Informality in Global Health Governance

by

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I am thankful to those who I consider as family for motivating me throughout my journey and keeping me going through this thesis. I dedicate this thesis to my dear mom and dad, my brother Arda, my best companion Efe, and my precious babies Badem and Tombiş.

ABSTRACT

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This thesis focuses on changing dynamics within the global health governance (GHG), especially one regarding the position of the World Health Organization (WHO) within the existing system. Informal practices within the global health governance, and how this informality impacts the functioning of the global health system is examined in this thesis. For a long time, global health governance has been dominated by the WHO as the primary actor responsible for systematical functioning of the global health system. In the light of diminishing influence of the WHO in global health governance and increased presence of new actors in this field, this thesis project focuses on the puzzle of informality within global health governance, while examining the diminishing role of the formal practices undertaken by the WHO authority within this framework. This study aims to answer the questions of "How informality impacts global health governance?", "How has the WHO lost its function over time?", and "What kind of implications the competition WHO faces will have on global health governance in a post-pandemic world?". In this thesis, three illustrative cases of China, Bill and Melinda Gates Foundation and the Global Fund were analyzed through the three-way typology of informality (Westerwinter et al. 2021) to examine the changing dynamics in global health governance. In GHG, the existence of more than one influential actor may cause conflict in the negotiation of many important health issues, however, this variety may also contribute to a positive multilateral approach. It is certain that informality plays an important role in global health governance. In some cases, informal practices bring a new approach to common issues within the global health system and help improve the condition of the global health and individuals who are primarily affected by the policies of the global health community. In my analysis, informality within the WHO has negative impact on global health governance. Informality around, and of institutions have positive impact in global health governance to a certain degree. However, this outcome is heavily dependent on the fact that the two institutions I have examined are willingly abide to the rules and norms of global health governance set by the WHO. Therefore, in different cases focusing on different actors, which aim to create an alternative governance structure, informality around and informality of institutions may also have negative impact on global health governance. If informal practices abide by the rules and norms of global health governance, which prioritize individuals' right to health and wellbeing and principle of human security, informal practices have higher chance to have a positive impact on global health governance.

ÖZETÇE

Küresel Sağlık Yönetişiminde İnformalite

Elifnaz Yalçındağ

Siyaset Bilimi ve Uluslararası İlişkiler, Yüksek Lisans

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Bu tez, özellikle Dünya Sağlık Örgütü'nün (DSÖ) mevcut sistem içindeki konumuyla ilgili olarak, küresel sağlık yönetişimi (KSY) içindeki değişen dinamiklere odaklanmaktadır. Bu tezde, küresel sağlık yönetişimi içindeki informal uygulamalar ve bu informalitenin küresel sağlık sisteminin işleyişini nasıl etkilediği incelenmektedir. Uzun süredir küresel sağlık yönetişimine, küresel sağlık sisteminin sistematik işleyişinden sorumlu birincil aktör olarak DSÖ hâkim olmuştur. Bu tez projesi, DSÖ'nün küresel sağlık yönetişimi üzerindeki etkisinin azalması ve bu alanda yeni aktörlerin ortaya çıkması ışığında DSÖ tarafından üstlenilen formal uygulamaların azalan rolünü incelerken, küresel sağlık yönetişimi içindeki informalite bulmacasına odaklanmaktadır. Bu çalışma, "Kayıt dışılık küresel sağlık yönetişimi nasıl etkiler?", "DSÖ zaman içinde işlevini nasıl kaybetti?" ve "Pandemi sonrası dönemde, DSÖ'nün karşı karşıya olduğu rekabetin küresel sağlık yönetişimi üzerinde ne gibi etkileri olabilir?" sorularına yanıt vermeyi amaçlamaktadır. Küresel sağlık yönetişimindeki değişen dinamikleri incelemek için üç açıklayıcı vaka – Çin, Bill ve Melinda Gates Vakfı ve Küresel Fon – üç yönlü kayıt dışılık tipolojisi (Westerwinter ve ark. 2021) aracılığıyla analiz edilmiştir. KSY'de birden fazla aktörün etkin varlığı, birçok önemli sağlık sorununun müzakeresinde çatışmaya neden olmakla beraber, bu çeşitlilik aynı zamanda çok-taraflı bir yaklaşıma da katkıda bulunabilir. İnformalitenin küresel sağlık yönetişiminde önemli bir rol oynadığı kesindir. Bazı durumlarda, informal uygulamalar küresel sağlık sistemi içindeki ortak sorunlara yeni bir yaklaşım getirmekte ve küresel sağlığın ve küresel sağlık topluluğunun politikalarından öncelikli olarak etkilenen bireylerin durumunun iyileştirilmesine yardımcı olmaktadır. Bu teze göre, kurumlar içindeki informalitenin küresel sağlık yönetişimi üzerinde olumsuz bir etkisi vardır. Kurumlar çevresindeki informalite ve kurumların informal olması ise küresel sağlık yönetişimi üzerinde belirli bir dereceye kadar olumlu etkiye sahiptir. Ancak bu sonuç, incelediğim iki kurumun DSÖ tarafından belirlenen küresel sağlık yönetişimi kurallarına ve normlarına isteyerek uymasına büyük ölçüde bağlıdır. Bu nedenle, alternatif bir yönetişim yapısı oluşturmayı amaçlayan aktörlere odaklanan farklı vakalarda, kurumların çevresindeki informalite ve kurumların informal olması, küresel sağlık yönetişimi üzerinde olumsuz etkilere sahip olabilir. Informal uygulamalar, bireylerin sağlık ve esenlik hakkı ile insan güvenliği ilkesini ön planda tutan küresel sağlık yönetişimi kural ve normlarına uyduğu takdirde, informal uygulamaların küresel sağlık yönetişimi üzerinde olumlu bir etki yaratma şansı daha yüksektir.

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TABLE OF CONTENTS

ABBREVIATIONS

AIIB	Asia Infrastructure Investment Bank
AMA	Agreed Management Actions
BMGF	Bill & Melinda Gates Foundation
BRI	Belt and Road Initiative
CCM	Country Coordinating Mechanism
COVAX	COVID-19 Vaccines Global Access
COVID-19	Coronavirus disease 2019
DAH	Development Assistance for Health
DALY	Disability-Adjusted Life Year
DSR	Digital Silk Road
FCTC	WHO Framework Convention on Tobacco Control
GAVI	Gavi, the Vaccine Alliance / Global Alliance for Vaccines and Immunization (previously)
GBD	Global Burden of Disease
GHG	Global Health Governance
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome
HPV	Human Papillomavirus
HSR	Health Silk Road
IGO	Intergovernmental Organization
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IO	International Organization
MDG	Millennium Development Goals
MERS	Middle East Respiratory Syndrome
MoU	Memorandum of Understanding
NGO	Non-Governmental Organisation
NHC	China’s National Health Commission
NZD	Neglected Zoonotic Disease
OBOR	One Belt One Road
ODA	Official Development Assistance

OECD	Organization for Economic Co-operation and Development
OIG	The Office of the Inspector General (The Global Fund)
PATH	Program for Appropriate Technologies in Health
PPP	Public-Private Partnership
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goals
TB	Tuberculosis
THE GLOBAL FUND	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TGI	Transnational Public-Private Governance Initiatives
TRIPS	Trade-Related Aspects of Intellectual Property Rights
TRP	Technical Review Panel (The Global Fund)
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	The United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1:
INTRODUCTION

As of early 2020, COVID-19 pandemic had an immense impact on a wide range of issues such as the management of global systems in many sectors to our comparatively insignificant daily activities. Throughout the early 21st century, humankind has experienced global health crises such as the 2003 SARS pandemic, 2009 swine flu pandemic, 2012 MERS epidemic, and 2013-2016 Ebola epidemic in West Africa. However, the unique characteristics of the recent COVID-19 pandemic was the unprecedented degree of contagiousness of the COVID-19 virus, ability of the virus to mutate in a short period of time, and the unpreparedness of the local and global disease surveillance and health systems for a timely response to pandemic. As a result, as of June 2022, the virus has claimed the lives of over 6 million people and 549 million cases were reported all around the world. In addition to the track record of the pandemic, which is usually represented by quantitative data, the pandemic had a serious impact on the global economy, trade, and social dynamics in the world[1]. Global health governance (GHG) became the focal point of attention in global politics with the observable immense effects of the pandemic on the daily lives of a range of populations from the rural workers in mainland China to the white-collar employees who were now cramped in their home-offices in New York. While this period had significant impact on my personal and academic life through the challenges it brought, it also inspired me to investigate the existing system in global health governance and to answer several questions such as “How global health governance is structured?”, “Why once-dependable institutions, such as the World Health Organization (WHO), have lost their credibility over time?”, and “How sustainable disease preparedness mechanisms can be established in a system that is much less fragmented due to the conflict of authority between different type of actors in global health governance?”.

Therefore, my investigations on the changing dynamics within the global health governance, especially one regarding the position of the WHO within the existing system, have brought me to a point where I have been interested in analyzing the informal practices within the global health governance, and how do this informality impact the functioning of the global health system. In this thesis project, I have focused on the puzzle of informality within global

[1] Data extracted from “Who Coronavirus (COVID-19) Dashboard,” World Health Organization (World Health Organization), accessed July 8, 2022, https://covid19.who.int/.

health governance, while examining the changing influence of the WHO within this framework. For a long time, global health governance has been dominated by the WHO as the primary actor responsible for systematical functioning of the global health system. The ability of the institution to uphold itself within contemporary global health governance, and despite its diminishing influence its ability to exert considerable impact in global health governance shows us the historical prominence of the organization. Its unique mandate and organizational structure, which enables the organization to bring various actors of global health society together, still forms the influential basis of the organization. Therefore, in my study, I have chosen to analyze the informality practices in global health governance in comparison to the diminishing role of the formal practices undertaken by the WHO authority. Through this study, I wanted to answer the questions of "How informality impact the global health governance?", "How has the WHO lost its function over time?", and "What kind of implications the competition WHO faces will have on global health governance in a post-pandemic world?".

The concept of global health governance was first introduced in the beginning of 21st century, Hein and Kickbusch defines the GHG as "a mechanism for collective problem-solving, that is, health improvements through the interplay of three different institutional forms and actors in different levels" (2010, p.2). Starting from the 1980s, with the impact of globalization and post-Westphalian international setting, new-comer actors have gained influence in GHG, and this contributed to transition from traditional formal governing forms to informal practices in the global health system. The foundation of my research on informal practices in GHG will be based on the WHO, as the organization has undertaken the responsibility of leadership in the global health system starting from its establishment in 1946. However, the ability and willingness of the organization to maintain its authority in global health is often contested due to its problems regarding the organizational structure and changing global health environment with globalization and interdependence created in governance systems. Global health governance came to be an increasingly diversified arena as the number of participants has grown, and apart from benevolent humanitarian concerns of actors, ideas rooted in national and global security create a push for actors to be actively involved in global health governance (Chattu 2017). Several triggers such as "changing patterns of microbial resistance, climate change, environmental degradation, poverty alleviation, ands sustainability of healthcare systems" impact the global health and wellbeing, as well as the "increased tensions over securitization of global health problems" (Chattu 2017, p.135).

The topic of health has become a major issue that is considered outside the jurisdiction of the WHO, and the objective of developing global policy for health has entered agendas of numerous actors outside the traditional framework of the WHO which represented the global help governance (Chattu 2017). WHO is consistently criticized about its organizational and ontological problems on the basis of problems as the likes of: abundance of politically assigned post-holders; inability to build a cohesive administration scheme among headquarters, regional and national offices; struggle for allocation of institutional resources and prioritization among the administrative offices; ambiguity about which responsibilities of the organization should be prioritized, technical or normative responsibilities; heavy-footed bureaucratic relations; ability to implement policies on domestic level; accountability and transparency problems; diminishing authority in global health governance (Lee et al. 2014). As a result of accumulation of several problems and challenges related with organizational structure of the WHO, and the impact of changing global health scene over years, the WHO's leadership claim in global health has started to erode, causing a legitimacy problem for the existence of the organization. Accordingly, in my thesis project, I focused on this eroding leadership status in relation to examples of informal practices of governance in global health.

