protect the independence and the integrity of WHO, particularly with respect to its normative and standard-setting functions.

» Some **non-private sector entities** may be influenced by private sector entities. It was suggested that non-governmental organizations, philanthropic foundations and academic institutions not “at arm’s length” from private sector entities should be also considered as private sector entities. It was further suggested that the concept of “non-State actor” could be further refined to include entities falling outside the defini-

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\(^{143}\) Cf. WHO (2000) and Richter (2012).
\(^{144}\) Cf. Chan (2013).
\(^{146}\) Cf. WHO (2014e), paras. 5–20.
tion, such as public–private partnerships and multi-stakeholder initiatives.

» This also relates to which organizations should be eligible for admission into official relationships, with particular regard to international business associations. Although there is agreement that WHO should not engage with the tobacco and arms industries, this restriction could/should be extended to others, including notably the alcohol, food and beverage industries.

» It was suggested that the respective roles of the governing bodies and of the Secretariat should be clarified, that private sector involvement should be open to WHO Member States scrutiny and that Member States should be involved in due diligence.

» It was further proposed to increase to more than six the number of members of the Committee on non-State actors of the Executive Board and to require the Committee to report also to the Health Assembly. Some Member States proposed that WHO Member States should be able to participate in the Senior Management Committee on Engagement.

» It was pointed out that it is not clear whether the framework applies also to partnerships that WHO is hosting or involved with or how conflicts of interest are managed in such partnerships.

» It was suggested that WHO should introduce the concept of “competitive neutrality” (also known as “level playing field”) in its engagement with the private sector. This is meant to ensure that the organization’s interactions do not confer undue competitive advantages.

» It was proposed that provisions be added in order to clarify how the organization should act in emergency situations and how it should avoid the disguised dumping of medicines in the form of donations. Some Member States suggested the need for objective and justifiable criteria for the selection of the countries, communities or patients to benefit from such donations.

» It was asked whether WHO is using the appropriate mechanism and measures to ensure the protection of its name and emblem against misuse for promotional purposes, in particular by private sector entities.

» Some Member States noted that a process for evaluation of the framework, including with regard to due diligence and risk assessment, is missing from the draft policy. They suggested that the evaluation function should be embedded into the framework with a view to informing future decisions on the revision of the framework two, three or five years after its approval.

» One WHO region proposed that the revised framework should better reflect the role and function of academic institutions, in particular regarding the ways in which such institutions can complement WHO’s work.
The final version of the framework was expected to be adopted during the 2015 session of the WHA. While many issues were agreed upon, the intense negotiations did not lead to consensus among governments over crucial issues, such as definitions of resources, secondments, the relation of WHO with industries other than the tobacco and arms industry, transparency requirements, oversight mechanism of engagements with non-State actors and ceilings on financial resources.\textsuperscript{147}

The WHA convened an open-ended working group to finalize the draft framework and requested the Director-General to submit the final draft text to the WHA for adoption in 2016 and to develop a register of NSAs.\textsuperscript{148}

Since the framework is still under negotiation, it is difficult to assess its final content. The framework will probably address risks for the WHO of engagement with non-State actors and reflect many of the concerns mentioned above.\textsuperscript{149} Furthermore, the framework will formulate overarching principles for WHO’s engagement with non-State actors. It is also expected to clarify different types of interaction, which can be the attendance at WHO meetings (e.g., meetings of the governing bodies, consultations and hearings), contributions of resources (funds, personnel or in-kind contributions), the gathering, analysis and generation of information, advocacy and awareness-raising of health issues and technical collaboration (product development, capacity-building, support to policy-making at the national level, operational collaboration in emergencies, contributing to the implementation of WHO’s policies).\textsuperscript{150}

Several concrete steps to manage potential risks could include due diligence on the nature of the non-State actor and a risk assessment regarding the engagement, a publicly visible register of non-State actors,\textsuperscript{151} and an electronic tool for the management of individual conflicts of interest. Since this part of the framework is heavily contested and debated, it is impossible to make predictions about its final form and, thus, its effectiveness. Also under debate are specifics concerning the financial contributions of non-State actors.\textsuperscript{152}

Civil society organizations (CSOs) also have been actively following these discussions and advocating for a robust framework, repeatedly pointing out important possible shortcomings of the document being negotiated. According to Third World Network, for example, the draft framework lacks a comprehensive conflict of interest policy to manage both institutional and personal conflicts of interest in the WHO.\textsuperscript{153} Currently, WHO does not engage with tobacco and arms industries.

\textsuperscript{147} Cf. WHO (2015c).
\textsuperscript{148} Cf. Third World Network (2015).
\textsuperscript{149} Cf. WHO (2015c), para. 8.
\textsuperscript{150} WHO (2015c), paras. 15–21.
\textsuperscript{151} A pilot register can be found on: www.who.int/about/who_reform/non-state-actors/register/en/.
\textsuperscript{152} Cf. WHO (2015c), paras. 22ff.
\textsuperscript{153} For a more detailed critic see: www.twn.my/title2/health.info/2015/hi150103.htm.
However, whether the framework will take up the concerns raised by several Member States and CSOs to extend this restriction to the alcohol, food and beverage industries, seems doubtful. ¹⁵⁴

That the framework may not differentiate sufficiently between corporate actors, business interest NGOs and public interest NGOs is a further matter of concern. It is possible that it will propose to treat international business associations as part of the private sector but also as NGOs and so allow them to attend governing body meetings. ¹⁵⁵

The challenge still remains for WHO to develop a system of legal and ethical regulation for interaction with corporate and other non-state actors that goes beyond what has already been proposed; one that would tackle vested interests and return priority setting powers to democratic and accountable entities—the Member States of WHO. However, before this can happen Member States must refocus on their responsibility to defend the right to health for all of their citizens and enhance their financial and political support of WHO as the key enabler of such an outcome at the global level. For public health not to be left to the shifting priorities of corporations and philanthropy, this responsibility must include an increase in the regular assessed contributions of Member States to ensure the continuity of WHO budget and to allow the Director-General to be able to use these untied funds flexibly, when necessary.

It is only through such efforts that the ongoing contradictions between WHO’s constitutional mandate and donor and private interests will be resolved and a functioning and independent WHO governed by the principles of social justice, global solidarity and human rights will be made possible.

¹⁵⁴ Cf. WHO (2015c), para. 44.
¹⁵⁵ Cf. WHO (2015c), para. 10ff.