Informal practices in global governance are a rising phenomenon especially since the 1990s. The number of informal institutions, specifically Informal Intergovernmental Organizations (IIGOs) and Transnational Public-Private Governance Initiatives (TGIs), has rapidly expanded, and most importantly, this expansion in number of informal institutions is remarkable compared to the one of Formal Intergovernmental Organizations (FIGOs) (Westerwinter et al. 2021). While only 28 IIGOs existed in 1990, their number increased to 82 in 2014, which illustrated a 193% growth. The number of TGIs increased from 74 to 559, by illustrating a 6658% growth in numbers in the same period. While only 15 trans-governmental networks existed before 1990, 116 trans-governmental networks were created since 1990. By the year 2005, number of TGIs exceeded FIGOs, and decrease in number of FIGOs have coincided with sharp increase in number of IIGOs and TGIs (Westerwinter et al. 2021, p.7).

Before explaining the cases that illustrate informal practices in global health governance, first I would like to explain what the causes behind informality in global health governance may be. The literature on informality in global governance proposes different causes for the emergence of the informal practices. In the most simple sense, scholars agree that informal governance practices emerge as a strategy for states and transnational actors' who want to act outside the set rules and norms of formal institutions governing global governance structures.

The rapid increase in the informal institutions, since the early 1990s, is related with the changing power dynamics between state and non-state actors. Some scholars suggest that de-globalization and rising antagonism between Great Powers create an environment in which actors prefer informal settings to engage within each other on specific issue areas[2]. First, it is important to examine the relation between de-globalization and Great Power dynamics. Ripsman (2021) suggests that rather than de-globalization, increasing multipolarity and expansion of nationalist populism explains the conflict we observe between Great Powers today. The scholar suggests that the Great Power cooperation created the environment for rapid globalization in the early 1990s, as unipolarity under US hegemony after the end of Cold-War contributed to Great Power cooperation, and globalization through the liberal international order set by formal institutions of Washington Consensus.

However, today, globalization is threatened by events born out of its own successes and failures. As one of the failures of globalization, consequences of neo-liberal policies have caused the rise of illiberalism and authoritarian populism in both Global South and Global North (Miller 2021). Economic inequalities are the major failure of globalization, and they created discontent on the domestic level in many countries and caused the rise of nationalist populist leaders in power which favored protectionist trade policies and isolationism. In addition, the US's suspicions towards multilateralism as a hegemon was illustrated by the American preference for use of informal governance practices as opposed to formal governance settings, such as the UN or NATO (Cooper and Flemes 2013). The unwillingness of the US to bear the burden of being the sole hegemon in the existing liberal international order have altered the country's foreign policy starting from the Obama administration. Therefore, some scholars even claimed that the US was the actual revisionist Great Power which inflicted the de-globalization process rather than the usual suspects such as China and Russia (Chan 2021). It is true that under the Trump administration, the USA continued to show its discontent with multilateral engagement through the administration's challenge to the WTO, its abrupt decision to withhold funds from the WHO, and its withdrawal from the Paris Climate Change Accord (Paul 2021). However, while we can argue that this change of direction in the US's foreign policymaking had an impact on de-globalization, it is not the only determinant. Decreasing political and economic power of Americans after the 9/11 attacks, and 2008 global financial crisis have

[2] This section, which explains the cause behind informal practices in global governance in relation with multipolarity, de-globalization and Great Powers conflict, was incorporated into this thesis in the light of valuable feedback provided by Prof Ziya Öniş and Dr Mustafa Kutlay during my thesis defense.

created a cultivating global environment for rising powers to emerge. Consequently, a shift was experienced in the global environment, from a unipolar to a multipolar system, and this emerging multipolarity has contributed to Great Powers conflict and de-globalization (Ripsman 2021).

As one of the success stories of globalization, the spread of liberal economic policies has contributed to the emergence of rising economic powers in the world, hence, to changing dynamics in international order. Current global order reflects "a dynamic mix of established great powers, newly emerging great powers, and regional powers", which contributes to today's multipolar system (Cooper and Flemes 2013, 945). On the other hand, Western oriented nature of globalization and liberal international order created discontent in rising powers, as countries such as China and Russia started to search for alternative governance schemes to the existing institutions of global governance (Ripsman 2021). De-globalization, born out of rising Great Power conflict, created a trend in the Global South which pushed these countries to take control of national economic and political affairs from both formal and informal neo-liberal institutions such as the G7 group and World Trade Organization. As a consequence of Great Powers conflict and de-globalization, we have experienced a rise in informal institutional setting both among the countries from the Global South and the Global North.

As an example, informality caused a crisis in global trade governance and later this resulted in the "crisis of the institution" (Sinha 2021, p.1522). Throughout the period between 1980s and 1990s, which was marked by global trade liberalization, the WTO faced crises within the institution. Its new members were criticizing the low levels of proper representation, while they conformed with the formal structure set by the organization. However, now, the tension is increased due to power shifts in the global economy, which was caused by the rise of emerging powers and protectionist policies of the US, the alleged hegemon of the liberal international order. The rise of emerging powers and multipolarity created a more severe crisis for the existing order, named as a "crisis of the institution" by Sinha (2021, p.1522). WTO became more representative of the voices within itself through the reforms that aimed to adjust the existing structure to contemporary global dynamics. However, this progress also made the organization ineffective in arriving at multilateral agreements among its 164 member countries. Countries in both Global South and Global North south to informal practices in global trade governance as a consequence of this development. Emerging powers supported informal practices against rule-based orders in global trade governance. This resulted in the adoption of a dual strategy by rising powers, in which they aimed to consolidate their place within the WTO

while investing in alternative networks such as the BRICS (Sinha 2021). In short, the antagonism between the Global South and Global North, and discontent of both parties with the existing formal governance structures have caused an increase in informal practices in global trade governance (Sinha 2021). Compared to global trade governance, we can observe a similar progression in global health governance which caused an increase in informal practices.

Some scholars suggests that de-globalization may cause to emergence of "two overlapping international orders" (Owen 2021, p.1416). As opposed to a reduced version of liberal international order led by the US and Europe, a capitalist international order led by China, which emphasizes authoritarian form of governance, state-led development policies, and state sovereignty (Owen 2021). However, Owen (2021, p.1430) also suggests that China's goal is to "remain in the liberal international order but to deliberalize it" through acceptance of new rules and norms in global environment. Some scholars argue that multipolarity and the external challenges posed to liberal international institutions did not necessarily cause de-globalization (Coleman and Job 2021). Coleman and Job (2021, p.1451) differentiate "deliberalization and dewesternization" from de-globalization in their study, which illustrates the efforts of African group and China towards reformation of UN peacekeeping activities as a globalized but less liberal and less western institution. Neo-Westphalian values, which prioritize principles of sovereignty and non-interference, are embraced by rising powers such as China (Lake et al. 2021). While China aspires to be a significant actor in existing prominent multilateral institutions, she also copied their structure to create alternatives institutions based on neo-Westphalian norms. Neo-Westphalian ideology pushes China to align itself with the interests of Global South, its involvement with G77 and Non-Aligned Movement (Cooper 2020). The most recent example of this deliberalization project is China's Belt and Road Initiative, which helps the Chinese government to form an informal governance network with partner countries on specific issue areas according to their own set of rules and norms.

Until the 2008 global financial crisis, informal institutions were mainly used by countries from the Global North, as a form of private clubs focused on a designated issue area, such as the G7 group (Cooper 2022). Global financial crisis of 2008 created a major transition in institutionalism (Cooper 2022), changing economic power dynamics, unipolar structure of the international order to a multipolar one, and contributed to an increase in Great Powers conflict. As the Global South countries perceived their positions as the outsiders of the system and institutions, the rising economic powers outside the G7 grouping established a new set of informal institutions. These institutions varied as both pluralistic and solidaristic informal

institutions were established by some of the significant rising powers. Pluralistic informal institutions such as G20 consists of both Global South and Global North countries, while solidaristic informal institutions such as BRICS aims to increase convergence of policies of Global South countries (Cooper 2022). To explain this phenomenon, Cooper (2020, p.1947) suggests that in foreign policy decisions of the rising Great Powers, "duality" or "ambivalence" plays an important role. All rising powers face a puzzle; to cooperate with or separate from the existing international order (Cooper and Flemes 2013). Scholars suggest that the emerging Great Powers respond differently to this puzzle, by willingly choosing not to take a certain stance in this dilemma and acting ambivalent. Rising Great Powers prefer to engage in new trends of governance, as they prefer informal governance networks to strengthen rising powers cooperation and coalition building rather than acting individually. Compared to Great Powers antagonism in the past, multilateralism is important in today's emerging governance structures. In this sense, governance networks contribute to the evolution of new and informal types of multilateral institutions.

In the light of globalization, we can observe that the increasing interconnectedness in technical dimension of global health, while the political dimension further diluted as it has been significantly influenced by the de-globalization trend and Great Powers conflict caused by the multipolarity of international order (Kornprobst and Strobl 2021). According to this, rising powers who seek alternative global governance methods sought to establish informal institutions and governance networks to work around the rules and norms of liberal international institutions in global health. Accordingly, in the first illustrative case, you can observe that as a rising Great Power, China uses informal practices within the WHO, first to increase its influence in the organization, second to change the set rules and norms within the institution. In addition, to create an alternative to the existing global health governance system controlled by the WHO, China established an informal governance network such as BRICS grouping in order to strengthen its Great Power position by strengthening the country's solidarity with the Global South and to institutionalize an alternative global order with like-minded partners. In addition, inequalities in the global health caused by the outpour of sources to research and development agendas of wealthier nations, and unrepresentativeness of Global South in formal global governance structure such as the WHO, have impacted the legitimacy of the formal global health institutions. This situation has narrowed the already insufficient capacity of the WHO, and contributed to the increase of informal institutions, which aimed to close this alleged governance gap in global health. In the illustrative cases of Bill & Melinda Gates Foundation,

and the Global Fund, we can observe that lack of capacity of the existing formal global health institutions have contributed to the rise of informality in global health governance.

In my thesis, I will be using the three-way typology of informality established by Westerwinter et al. (2021): informality within, of and around institutions. For this purpose, first I would like to introduce the theory of informality in institutions. In the state-centric international relations until the late-20th century, convergence of actors in issue areas was sustained through "international regimes and formal intergovernmental organizations" (Westerwinter et al. 202, p.1). However, starting with the emergence of new non-actors in global scene such and experiencing a rapid increase of numbers of such actors in 1990s, both state and non-state actors have preferred "informal governmental organizations and transnational public-private governance initiatives" over traditional global governance methods (Westerwinter et al. 2021, p2). While formal intergovernmental organizations still hold a significant place in many global governance areas, informal practices can be used in cases where formal governance practices are insufficient to address certain problems or issue areas are overly contested and formal governance practices are not feasible and sustainable. Westerwinter et al. defines informal governance as "any rules, norms and institutional structures and procedures that are not enshrined in formally constituted organizations or in their constitutions" (2021, p.2).

I would like to explain the three-way typology of informal governance which was used in this thesis project, and the illustrative cases I focused on during my research. For my thesis research, I have conducted analysis on three illustrative cases while using the three-way typology theorized by Westerwinter and colleagues to examine the changing role of the WHO in the global health governance within this framework. I believe that the in-depth study of three different cases for the practice of informality is what distinguished my thesis project from the existing literature which do not necessarily focus on the issue of informality in global health governance through a theoretical approach on informality practices in more than one form. This study also benefited from Angin's (2022) research project using the same theoretical framework to detect the informal practices within the global health governance through use of sentiment analysis to analyze the verbatim of speeches of the World Health Assembly (WHA) and WHO Executive Board meetings. Angin proposes a new research agenda that invites scholars to complement her quantitative analysis with qualitative methods, including case studies. My

thesis builds on this motivation and contributes to the literature with three illustrative cases that Angin suggests to take a deeper look into for unpacking informality in GHG[3].

The first illustrative case I have used is the case of China assuming a global health leadership role, as an example for the informality within pillar of the typology in global health governance. Informality within formal and informal organizations is defined as "informal arrangements, understandings, practices or norms operating within organizations" (Westerwinter et al. 2021, p.5). The second illustrative case is focused on informality around institutions in GHG through the examination of illustrative case of Bill and Melinda Gates Foundation (BMGF), and informality around institutions is defined as "diverse informal institutions and networks exist around institutions of global governance" (Westerwinter et al. 2021, p.6). The final illustrative case is the analysis on informality of institutions within the GHG through an examination of the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund). Informality of institutions is defined as "emergence of informal governance institutions, expansion of new institutional forms, trans-governmental networks of domestic regulators and trans-governmental regulators and transnational public-private governance initiatives" (Westerwinter et al. 2021, p.6). Through these illustrative cases, I would like to shed light on the reason for the emergence of informal practices in GHG, and how these practices elevate certain global health actors in the global health system in parallel with decreasing influence of formal institutions designed to govern global health systems such as the WHO.

In the upcoming sections, first I will inform the readers about the existing literature on informality in GHG, and the WHO. Later, I will present my analysis on the three illustrative case studies, and through the help of this analysis I will explain the impact of informal practices in GHG to the functioning of the global health system. In the second chapter, you can find the literature review on informality in GHG, and the WHO organized under two separated subheadings for the convenience of the readers. In the third chapter, you can find the three illustrative cases analyzed through the framework of three-way typology of informality. In the fourth and last chapter, you can find my concluding remarks on the thesis project. When I started this project, my expectation was to find prove for the increasing role of non-state actors within the global health governance, and as a result, the diminishing role for the WHO in GHG, which experienced a decrease in influence in global health aid and attained a focal role in

[3] For further information, please refer to: Angin, Merih. 2022. "Informality in Global Health Governance: A New Research Agenda." International Paris Conference on Social Sciences – VII, July 6-7, Paris, France.

disease surveillance through acceptance of a fragmented approach in global health governance. Also, while investigating the impact of informal practices in GHG, I have expected to find that out of the three types of informality, while some have positive impact on GHG, others have contentious effect on GHG, therefore, attracted more attention in existing literature.

Chapter 2:
LITERATURE REVIEW

2.1 History of the World Health Organization and Literature on the WHO

The World Health Organization was created in 1946, as the single authority responsible for international health. The WHO is a "multilateral organization with a quasi-universal membership of 194 states" which provides the organization a central role in global health governance (Fenk 2013; Hanrieder 2015a, p.195; Hein & Kickbush 2010). Although the WHO's traditional central role provides a strong administrative role and bureaucratic ties for the organization, the WHO still encounters problems regarding its inefficiency to undertake the governing role of the global health system (Hanrieder 2015b; Hein & Kickbusch, 2010).

The WHO undertakes an important technical leadership role in the field of health development, and it has significant influence in the developing world, however, it lacks to provide appropriate financing for its endeavors (Perez 2015; Hein & Kickbusch, 2010). The organization assumes the role of an organizational network with the objective of assistance to developing regions in access to affordable health services and medication, as it backs the interests of developing regions with their relations to other states, inter-governmental organizations, pharmaceutical companies, and civil society organizations (Hein & Kickbusch 2010). This technical leadership role, and organization's normative power is provided by the constitution of the WHO. For example, the organization's active role in SARS epidemic, avian influenza and H1N1 influenza was sustained through the support of the new International Health Regulations (IHR) introduced by the WHO and WHO Framework Convention on Tobacco Control (FCTC) (Perez 2015; Hein & Kickbusch 2010). The new IHR and the FCTC are "binding international agreements", which also helped enhance non-state actors' involvement through organizational restructuring (Hein & Kickbusch 2010, p.1). However, as the global health system has been changing, this has an impact on the position of the WHO within the GHG. There is an increasing need for the WHO to excel among emerging actors within GHG, and this situation creates a competitive environment between prominent health

actors. Therefore, this may distract the institutional focus of the WHO, and puts its role as "trusted neutral brokers between the scientific and the technical communities on one hand, and governments of developing countries on the other" (Hein & Kickbush 2010, p.5).

The historical event that put an end to the WHO supremacy in global health governance is considered to be its response to the HIV/AIDS epidemic (Hanrieder 2015b; Perez 2015). Historically, the HIV/AIDS epidemic was not the first failure in the WHO's track record, as its unsuccessful malaria eradication campaign in 1950s to 1960s, and its inadequate response to smallpox eradication in 1979 were significant examples which put WHO influence in danger (Perez 2015, p.5). The global response to HIV/AIDS mainly came from the health sector in the 1980s, and cooperation of different health-oriented-agencies in the later decade. During this process, WHO lost its influence and reputation among global health society and many UN agencies including UNICEF, UNDP, and World Bank and UNESCO introduced their own recipes for the disease response (Hanrieder 2015b; Perez 2015; Kickbusch 2004). In addition, a new UN institution emerged, dedicated to the issue of AIDS, called the Joint Nations Program on HIV/AIDS (UNAIDS). Although the WHO was included in the establishment process of the new institutions, it could not take on the main role as the orchestrator of this response system.

A significant change within global health was the establishment of the relationship between health and development in the 1970s. Health assistance became the main field, which this newly established relation has exerted its impact. As a consequence of the relation established between health and development, new actors pursuing the leadership role in the health assistance emerged, and this situation inflicted a decrease on WHO's influence. With the introduction of the new Sustainable Development Goals in 2015, global health governance had transitioned from being a rather restricted policy arena focused on disease control to being a regime responsible for a global health in a more comprehensive understanding of health (Held et. al 2019).

The emergence of health development and the emphasis on this concept within global governance also entails problems regarding achievement of certain global health objectives. It has been criticized that the global health system should focus on eradication of several diseases and health problems rather than solely focusing on trendy diseases in the field of health development (Hanrieder 2020b). In addition, universal health coverage, a principle that the WHO advocated for since its establishment, should be put forward on the global health agenda. Unfortunately, the achievement of universal health coverage has long been overlooked by many

actors in GHG. There are two reasons behind this phenomenon. First, "social policy initiatives of the WHO have met with massive resistance" (Hanrieder 2020b, p.1). Secondly, since the WHO is seen as merely a technical organization by many of its members and external actors, although the organization has been vocal about the inequalities and "non-medical determinants of poor health – poverty housing deprivation, job insecurity, racism, violence, environmental pollution, or patent regulations" – the organization failed to ensure implementation of policies targeted into developmental aspects of global health (Hanrieder 2020b, p.1).

The WHO embarked on many ventures starting with the failed initiative of World Health Forum, which was launched by WHO Secretariat to support cooperation among prime global health stakeholders. Furthermore, the decreasing authority of the WHO has also damaged its autonomy against the member states, as they started to show a tendency to take other health stakeholders as central authority. This is highly related to the increasing numbers of initiatives and actors in global health. The WHO faces a budgetary problem as assessed contributions, which consists of regular contributions by member states, are diminishing year by year. While some member states are unwilling to pay their appointed contributions, some clearly do not even provide their assessed contributions (Fee 2016). While many member countries who have experienced rapid economic growth in the last decade fail to align their contributions to their increasing prosperity and authority, the "zero nominal growth policy" adopted in 1993 has caused a decrease in financial contributions provided by the economically developed members of the WHO (Frenk 2016). This situation also reduced the attractiveness of the WHO to other global health actors. Member states of the WHO started to undermine its authority through their "earmarked budgetary contributions" (Hanrieder 2015b; Frenk 2016). As of 2022, only assessed contributions cover only less than 20% of the total organizational budget[4]. A major part of the voluntary contributions to the WHO are discretionary fundings provided with the condition of use in appointed issue areas by the donor states. Therefore, in most cases, voluntary contributions account for specific agendas rather than contributing to the core objectives of the WHO mandate, which are universal health coverage and disease eradication in the world (Sridhar et al. 2014). Furthermore, many member states can establish informal cooperation schemes outside the WHO in order to distinguish their own health agenda and find financial support for it, as it can be observed in the BRICS cooperation's annual meeting of health

[4] Further information regarding budgetary assessment of the WHO can be find in "How Who Is Funded," World Health Organization (World Health Organization), accessed July 1, 2022, https://www.who.int/about/funding.

ministers (Sridhar et al. 2014).Consequently, the WHO is unable to maintain its monetary accumulation and to be able to financially support its programs, the organization is driven to cooperate with "global foundations, development banks and multinational corporations" (Fee 2016, p.1903; Frenk 2016). Therefore, the current organizational structure of the WHO makes it impractical to fund its activities without reliance on external financial assistance (Fee 2016). There has been criticism towards the WHO, as it is assumed that financial reliance on non-state actors has a negative impact on the WHO's leading role in the GHG.

Institutions designed to be part of global governance in other issue areas, such as World Bank, gained prominence in global health, and even created itself a central position through its advancements related to health development, which undermined the authority and focal position of the WHO in the context of health assistance. On the other hand, the WHO was able to maintain its central role in terms of "disease surveillance and response" (Hanrieder 2015b). The reason behind the erosion of WHO's authority in health aid, is the organization has limited resources to implement its advice to member countries, and this makes WHO to cooperate with other global health actors. Therefore, the relation between health and development not only changed the methods of health aid, but it also put other IGOs, such as development-oriented organizations, that are not specialized in global health in the game. For example, the World Bank project for strengthening primary health care and the importance given to health-related initiatives in the 1970s paved the way to organization's active involvement in global health. After two decades, the World Bank became the "largest health donor" and "claimed intellectual leadership with its 1993 World Development Report entitled Investing in Health" (Hanrieder 2015b; Lee 2014). In addition to the emergence of the health development agenda, health governance has started to be shaped within issues of international politics, as of "international trade, migration, and environmental influence on health", rather than technical aspects (Frenk 2013, p.937). As the WHO's response capacity fell short of supply for global demand for health governance in certain issues intersecting with international politics, the WHO started to lose supremacy in GHG. For example, the World Trade Organization has played a leading role in the formation of intellectual property rights for pharmaceuticals (Frenk 2013). However, this kind of informal governance practices can be damaging for the societal trust in global health authorities. As management of the intellectual property issues was undertaken by a trade-focused organization, and not by an experienced global health actor with set rules and regulations, this experience has caused transparency problems regarding the negotiation process of the agreement and were criticized as non-inclusive (Kickbusch 2004). Another organization

which emerged as a competitor to the WHO in the health sector was another UN organization, UNICEF. UNICEF increased its capacity for technical assistance by employing health professionals and "formulating its own concept of Selective Primary Health Care" (Hanrieder 2015b). Eventually, after the Alma Ata Conference, which officially brought the understanding that health as a part of developmental endeavors, UNICEF ceased its cooperation with the WHO (Kickbusch 2004; Hanrieder 2015b).

Another challenge in GHG, which alters actors' preference for use of informal practices, is related to national sovereignty and health security. This challenge will be mainly investigated through the first chapter by focusing on the illustrative case of China's informal practices within GHG. In their article focused on emergency governance of international organizations, Hanrieder and Kreuder-Sonnen (2014)'s main argument is that where issues are securitized as global threats, exceptionalism can emerge at the level of supranational bodies, giving them the authority to redefine emergencies and lead political response accordingly. In this article, the WHO's response to the 2003 SARS outbreak is used as a case study. The authors claim that the WHO response to this crisis strengthened the institution's role in emergency response and in consequence, pawed the way to "institutionalization of emergency powers within the organization and contributed to securitizing the 2009 swine influenza outbreak as global pandemic" (Hanrieder & Kreuder-Sonnen 2014, p.331).

The 2003 SARS epidemic was a significant example of portrayal of the WHO's leadership role in disease surveillance and control. However, after this historical event generated a debate about whether we are shifting into a "post-Westphalian order in global health" (Hanrieder & Kreuder-Sonnen 2014, p.332). While some scholars considered the new IHR of 2005 as a sign of transition of "public health authority into supranational level" (Fidler 2004; Zacher and Keefe 2008), some scholars claims that authority of states in global health should not be undermined since the WHO is an organization dependent on its member states in terms of health security measures (Davies 2008; Kelle 2007) (Hanrieder & Kreuder-Sonnen 2014, p.332). Additionally, since the WHO is dependent on its partners for its budget accumulation (Graham 2013; Hanrieder 2015b), some scholars underline governmental control may impede WHO from adequately ensuring global public health (Kamradt-Scott 2011).

In the following 2009 H1N1 outbreak, the WHO response was later criticized as "for the first time in its history, the organization declared a so-called Public Health Emergency of International Concern (PHEIC)" (Hanrieder & Kreuder-Sonnen 2014, p.332). However, in the

aftermath of the health emergency, the seriousness of the pandemic assessed by the WHO was found to be less than it was declared. As a result, the accountability and transparency of the organization was criticized by "journalists, state representatives and European parliamentarians" (Hanrieder & Kreuder-Sonnen 2014, p.332). Hanrieder and Kreuder-Sonnen (2014), put emphasis on the two different sides of the WHO, on one hand it is an inter-state organization financially dependent on its members, on the other hand the organization cannot take binding actions regarding its member states and its transparency problem diminishes its ambiguous legitimacy on member states. While securitization of certain issues can reinforce institutional influence, it may also create an environment for informal practices. Therefore, in order to prevent this informality international organizations should be transparent, and checks and balances should be imposed on these actors to strengthen their position in global governance schemes. These kinds of accountability mechanisms would not only prevent IOs from diverting from their mandates and norms, but also would control actions of individual actors like states and non-governmental entities in scenarios where these actors act upon their own interests and objectives in global governance of issues related with the common good of all such as public health.

It is important to emphasize that the historical progress of the WHO as a leading global health authority is more similar to a fluctuating wave rather than a linear line. Therefore, there have been attempts for reforms to improve the organizational structure of the WHO over the years, and many initiatives were inaugurated in order to enhance the influence of the WHO as an actor responsible for managing the global health cooperation among many different interests and actors. The Paris Declaration on Aid Effectiveness of 2005 had significant impacts on strengthening the WHO authority in GHG. Under the mandate of this declaration, contributing countries should consider the internal dynamics of the aid receiving countries, and their assistance should back the developing countries' development strategies (Hein & Kickbusch 2010). The aim of this mandate is to support good governance practices within development assistance, hence also advocating for good governance of global health.

Establishment of high-level expert commissions by the WHO was significant, as these commissions helped introduce new policies in global health over various health issues and created a cooperation mechanism for the increasing number of diverse actors focused on different issue areas in global health (Hein & Kickbusch 2010). "The Commission on the Social Health Determinants, The Commission on Macroeconomics and Health, and the Commission on Intellectual Property Rights, Innovation and Public Health were three important

commissions established by the WHO (Hein & Kickbusch 2010). In addition to these ventures conducted within the organization, the global health leadership of the WHO was recognized by prestigious actors in global governance such as the European Union. In May 2010, Council of the European Union advocated for the leadership of the WHO in GHG, through Conclusion on the EU role in Global Health. In this council meeting conclusion, there is a call for EU member states "to support an increased leadership of the WHO at global, regional and country level, in its normative and guidance functions addressing global health challenges as well as in the technical support to health systems governance and health policy, given its global mandate" (Council of the European Union 2010, p.3). There is a demand for member states to step away from voluntary contributions and gravitate into assessed contributions (Council of the European Union 2010).

Even though the WHO has gone through several reform processes, which aimed to strengthen the organizational structure of the organization, through the years, reforms were undertaken to increase the WHO influence and authority in the global health system that remained overlooked. In her study, Hanrieder (2020a) proposes three reforms for restructuring of the organization: by focusing on pandemics, by taking a general approach to health while designating certain primary concerns to focus on, and by finding a "niche" for the organization. Hanrieder (2020a, p.538) underlines that since the increasing number of new actors that emerged in the GHG pushes the WHO in a position that the organization is having to share its existing authority with others, the WHO should strategically choose its niche focus area and try to exert more influence in this context. For example, many newly emerged IOs, NGOs, and private and public actors have advantage in terms of acquiring finance, organization of large-scale projects, deployment and management of health services, the WHO merely becomes one of the actors among many in the global health sector in these terms. Therefore, the WHO should find its "comparative advantage" and it is suggested that this advantage is its universal mandate which supports the organizational activities as "UN's coordinating agency for global health" (Hanrieder 2020a, p.539). For instance, the recent role of the WHO in COVID-19 pandemic as the prominent agency that worked towards building global cooperation for disease surveillance and control is a remarkable example of why the organization should put more focus on this function. Although the primary supervisor role of the WHO in pandemics is supported by the IHR, the member states' consent is still needed to gather intelligence regarding diseases. In the light of the recent COVID-19 pandemic, the member states have become less reluctant to entrust their authority into the WHO as a leading organization due to certain factors of rising

nationalism particularly in European region, resistance against multilateral cooperation, and increasing skepticism against international organizations with claim of expertise in global health (Hanrieder 2020a).

However, the definition of the core functions of the WHO opposes a political challenge. Since the activities of the WHO is dependent on financial contributions of the member states and other partners in the global health system, member states and external actors in relation with the WHO will have to come to an agreement on which function should be designated as the core function of the organization (Hanrieder 2020a). Taking the consent of other global health actors in this context is crucial, since this kind of a reform should reinforce the authority of the organization, rather than wasting its potential, as states have the room for maneuver to bypass the WHO regulations and policies when they do not fit their interests and needs. This type of reform will be hard to implement since it is ambiguous how one can convince other actors while building a niche imaginary based on appointing oneself as an overarching authority in the global health system and demanding financial assistance (Hanrieder 2020a).

2.2 Literature Review on Informality in Global Health Governance

While informal governance practices in global issue areas such as international law, trade, security, and environment have attracted attention of political economy scholars, global health governance has maintained as an issue area which did not attract significant attention in the context of investigation of informal governance practices. In this respect, I believe that this thesis project will deal with an overlooked intersection of global governance and informal practices through concentrating on the informal practices in GHG. In global health governance literature and literature on the WHO, scholars have focused on issues such as ambiguous the leadership role of the WHO in GHG, organizational structure and historical evolution of the WHO, emergence of new actors in GHG, and facilitating cooperation in GHG through formal and informal practices. However, the existing literature does not prioritize informal practices as in the likes of the existing literature on informality in global governance in other issue areas. For that reason, I believe that this thesis project is novel in the sense that it primarily focuses on informal practices in GHG, and rather than providing a policy proposal for the WHO, the main objective of the article is to investigate the impact of informal practices in general structure of the GHG through using the WHO as a reference point, as the organization is traditionally considered as the legitimate authority in global health field. It is also important to emphasize

that rather than using hegemonic stability theory as a theoretical perspective, this research takes on constructivist, neoliberal institutionalist, and discursive institutionalist approaches.

Bueger's study focuses on the "informalization or deformalization" trend in global governance (2021, p.1). It is suggested that through informal practices in specific issue areas in global governance, new "informal governing spaces" and "new governance techniques" such as "benchmarks, goals, rankings or commitments" emerge (Bueger 2021, p.1). The author tries to answer the question of why informalization happens. According to the rationalist perspective, informal practices is chosen by actors in a way that will align with their interests. However, the current literature falls short to explain why informal practices are observed more in some issue areas compared to others. When existing institutions and mechanisms are insufficient to govern certain issues in global arena, actors problematize the issues in question in informal settings. Over time, these informal settings can transform into institutional settings with policy mechanisms and assignment of established authorities through new roles for existing and emerging actors (Bueger 2021). However, it is also implied that informality may re-emerge in the formalized institutional settings even after the issues are adapted by certain organizational settings, or issues may remain heavily disputed and it may not be possible to institutionalize certain problematizations, which makes the informal arrangements permanent (Bueger 2021). In the context of GHG, we can observe the example of the later assumption of Bueger, which suggests that since the WHO lacks to address certain global health challenges, and unsuccessful to take on its responsibilities within the global health system, informal practices within and around the organization, and establishment of informal entities as a competition for the WHO emerge in global health system.

Hanrieder (2015b) argues the orchestrating role of the WHO by investigating the presence of the organization within the global health governance through the lens of orchestration theory. The orchestrating role in this case implies the authority of organization among its other inter-governmental organizations, non-governmental organizations, transnational institutions, and public and private actors within the global health system. In this specific study, the author focuses on the focality issues of IGOs in a world filled with intermediaries, which are always competing for more authority. The WHO's unique constitution puts the IGO in a top place of hierarchy of global health actors, and the organization being in the center of the global health system increases its value as a partner for intermediary health organizations.

The two main pillars of global health can be named as "health assistance and epidemiological surveillance". According to Hanrieder's study, while the WHO maintains its influence in the latter, it was not able to preserve its central role in the former due to changing information systems and increase of the number of new actors attending these issues in the 1990s. According to Hanrieder (2015b), intermediaries and their attachment to the central IGO is important. Along with the intermediary organizations such as public-private initiatives (GAVI, Global Fund, Bill and Melinda Gates Foundation) in the 2000s, the number of the IGOs related to health increased (Held et al. 2019; Lee et al 2014). As of 2014, there were "over 26 UN entities, 40 bilateral development agencies, 20 multilateral development funds, 90 global health initiatives" (Hoffman 2014, p.190). After this development, health became an issue of international relations through means such as health diplomacy, rather than maintaining its status as a reserved technical issue area.

Henrieder underlines that "intermediary" actors within global health play an important role in choosing the central authority by preferring to cooperate or not (2015, p.211-212). In the joint initiatives WHO participated in, the organization acted mostly as a partner with no "formal representation at the governing board" (2015, p.202). The Bill & Melinda Gates Foundation is more of a focal institution in global health governance by serving as the major financier of joint health initiatives such as GAVI and is on the governing body of all major health collaborations. The WHO was unable to keep up with the demands of the global health society, and as these examples illustrate, it was inadequate to undertake its role as a central actor in health cooperation. According to Henrieder's study (2015), WHO was able to maintain its leading role in the communicable disease surveillance and response, however, this finding may be contested after the recent COVID-19 pandemic. Historically, while WHO's active involvement in disease surveillance and intervention to health policies within the jurisdiction of sovereign state was restrained by state consent, the WHO's power was strengthened through "removal of the sovereign veto from the IHR" by means of redrafting of the IHR in 2005 (Hanrieder 2015b, p.209). This historical turning point came to existence after experience with the SARS outbreak, in which the member states did not attempt to retrieve their veto rights. This example shows us the acceptance of the WHO's leading role by the stakeholders in the issue of disease surveillance and emergency response. Under favor of the revised IHR, WHO could make sharp decisions and implement them effectively during the 2009 H1N1 influenza outbreak.

According to Henrieder (2015), cooperation with intermediary actors may empower IGOs through reinforcing their central role and increase the autonomy of IGOs against states.

Henrieder (2015, p.212) takes on a constructivist approach by suggesting that "focality has a discursive component" as it "depends on how issue areas are defined and redefined". The concept of "health development" redefined global health, and in terms of focality strengthened the position of already existing and newly emerged IGOs, NGOs and TGIs. Another important point regarding Henrieder's implementation of orchestration theory in global health demonstrates that there is no tendency towards constantly increasing or decreasing orchestration of the WHO, as it was both enhanced and weakened over time from different aspects. However, in global health, having more than one authority is denounced as it is damaging for health cooperation and introduction of consistent health policies.

Frenk (2016) illustrates the difference between core and supportive functions of the WHO and suggests that the WHO inclines to put more emphasis on its supportive functions while neglecting its core functions lately. The core functions of the organization cover global disease surveillance and control, emergency response systems, and provision of health services for all, which require an overarching role for the WHO over national authorities through its global mandate. The supportive functions of the WHO consist of the role of sustaining technical cooperation within the global health society and assisting national governments. Frenk (2016) argues that while other global health actors can accommodate the supportive functions of the WHO, neglecting its core functions would make the WHO merely one of the many actors working in the field of health development. Therefore, it is suggested that further emphasis should be put on the core functions of the WHO to protect the historical prestige of the WHO as the leading global health actor, in an environment where the primary influence of the WHO in GHG is decreasing over time (Frenk 2016).

Global health governance is also affected by the "three persistent governance challenges that are embedded in the structure of the global system: the sovereignty challenge, the sectoral challenge, and the accountability challenge" (Frenk et al. 2013, p.939). For the sovereignty challenge, national sovereignty hinders global cooperation and involvement of external actors in domestic health policies in times of health crisis in an environment of intensifying health interdependence. The sectoral challenges involve the fact that GHG today is built on the cross-sectoral cooperation in global health system, and many global health actors such as the WHO are unable to provide assistance for policy demands in sectors such as "trade, investment, security, the environment, migration, and education" on its own. The accountability challenges can be separated into two types, one being focused on accountability of intergovernmental

organizations towards civil societies of its member states, and other being focused on accountability problems regarding non-state actors (Frenk et al. 2013).

There are four main aspects of an effective GHG system (Frenk et al. 2013). The first requires full support of the member states of the WHO in their payments of assessed contributions and conforming with rules and regulations of the institution to provide public health goods equally. The second requires the existence of an authority which will bind and control the actions of the sovereign actors to overcome accountability problems and setbacks caused by negative externalities. The third one requires strengthening of organization schemes for financial and health service assistance to disadvantaged and vulnerable regions in case of certain health crises or natural emergencies causing health concerns. The fourth one is related to the "stewardship" role of the WHO, which means that the organization is responsible to provide "overall strategic direction to the global health system" with the intention that through setting global health objectives directed towards common public good of all, this will contribute to the smooth functioning of other agenda items of the global health system (Frenk et al. 2013, p.940).

Frenk et al. (2013) suggests that there should be a common understanding on which actor will commit to which objective in institutional level and undertake this certain global health issue as its core function as the main authority. For example, the distinctive global health stewardship role of the WHO should be preserved and highlighted even through the restructuring of the institution (Frenk et al. 2013). In addition, there has been affords to increase "accountability and legitimacy" through delegating authority between several actors within some major global health institutions such as the GAVI Alliance, UNAID, and the Global Fund, which have "non-state representatives, such as civil society organizations, communities of people affected by target diseases, and foundations" (Frenk et al. 2013, p.941). However, since this kind of organizational design, which advocates for more inclusivity, is still few in numbers, there is a need for more non-discriminatory, and liable actors in GHG.

Perez (2015) suggests that the WHO should aim more than a global health leadership role, and in order to accommodate itself in this ever-evolving global health system, should attain a role of coordinator among many objectives and actors. In addition to these concerns regarding loss of the WHO authority to internal and external actors, there is an increasing call for further involvement of civil society participation into the organization, as it is sometimes criticized for being too "state-centric" (Perez 2015, p.5). Despite these claims of being a state-centric

organization, the WHO is also criticized for its endeavors to be a more normative organization through trying to address health challenges in the developing world. As a result, many developed member states pressure the organization to prioritize its technical role in GHG and claim that "politicization" of the organization is another factor that diminishes the WHO influence on its member-states.

The recent COVID-19 pandemic response of the WHO also lacks to reflect the organization's role as a leader in disease surveillance and control. For example, in the context of vaccine research and development for COVID-19, only forty member countries have agreed on the WHO-backed initiative for a patent pool granting patent-free licensing for anti-COVID-19 medications to anybody who wants to develop them. A joint action initiative, the COVAX Facility, which is led by the "GAVI Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the WHO" was preferred over the WHO-backed initiative by most of the developed countries in the world (Hanrieder 2020a, p.541). This development illustrates the position of the WHO in the GHG as merely a global health partner rather than undertaking the role of global health leadership due to its legitimacy problem.

In this chapter, I laid down the current situation of the WHO and its position in the GHG through emphasizing the organization's historical evolution and changing understandings, actors, and forms of governance in global health. I also wanted to inform the readers about the existing literature on informality in GHG, however, due to the rareness of the literature specifically focused on this issue area, this section was limited. On the other hand, the main objective of this thesis project is to enlighten this often-undermined topic of informality in GHG, hence, in the later chapters, readers can fulfil their need for more extensive knowledge on the informality in GHG.

Chapter 3:
EMPIRICAL CASE STUDIES ON INFORMALITY IN GLOBAL HEALTH GOVERNANCE

3.1 The Illustrative Case of China in Global Health Governance

In this section, I will focus on the illustrative case of China in global health governance with respect to its positioning in the WHO, and its individual endeavors in the global health system. According to the informal governance practices typology, the case of China corresponds to an informal governance type of *informality within* the WHO. In order to explain informality within the GHG, I will focus on the historical process in China regarding transformation of its role distinctively within the WHO, and generally within global health governance. In this section I will focus on; first, the transformation in domestic health policy and foreign health aid policies of China, second, the watershed moments in history that impacted China's involvement in GHG, and third, the recent COVID-19 pandemic and impact of pandemic on China's influence in global health community and the WHO.

To understand the position of China in global health governance today, it is necessary to understand China's engagements with other actors of the global health community, which constituted China's health diplomacy, and how the experience gained through these engagements had affected China's domestic and international health policies. Therefore, first, I will examine the expansion of Chinese influence in global health governance through export of the Chinese primary health care model to the developing and underdeveloped regions in the world through its health diplomacy in the mid to late-1990s.

China has traditionally been source of numerous contagious epidemics, such as Manchurian plague epidemic which captured the attention of international community in 20th century, as well as major health advances such as the barefoot doctor and artemisinin, a powerful anti-malaria treatment created from plant-based Chinese traditional medicine (Liu et al. 2014). Liu et al.(2014) suggest that there are four pillars of global health: firstly, the goal of health aid is to provide global health equity, and official development assistance (ODA) coordinated by OECD countries can be given as example for this purpose; secondly, interdependence should be maintained in the global health community for protection against health risks; thirdly, health governance is needed to set negotiated rules and norms through health diplomacy; lastly,

knowledge transmission and implementation should be available within the global health community.

Chinese health aid is divided into five categories: medical teams, hospital development, medicine and equipment donations, health professional training, and malaria control, while the majority of health aid funds are spent on medical teams and donated facilities. China's annual health aid to Africa is estimated to be over $150 million (Liu et al. 2014). Unlike other OECD donors, China does not provide broad sectoral assistance, despite limited monetary donations to a few countries in recent years, and its health assistance takes a project-based approach. Starting from the early 1960s, according to the convention on the deployment of health work forces agreed by China and the receiving nations, over 23,000 Chinese medical personnel have been dispatched to around 66 countries to offer services to an approximately 270 million inhabitants (Liu et al. 2014, p.795). These developments are examples of the initial use of health diplomacy by China as a tool of foreign policy. Health diplomacy usually emerges in the form of technical or financial health assistance by countries to enhance their global influence in cases of geopolitical interest, forming alliances with others, or simply for increasing their reputation through use of soft power in the global arena.

China was accustomed to using health diplomacy as the country's "bilateral foreign policy agenda in the 1960s remained isolated from the global community, excluded from multilateral forums like the UN and the WHO" (Killeen et al. 2018, p.4). In order to assist the development of shattered local health systems in Algeria, who had recently gained its independence, China initiated its first health assistance in Africa in 1963. Premier Zhou Enlai of China dispatched a group of Chinese medical personnel to Algeria, which became China's first health mission to another country in its modern history, with 13 Chinese healthcare professionals, at the same time functioning as a concrete worldwide demonstration comradery between countries who take a communist ideology (Killeen et al. 2018). In order to strengthen the South-South cooperation between China and the African region, China aimed to mobilize African countries, who recently gained their independence, to protect their sovereign rights through building their independent economies and promote global peace (Killeen et al. 2018). In alignment with this aim, China announced eight principles of Chinese aid focusing on no-strings-attached aids, support for mutual benefit and equality, China's aim to be a burden-bearer for other countries, final aim being endorsement of national independence in recipient countries, giving priority to efficiency to China's aid endeavors (Killeen et al. 2018, p.5). Chinese health diplomacy with Africa also

contributed to China's global recognition as the legitimate government of China. After newly independent African states grew to account for nearly 30% of UN votes, China's help to Africa in the 1960s and 1970s reinforced African state support for China's global recognition against the nationalist government in Taiwan (Killeen et al. 2018). In the UN General Assembly of 1971, People's Republic of China was voted as the legitimately recognized Chinese government, followed by its recognition in the WHO.

A signature characteristic of Chinese health diplomacy is the use of dispatch of medical teams, which are not only responsible for treating patients but also responsible for establishing a sustainable healthcare system on a regional level through sharing experience and building infrastructure. Following China's embracement of universal health care principle in the early 1950s, country's health education system showed immense efforts to produce profitable and efficient methods to expand these policies into rural regions. One of the significant developments of this process was "*barefoot doctors"*, which consist of local individuals who received brief medical education in order to deliver primary healthcare services in local communities (Killeen et al. 2018, p.6). China was increasingly leveraging public health to establish diplomatic ties with developing countries, notably in the African region, as the Chinese government started sending "*angels in white*" and "*barefoot doctors*" to the Sub-Saharan area in the 1960s to deliver health care (Chan et al. 2010, p.4).

The Chinese government wanted to promote the accomplishment of its health diplomacy throughout the world, and the WHO would provide it the opportunity to do so. In 1973, one year after China joined the WHO, the WHO Director-General proposed the organization to investigate the circumstances in local health systems activities in several countries, including China. As an outcome of this investigation, China's domestic health-care policy influenced the 1977 World Health Assembly decision on *Health for All by the Year 2000*, and the Alma-Ata Declaration on Primary Health Care. Nonetheless, even though China's primary health care system served as the main pattern for the primary health care debates in the Alma-Ata Conference, geopolitical rivals of China had restrained China's participation in the conference, hence, hindered the country's health diplomacy efforts (Killeen et al. 2018). From 1979 through the 1990s, China had reconfigured its health policy priorities, and participation of Chinese government to health initiatives in Africa was weakened due to China's shifting focus on domestic economy, and successful adoption of a neoliberal agenda in African states by other global health aid donors.

3.1.1 Changing Health Diplomacy of China

The twenty-first century has seen a resurgence of Chinese participation in health development assistance in the African continent, while Chinese Foreign Minister Li Zhao Xing described this new involvement in 2003 White Paper on *China's African Policy*[5], which promised creating a framework for modern China-Africa ties. This new policy was built on a refreshed "set of constructivist" explanations for "a new series of horizontal programs" delivered through a range of "bilateral and multilateral" interactions (Killeen et al. 2018, p.8). Even with the unreassuringly condition of the domestic health system of China after SARS epidemic, China made effort to continue its relations with the African region as *African Policy* was officially issued in 2006 as a symbol of the country's dedication to development of health systems in Africa (Chan et al. 2010). As a successful Chinese foreign-aid-cooperation establishment technique, China's foreign assistance investments in African health development typically entail the implementation of projects linked to Chinese firms and promote Chinese exports, resulting in reciprocal advantages – win-win situations –for both parties (Lisk and Sehovic 2019). In 2009 a new health initiative between China and African region was established in Beijing with the initiation of the *1st International Roundtable on China-Africa Health Collaboration*, where China's efforts for and good contributions to development of African region was recognized by observers from global health society (Chan et al. 2010). In most cases, traditional foreign health aid practices of China did not have any political strings attached to them, therefore, these health aid programs were seen as alternatives to those which are provided by the Western countries, and requiring transparency, good governance, and respect for liberal rights. Differing from the dominant health aid practices in global health governance, China's health foreign aid was not tailored to benefactor countries, and usually bilateral cooperation was preferred. On the other hand, while today OECD countries have left economic tied aid policies, China's health aid may have economic requirements which supports its national sovereignty and economic development through methods such as promoting its pharmaceutical exports (Huang 2012, p.5).

Another important aspect of Chinese health diplomacy is that it creates a platform for exchange of medical experience and knowledge through cooperation for disease surveillance and emergency response. As an example of an aspect of China's health diplomacy, we can

[5] "White Paper on China's African Policy, January 2006." *China Report* 43, no. 3 (July 2007): 375–91. https://doi.org/10.1177/000944550704300309.

investigate China's contribution to eradication of malaria in the African continent. China had no local cases of malaria in 2017, and since then the Chinese government has made a pledge to eliminate malaria on domestic level by the year 2020. This effective response against eradication of malaria within Chinese territory was fulfilled by the means of an antimalarial drug called *artemisinin,* which was produced by using Chinese traditional medicine and is considered as a vital tool for malaria treatment (Chen at. al 2019). Following this development, China emerged as a model case for the global health community in the fight against malaria. In addition to its disease eradication objectives, China's collaborations with Asian and African countries in disease monitoring have created a blueprint for other developing countries. For instance, "trilateral collaboration" method was used in global health partnerships to provide development assistance for health, as in one example, while Australia acted as the donor country, China was responsible for technical control of the program which targeted eradication of malaria in Papua New Guinea. This joint health assistance program also acted as a step for "regional health security agenda of a malaria-free Asia-Pacific by 2030" (Chen et al. 2019, p.7). Consequently, the Chinese domestic health system became a blueprint for the WHO in implementation of a feasible method to achieve Universal Health Care, as China was able to eradicate serious illnesses in its less developed regions and minimize the healthcare divide between the urban and rural regions in a short amount of time (Chen at. al 2019). In this case, we can observe the positive impact of medical knowledge and experience sharing aspects of China's health diplomacy on improvement of global healthcare systems.

China is an important official development assistance and development assistance for health (DAH) contributor in global health (Tang et al. 2017, p.2595). Until the publication of the China's White Paper on *China's International Development Cooperation in the New Era*[6], use of bilateral health aid was more prevalent compared to its use of multilateral aid. In general, by leading global health aid donors, multilateral aid is preferred over bilateral aid because it is believed to be a more efficient method of funding. Since pooled funding minimizes operational costs and divides the financial burden of the receivers, this funding method makes multilateral aid more effective. However, in some cases, facilitating cooperation through multilateral aid can be an obstacle (Huang 2012, p.4-5). China did not have legal procedures to determine decisions of providing foreign aid, most of its foreign contributions are conducted through

[6] State Council Information Office (SCIO), 2021, *White Paper on China's International Development Cooperation in the New Era*. Available from http://www.xinhuanet.com/english/2021-01/10/c_139655400.htm

impromptu ministerial documents and regulations (Huang 2012). As China did not have any official foreign aid agency until the establishment of the Global Health Cooperation Office of China, health-related foreign aid decisions in China were provided by four central institutions: the Ministry of Finance, Ministry of Commerce, Ministry of Foreign Affairs, and Ministry of Health (Huang 2012).

China's stance on multilateral foreign aid has started to change as China started to have a more active role in global health institutions and changed the direction of its foreign aid policies into a more development-oriented and inclusive one. According to the UN Development Programme's Issue Brief on China's third White Paper on Development Aid, China's development strategy has expanded from limited foreign aid perspective to extensive recognition of development cooperation. The brief underlines that China's development aid objectives go out of its accustomed bilateral foreign aid practices and pursues a new cooperation mechanism with the developing world based on both bilateral and multilateral relations (United Nations Development Programme in China 2021). The brief highlights the use of the term 'new era' in the title, which represents the new policy direction of China commenced with the 18th Congress of the Chinese Communist Party in 2012. The new and expanded nature of Chinese foreign aid policy is identified in "the concept of grand foreign aid (da yuan wai)" (United Nations Development Programme in China 2021, p.2). Policy objectives in China's international development partnerships is discussed as "promoting global community of shared future" is the mission, "pursuing the greater good and shared interests, with higher priority given the former" is the underlying guideline, "South-South cooperation is the focus", the mechanism which will help China to facilitate these is BRI, and the main goal is to "help other developing countries to pursue the UN 2030 Agenda for Sustainable Development" (United Nations Development Programme in China 2021, p.2). The perception of China is that international development cooperation creates "space and opportunities" for realization of BRI (The State Council Information Office of the People's Republic of China cited in United Nations Development Programme in China 2021, p.2).

In the White Paper, for the first time, Chinese foreign aid is conceptualized in international methods, as given specific importance was put in 2030 Agenda for Sustainable Development and China's alignment with this agenda (United Nations Development Programme in China 2021). Between the years 1998 and 1999, China received and contributed around $5 million to WHO, while China's estimated contribution to WHO had climbed to $30 million by 2012-13,

but WHO financing to China had stayed flat. According to the second White Paper on Foreign Aid, China donated $280 million in 2010-12 to assist the Global Fund and other international organizations (Liu et al. 2014).

Although its foreign aid for health development in developing regions of the world, especially in Africa, have contributed to increasing influence of China in global health governance, there were few historical moments which transformed China's perception of its role and changed its stance in global health governance. The first historical development in this aspect is the 2002-2003 SARS crisis. The SARS epidemic was a watershed moment for China to reconsider its existing practices of health cooperation within actors of the international health community. While the SARS epidemic had a positive impact on improvement of domestic disease surveillance and health-crisis response systems within China, the epidemic also changed the traditional mindset of China in terms of relations with the international actors in the state of health emergencies. After the SARS epidemic, China created new mechanisms to enhance the communication with actors within the international society based on domestic health problems (Huang 2012). Prior to the SARS outbreak, the Chinese government continued to prioritize national sovereignty, as the government considered prioritizing health policies based on basic human rights would create an opening to outside meddling in its domestic affairs (Chan et al. 2010). However, The SARS epidemic made China recognize the importance of establishment of robust domestic health systems based on public health rights. Since public health issues of a country cannot be separated from the global health in today's globalized governance systems, China had to consider prioritizing public health security in order to establish concrete foreign policies on global health and preserve its health security. According to the opinions of the global health community, China had a late response to the SARS epidemic, as the country acted reserved towards the global health community when it came to share information about the disease surveillance and emergency response within the borders of China. The refusal of WHO assessment teams to enter the Chinese territory for virus inquiry in 2003, directed global attention on China. (Chan et al. 2010).

3.1.2 China's Approach to Global Health after the SARS Crisis

The SARS epidemic has changed both the domestic health system in China, and the government approach to global cooperation in the context of health emergencies. After taking office in early 2003, the new Hu Jintao-Wen Jiabao administration quickly took a more

transparent and cooperative stance toward WHO member countries and Southeast Asian states in the management of epidemic (Chan et al. 2010). As a result of the SARS epidemic, the country's approach to health diplomacy has moreover changed with the significance of "non-traditional security issues" gained in the global arena (Chan et al. 2010, p.1). The SARS epidemic showed a critical weakness in China's domestic health-care system. As a result, China needed a national health reform to enhance its monitoring program and redirect its fixed endeavor of economic expansion since the late 1970s toward a more sustainable approach of economic growth and constructing public infrastructure.

Asian Development Bank figures show that the SARS epidemic had tremendous damage on China's economy as China lost US$6.1 billion, which constituted 0.5% of its GDP in the year 2003 (Chan et al. 2010, p.1). Considering the significance the Chinese government puts on economic development and stability of the regime, political ramifications of a possible financial downturn caused by a health crisis can have an immense impact on China. Accordingly, in alignment with the economic growth-oriented plan of the government, public health funding was improved remarkably after the 2003 SARS epidemic in China. In total, the central and municipal governments collectively contributed 111.69 billion yuan for public health, which is a 23 percent increase compared to the previous year (Chan et al. 2010, p.1). The government's health expenditure increased by about 100% between 2002 and 2006, the figure increased by 29.1% to 229.71 billion yuan by 2007 (Chan et al. 2010, p.1). In addition to the domestic pressures that changed the importance given to healthcare system within China, external pressure also contributed to improvement of public health system within the country, as the WHO assessed in their mission report to China, "there was an urgent need to improve surveillance and infection control in the country" (Schnur cited in Chan et al. 2010, p.2). Considering both the SARS epidemic and China's desire to be acknowledged as "a responsible state" have driven China to strengthen its collaboration with global health organizations to address critical health challenges, China had chosen to implement "a new rural cooperative medical system" as an ademption to deliver more balanced and available health care to its rural populations by 2010 (Chan et al. 2010, p.2).

After experiencing the political and economic repercussions of the poor decisions undertaken during the SARS epidemic regarding cooperation with the global health society, China had a differing response to the 2005 outbreak of Avian Influenza A (influenza H5N1, bird flu). The SARS outbreak became a milestone in the progression of foreign policy agenda of China, as Beijing has taken a more assertive role in global health governance. After joining

the WHO, China has maintained an inactive role in the organization until the SARS outbreak. The SARS epidemic demonstrated the authority of the WHO to China. This incident was viewed as a learning opportunity for China, as the WHO's political relevance was recognized, and efforts were made to strengthen its engagement in GHG. China nominated and backed a Chinese official at a high position for the 2006 election for WHO director-general, Margaret Chan, for the first time since its admission to United Nations agencies in 1971 (Chan et al. 2010). During the Avian Influenza epidemic, China was more open to information sharing with the international health community, and even was considered as a role-model compared to countries such as Indonesia, who rejected to share information about domestic condition and virus samples with the WHO during the crisis on the basis of "viral sovereignty" (Huang 2012, p.6). In this period, China has shown its ambition to be more open to change for the sake of undertaking a more cooperative role within the global health governance. China started to become an actor that can be seen more in multilateral cooperation in global health by taking roles in international and regional platforms. "In 2006, China hosted the International Pledging Conference on Avian and Human Influenza", in which the global health society "pledged $1.9 billion dollars" for the avian influenza epidemic, which China also has contributed $10 million of the sum (Huang 2012, p.7). In 2009, China hosted the International Scientific Symposium on Influenza A (H1N1) Pandemic Response and Preparedness.

Although China showed its willingness to be involved in the existing multilateral health initiatives, the Chinese government also planned for establishment of new initiatives as alternatives for the existing ones. In 2011, for the first time in history, health ministers from the BRICS countries held a meeting in China[7], and as an outcome the participant agreed on *Beijing Declaration* to investigate technology transfer to help underdeveloped countries to develop low-cost, high-quality life-saving medicines for health conditions such as HIV/AIDS, TB, and hepatitis. As a part of its multilateral initiatives, China also took part in multiple healthcare-oriented conferences in regional networks such as "ASEAN+3 Summit, the East Asia Summit, and the Asia Europe Meeting" (Huang 2012, p.7). As a part of China's ventures for undertaking a role for effective response to avian influenza, China recommended significant initiatives for disease control, for example, endorsement of the Greater Mekong Six-Nation (GMS) Ministerial Meeting on Disease Surveillance Cooperation Project and organized the second

[7] UNAIDS, "First Meeting of BRICS Health Ministers Brings New Leadership to Global Health," UNAIDS (UNAIDS, July 11, 2011), https://www.unaids.org/en/resources/presscentre/featurestories/2011/july/20110711bchinabrics.

GMS Public Health Forum in 2009. During the tenure of Hu Jintao, which took place between 2002 and 2012, the president's active involvement in establishment of health diplomacy advocated for "peaceful development" and "harmonious world" within the of "*Harmonious Society*" project. Through this project, China tried to better its national image on a global level as an altruistic country after the SARS epidemic (Gauttam et al. 2020, p.323). However, China was still criticized by its Western counterparts despite its increasing investment in multilateral cooperation in international health, as its concentration on state sovereignty and historical opposition to collective decision-making mechanism which limits its domestic policy making autonomy made China take role in global health governance strategically and selectively (Huang 2012). Some scholars such as Huang (2012, p.7), suggest China's inadequacy to be more open to information sharing and accountability problems during the H5N1 bird flu epidemic in 2005 and H1N1 swine flu pandemic in 2009, which illustrates its new health diplomacy's limits.

There are concerns about the misuse of China's role in global health governance, and specifically there are concerns regarding the misuse of China's influence within the WHO. Since the SARS pandemic demonstrated the importance of the WHO as an institution, which has power to set the rules and norms in the global health governance, China had been more active in the institution to increase its national influence strategically within the global health governance (Huang 2012). China has presented itself as a responsible actor within the global health governance, who is open to cooperation with governmental and non-governmental actors with different interests. The first act of China, which for the first time took an active role towards rules-and-norms-changing initiatives within the WHO, is considered as a negotiation process of the Framework Convention on Tobacco Control (FCTC). While China owned the largest state enterprise tobacco monopoly in the world, the Chinese government supported significant provisions which put public health over trade and allowed legal advantage for countries against tobacco companies within the jurisdiction of domestic laws (Huang 2012). China also played an important role in the revision process of the International Health Regulations after the 2003 SARS outbreak. On the other hand, political considerations impacted China's actions in the revision process of the IHR. *Universality principle* was to be introduced during this revision process, and this principle could remove the obstacles in front of Taiwan to acquire the formal WHO membership. Since China considered this possibility as a threat against its national sovereignty, Chinese representatives in the negotiation process emphasized that national sovereignty and territorial integrity of China had outweighed the issue of health. This

situation has a negative impact on the negotiation process. However, China later changed its stance against Taiwan's participation to the WHO when the new Taiwanese president ensured China's sovereignty through endorsing *One China Principle,* which supported China's inseparable territorial integrity in regions such as Taiwan and Hong Kong. Later in 2009, Taiwan gained observer country status in the World Health Assembly (Huang 2012). It is important to be reminded that not all international activities in health agenda formulation promote beneficial change, as international actors, motivated by their own interests or organizational goals, often transmit mixed messages which can be subsequently utilized by the government of China to legitimize continuation of its poor practices (Huang 2012).

If the WHO condemned Beijing in 2003 for its initially clandestine and lax response to the SARS pandemic, the same agency avoided criticizing China's travel and trade restrictions during the 2009 H1N1 outbreak, even though they obviously contradicted the WHO's guidelines. China then utilized the WHO's agreement to legitimize its harsh and often unneeded domestic health regime. The worry is that as China's voice in global health governance increases, international organizations and other countries may soften their critique of China. During a visit to China in 2010, the executive director of the Global Fund praised the governmental efforts in the fight against AIDS, while being discreet about the human rights problems regarding the HIV/AIDS patients in China or the local activities working for eradication of the disease (Huang 2012).

3.1.3 Health Pillar of the Belt and Road Initiative: Health Silk Road

Another important aspect of China's health diplomacy is the health cooperation network established with the introduction of the Health Silk Road through The Belt and Road Initiative (BRI). One Belt, One Road (OBOR), was a global infrastructure investment project launched by the Chinese government in 2013 with the goal of investing in roughly 70 nations and international organizations (World Bank 2018). OBOR was re-introduced in 2015 as Belt and Road Initiative with a name renewal and expanded objectives in 2015 (Cao 2020). Belt and Road Initiative is a multifaceted initiative, and its commitments also involve other developmental objectives than economic improvement. One of the significant aspects of the BRI, the aspect which this research will be focused on, is health cooperation. As an important aspect of the BRI, Health Silk Road is "an emerging diplomatic initiative for promoting health cooperation" (Cao 2020, p.19). Belt and Road Initiative was built on five main pillars, and as a

part of the ‘closer people-to-people ties’ pillar health became a prominent issue in the Chinese diplomacy (Permanent Mission of the People's Republic of China to the United Nations Office at Geneva and Other International Organizations in Switzerland n.d.). Since cooperation in the health sector is one of the many elements to attain closer people-to-people bonds, Health Silk Road is an important aspect of the BRI, which acts as an instrument to achievement of one of the main pillars of the initiative through increasing international cooperation for health development along the BRI region (Cao 2020, p.21). Health Silk Road was first introduced as a three-year plan for promoting the health aspect of the BRI in October 2015 by China’s National Health Commission (NHC) (Cao 2020; Qian et al. 2019). Through the establishment of the Health Silk Road, China aims to consolidate health development cooperation among the BRI regions through establishment of disease surveillance systems, sharing of medical knowledge and experience, providing financial assistance to partners when it is necessary, and work towards eradication of many diseases and health problems prevalent in the region.

In accordance with the Health Silk Road agenda, when the United Nations presented its 2030 Agenda for Sustainable Development in 2016, the Chinese State Council issued a *Healthy China 2030* blueprint pledging to increase China's health standards to those of developed countries by 2030 and contribute to the attainment of the 2030 Agenda, particularly the attainment of the SDG 3, which consists good health and well-being (Cao 2020). The Healthy China 2030 Plan had put universal health coverage as one of the primary objectives of Chinese national policy and given pivotal importance to healthcare policies locally and globally (Tang et al. 2017; Chen et al. 2019). Following this development, to enhance the efficiency of the Health Silk Road initiative, Chinese president, “Xi Jinping called for increased cooperation in infectious disease prevention and information sharing, medical assistance, and traditional medicine development” in June 2016 (Cao 2020, p.22).

In January 2017, Chinese President Xi Jinping visited the WHO headquarters in Geneva, and a “Memorandum of Understanding (MoU)” on health pillar of BRI was agreed on to promote “health security and development along the terms of the initiative” (Cao 2020; Chen et al. 2019, p.1; Tang et al. 2017). In the same year, a Country Cooperation Strategy between the WHO and China was signed to create a framework for “cooperation in health policies, planning, technology, and human resources” (Qian et al. 2019, p.63). In the May of same year, Belt and Road Forum for International Cooperation was held for the first time, and later China hosted a conference fostering health cooperation under the BRI framework, featuring several

representatives from different countries and international organizations such as the WHO, UNAIDS, GAVI, and the Global Fund (Cao 2020). In August 2017, Belt and Road High-Level Meeting was held by China with the objective of encouraging health partnership. In August 2017, officials from several nation-states and multilateral organizations signed the Beijing Communique, as China inaugurated the very first of biannual global conferences on health and the BRI. China signed seventeen bilateral MoUs with Silk Road countries and organizations such as UNAIDS, the Global Fund, and GAVI. These bilateral MoUs covered areas such as "health security, maternal and child health, health policy, health systems, hospital management, human resources, medical research, and traditional medicine". The government of China plans to initiate four frameworks – "public health, policy research, hospital alliance, and health industry" – to encourage constant dialogue in the quest for collaborative opportunities in support of the greater purpose of attaining the UN 2030 Sustainable Development Goals (Tang et al. 2017, p.2596).

The idea for the Health Silk Road evolved into a global endeavor to promote health cooperation, including policy elements already included in various local and international health action plans. Ever since, China has worked to institutionalize health cooperation inside the HSR framework by holding and funding several health-related regional conferences, such as "the Silk Road Health Forum, China-ASEAN Health Forum, China-Central and Eastern European Countries Health Ministers Forum, and the China-Arab States Health Forum" (Cao 2020, p.23). The Health Silk Road is perceived as a geopolitical strategy of China. In 2017, the Belt and Road High-Level Meeting for Health: Towards a Health Silk Road was conducted to promote communication in health among "health ministers, senior officials from national and local health authorities, high level representatives from international health bodies, experts and academics, and health industry representatives" to examine possibilities and problems, create agreement on health partnerships, and discover how the Health Silk Road might help to SDG accomplishment (National Health Commission of the PRC, n.d.). At this meeting, the Director-General of the WHO Dr Tedros Adhanom Ghebreyesus made optimistic comments about the initiative by stating that Health Silk Road has the potential for vitalizing the much-needed global health cooperation towards implementation of universal health coverage, and it has the technical and medical capabilities for health knowledge transmission and fostering robust health systems (Chen et al. 2019, p.1). Representatives from the OECD, GAVI, the Joint UN Programme on HIV/AIDS, the Global Fund and participating countries signed the Beijing

Communique in this meeting to pledge their commitment to participate in the Health Silk Road initiative (National Health Commission of the People's Republic of China 2017).

Within the scope of the SDG-3 related with health and well-being, China has been invested in several programmes[8], to reduce the poverty and poverty-induced healthcare problems. By the means of these programmes "China [is aiming to] cancel the debt of the least developed countries, launch 600 specific projects to end poverty, and support better health services" (Chen et al. 2019, p.9). Within the scope of these programs, US$2 billion was allocated to the "South-South Cooperation Trust Fund", a fund helping low to middle income countries in the global South in achievement of SDGs (Chen et al. 2019, p.9). Additionally, an additional financial assistance of US$2 billion, which is expected to be expanded to US$ 12 Billion by the year 2030, was made by China towards the achievement of the SDGs in developing regions (Chen et al. 2019, p.9).

Health Silk Road's uniqueness can be attributed to China's ambition to make this initiative a platform for international health cooperation through sharing of resources and medical knowledge and improving the capacity of local and regional basic health care systems, as well as eradication of social determinants of health problems. Through constant travelling of people and ever-expanding trade routes BRI can spread communicable diseases or unintentionally bring new communicable diseases, which would create a pressure on regional health services. On the other hand, Health Silk Road aims to contribute to the SDG number 3.3 by creating cooperation through the geography of the BRI through eradication of epidemics such as AIDS, tuberculosis, malaria and 17 neglected tropical diseases (NTDs), poverty-induced health problems and attain universal health coverage (United Nations 2015). Since the Silk Road region consists of many developing countries who still struggle to provide domestic healthcare and disease surveillance for potential epidemics in the region, Health Silk Road offers an opportunity for international health cooperation between these countries and China and creates a platform for "shar[ing] experience, financial support, multisector intervention, professional healthcare deliver, and technical innovation" (Chen et al. 2019, p.5). The Health Silk Road prioritizes provision of medical assistance in forms of medical equipment, medical personnel,

[8] The East Asia Poverty Reduction, Pilot China-Africa Cooperation Plan for Poverty Reduction, and People's Benefit programmes can be given as examples for China's involvement in poverty-reduction focused programs.

technical information sharing, financial aid, and creating an environment of cooperation to combat any possible health emergencies along the region.

"Mongolia-led, China-supported, and results-sharing approach" (p.62) is an example of the public health cooperation of China with other countries along the Silk Road initiative, which benefits both to China's capacity to engage in global health and health system of the partner developing country (Qian et al. 2019). "[BRI] provides a channel through which China facilitates its global health strategy, through commercial, cultural, and personnel exchanges that will improve bilateral and multilateral cooperation" (Qian et al. 2019, p.63). The health partnership between China and Mongolia started in 2004 as a bilateral cooperation agreement, which is concerned with communicable disease prevention, traditional medicine, and quarantine, was established and had been reaffirmed each four years (Qian et al. 2019). Under this agreement, China became an important development partner of Mongolia through infrastructural development and medical care. For example, in 2015 *China-Mongolia Chingeltei Children's Hospital* was constructed with the endorsement of *China Foundation for Peace and Development*, which is considered as the landmark project of this bilateral partnership (Qian et al. 2019; Batchimeg 2019). The two countries' health cooperation is primarily focused on medical and health assistance, with little projects in the field of public health implemented. One of the far-flung neglected zoonotic diseases (NZDs) along the Silk Road initiative is echinococcosis, and this disease is a serious matter of public health that is high on Mongolia's government agenda (Qian et al. 2019).

NZDs are linked with individuals living nearby to livestock and can cause major human suffering as well as significant losses to the livestock on which they rely on. The absence of accurate and timely diagnosis, as well as a lack of trustworthy data on prevalence and effect of the disease, are serious issues regarding the NZDs (Qian et.al, 2019). Within the framework of 'One Health' approach (Centers for Disease Control and Prevention 2021), a three-way agreement was signed between the WHO, the Food and Agriculture Organization and the World Organization for Animal Health in 2010 (Qian et.al, 2019). As one of the priority NZDs, echinococcosis causes an estimated nearly twenty thousand deaths each year and nearly nine hundred thousand disability-adjusted life-years worldwide (Qian et.al, 2019). Approximately 270 million people in Central Asia, which consists of the 58 percent of the population, is at risk of echinococcosis, and this disease causes in an estimated annual economic loss of 1.92 billion USD among the affected population and 2.19 billion USD for livestock (Qian et.al, 2019).

According to the National Health Committee's national monitoring program on major parasitic illnesses (2006–2015), echinococcosis has been at the prime focus in China for decades as one of the NZDs (Qian et.al, 2019). Therefore, China sharing not only its technical medical assistance but also the medical experience about the eradication of echinococcosis with Mongolia can be shown as a significant example of health cooperation facilitated through the Health Silk Road.

The Health Silk Road initiative provides a cooperative environment for the national governments and indigenous authorities along the BRI region, international and local organizations, public and private sectors, civil society, and the people. Under the Health Silk Road, 41 active programs can be named as the likes of "China-ASEAN Plan Training One Hundred Health Professionals", and "the China-Africa Cooperation Plan on Public Health", in addition to the think-tank cooperation which constitutes the knowledge accumulation aspect of the initiative, such as International Silk Road Think Tank Association (Chen et al. 2019, p.7). Since the objectives set by the Health Silk Road initiative cannot be reached without cooperation with "multisector engagement and expert involvement", the initiative is designed to maintain communication and cooperation with health-related-organizations such as the "WHO collaborating centers and existing South-South networks" (Chen et al. 2019, p.7).

In addition to facilitating cooperation in the global health care system and being member of several international health-organizations, China is aiming to be a financial contributor in global health through establishment of its multilateral funds and banks such as the *Asia Infrastructure Investment Bank* and the *New Development Bank*. Asia Infrastructure Investment Bank (AIIB) providing $100 billion, New Development Bank contributing $100 billion, Silk Road Fund contributing $55 billion, China-Africa Development Fund contributing $10 billion, and China South-South Cooperation Fund contributing $2 billion; the entire value of these funds exceeds the World Bank's total capitalization of $253 billion. The most significant one out of these funds may be AIIB, which aims to meet the infrastructure needs of 56 percent of the world's population and 48 percent of global GDP (Tang et al. 2017, p.2598). These funding institutions will constitute China's new instrument to control development aid and funding along the Silk Road geography within the framework of the BRI.

Along with the Health Silk Road, *Digital Silk Road* (DSR) is also a considerable dimension of the BRI, which especially has contributed to health governance during the COVID-19 pandemic through benefits it provided to digital economy, and technical support in health sector

in developing regions such as Africa and Latin America (Lee 2021). China-based technology companies and electronic giants such as *Xiaomi, Oppo* and *Alibaba Group* made medical donations in the form of face masks, ventilators, protective gears, and computer tablets for health-care workers (Borak 2021; Cerulus 2020). Telecommunications companies of Chinese origin such as Huawei and ZTE provided help for improvement of health technologies in underdeveloped regions such as Africa, this has a positive impact of incorporating the African region to Health Silk Road for disease surveillance for Ebola, Zika and COVID-19 (Cao 2020, p.33). The technologic tools provided by the BRI also contribute to improving healthcare through innovative private sector, as in the example of "*Aucma Company"* assisted the supplement of vaccines during the Ebola epidemic utilizing "*Arktek* portable cold-storage devices". The Chinese private sector has been contributing to eradication of communicable diseases through various technological systems such as "data systems and mobile-based technologies" (Chen et al. 2019, p.7).

3.1.4 The Role of China in GHG during the COVID-19 Pandemic

Lastly, the recent COVID-19 pandemic and rise of China as a responsible stakeholder during the global emergency put China in a significant position both within the WHO, and in global health governance. In addition to increasing its influence through earning global reputation through pandemic response, China also increased its room for maneuver within the WHO through increasing its institutional power in global health governance. Relatively quick recovery of the Chinese economy compared to its Western counterparts after the COVID-19 crisis helped China to gain attention for its "anti-coronavirus diplomacy" (Cao 2020, p.21). Gauttam, Singh and Kaur (2020) focus on the positive impact of COVID-19 crisis on the rise of China as at hegemony in global governance, while they argue that China uses health diplomacy as an instrument regarding the COVID-19 pandemic as a way of utilizing China's soft power in global arena to enhance its "geopolitical influence" (p.318). The scholars argue that since the developing world was particularly vulnerable against this kind of a health emergency – due to their insufficient medical resources and ineffectiveness of their healthcare systems – China find an opportunity to exert its soft power through its health diplomacy in alignment with its geopolitical objectives to attain importance in global health governance (Gauttam et al. 2020).At the beginning of the COVID-19 pandemic, China has contributed to many multilateral initiatives which were focusing on enhancing health cooperation in the unprecedented times caused by this great global health crisis. As an example, Communist Party

of China came together with 230 political parties from 100 nations to issue a unified appeal for world leaders to prioritize people's lives, and to “avoid virus-induced politicization and stigmatization”, which might undermine international cooperation (Cao 2020, p.24).

President Xi Jinping was personally invested in China’s active participation to health cooperation during the COVID-19 crisis as Jinping communicated with national leaders and representatives from international organizations through phone calls and video conferences to inform other parties about China’s pandemic strategy, and stressed China's open, transparent, and responsible approach to information and experience sharing, and offered to provide any and all essential assistance to aid the global community in containing the virus at the shortest amount of time (Cao 2020). The G20 Extraordinary Leader’s Summit on COVID-19 and the 73rd World Health Assembly were platforms which created opportunities for this kind of communication, once again showing us the importance of multilateral cooperation in health diplomacy.

The WHO was criticized for not being able to give an effective global response to COVID-19 pandemic, as the organization’s involvement was limited to providing expert guidance on public health improvement, as well as supervising the implementation of the International Health Regulations rather than leading domestic health policies (Cao 2020). The inability of the WHO to enact its pandemic response powers, through the mechanisms provided by the IHR, was heavily criticized. The WHO was criticized through allegations of favoritism towards China, and the organization was often framed as being China’s pawn during the pandemic (Fidler 2020). As previously mentioned, the new IHR established after the 2003 SARS epidemic aimed to enhance disease monitoring and pandemic-response powers of the WHO. However, during the COVID-19 pandemic, the WHO was criticized due to its inability to use the IHR to interfere with China’s national pandemic-response policies.

Since IHR provides a certain degree of authority to the WHO in case of global health emergencies, the regulations are designed to enable intervention by the WHO to global and national health systems through its medical expertise. Therefore, especially after the SARS pandemic, the capabilities attained by the WHO, and implementation of these capabilities by the organization in health emergencies have not constituted political problems. On the contrary, WHO was constantly applauded based on its responsibilities such as information sharing, informing global health society about misinformation, and provision of public health expertise to countries in need (Fidler 2020). In case of global health emergencies, the IHR justifies WHO

actions, which are considered as challenging to the national sovereignty of member states. For instance, in the case of a public health emergency, WHO has the authority to collect disease-related information from the governmental authorities, and in the case of miscommunication, the organization can collect information regarding disease from local non-governmental entities, inquire the governmental authorities regarding the truth of data acquired, and share the acquired knowledge with global health society. In addition, the WHO Director-General has the authority to declare a public health emergency of international concern in the case of a global health emergency. IHR also helps the WHO to protect commercial rights of the countries and the right to move freely of individuals by ensuring that the member states should implement trade and travel restrictions according to rules and regulations of the organization. Lastly, the IHR enables the WHO to oversee national governments in order to protect basic rights of populations in a public health emergency.

Unfortunately, during the COVID-19 pandemic, the WHO received criticism on its incapability to fulfill its duties, especially in its bilateral relations with China. Critics claimed that while China was reluctant to use its knowledge on the newly emerged disease[9], the WHO failed to undertake its responsibilities of acquiring disease knowledge from local actors and informing other member states of this knowledge. The WHO Director-General was also criticized based on his "declaration of public health emergency of international concern at a time and manner indecisive and deferential to the Chinese government" (Fidler 2020). While some travel restrictions all around the world have flouted the rules and regulations set by the IHR, the organization's discreet stance on human rights violations have attracted criticism.

In the earlier stages of the COVID-19 pandemic, Chinese medical assistance has been sent to 28 Asian countries, 26 African Countries, 9 countries in the Americas and 10 countries in the South Pacific, while US$20 million was donated to the WHO as a pandemic assistance by China (Embassy of The People's Republic of China in The Republic of Fiji 2020). China's *mask diplomacy*[10] and *vaccine diplomacy*[11] became important aspects of its international COVID-19 action policy and contributed to its rising influence in the global health community (Lee 2021).

[9] The Associated Press, "China Has Rejected a Who Plan for Further Investigation into the Origins of Covid-19," NPR (NPR, July 22, 2021), https://www.npr.org/sections/coronavirus-live-updates/2021/07/22/1019244601/china-who-coronavirus-lab-leak-theory.

[10] Brian Wong, "China's Mask Diplomacy," – The Diplomat (for The Diplomat, June 2, 2020), https://thediplomat.com/2020/03/chinas-mask-diplomacy/.

[11] Xiaoyi Wang, "China, Not COVAX, Led Vaccine Exports to the World's Middle Income Countries in 2021," Health Policy Watch, February 11, 2022, https://healthpolicy-watch.news/china-covax-led-vaccine-exports-lmic-2021/.

At the beginning stages of the COVID-19 pandemic, China had donated a "considerable amount of medical assistance to the rest of the world, including 70.6 billion face masks, 340 million protective suits, 115 million pairs of goggles, 97,700 ventilators, 225 million test kits, and 40.29 million infrared thermometers to 200 countries and regions during the period of March 1 to May 31 of 2020" (Cao 2020, p.28). While China continued to position itself as a responsible global health actor during the pandemic, using its health diplomacy[12] and its involvement in multilateral cooperation initiatives, certain significant global health actors such as the US perceived the efforts of China as insidious and undependable (Fidler 2020). The medical aid and vaccine donations made by the Chinese government was considered as a method to conceal China's fault in the spread of the disease, and to change perception about China throughout different regions (Fidler 2021).

While China, as an aspiring global health leader, was accused of information dissimulation regarding the initial stages of the disease spread in Wuhan, its governmental response to the health crisis was criticized by the West based on the oppression against dissident voices, and human rights violations under government-imposed lockdowns (Fidler 2021). Most prominently, the president of the United States during this time, Donald Trump, publicly accused China as the perpetrator of the spread of the disease and pandemic. It has been argued that the existing political environment before the COVID-19 pandemic played a significant role in the development of a "geopolitical and ideological competition" between powerful states (Fidler 2021). During the pandemic, the inability of global health actors to establish a sufficient global health response exposed the damaged international cooperation exacerbated by the socio-economic and political consequences of the pandemic. Even the vaccine development process by countries such as the US, China and Russia resembled some sort of super-power competition between these actors, while these developments could have been supported by a multilateral initiative of global health actors. In the end, informal practices emerging within the WHO under the influence of China have a negative impact on the multilateral cooperation in global health.

[12] R. Maxwell Bone and Ferdinando Cinotto, "China's Multifaceted COVID-19 Diplomacy across Africa ," – The Diplomat (for The Diplomat, November 2, 2020), https://thediplomat.com/2020/11/chinas-multifaceted-covid-19-diplomacy-across-africa/.

3.2 The Illustrative Case of Bill & Melinda Gates Foundation in Global Health Governance

In this chapter, the illustrative case of Bill & Melinda Gates Foundation's role in global health governance will be investigated to explain the *informality around* the WHO. Bill & Melinda Gates Foundation (BMGF) has become a prominent actor in the global health governance starting from the initiation of the foundation, with its exceptional funding capacity for health initiatives and its bold health objectives designated through the dedicated efforts of its founders Bill Gates and Melinda French Gates. As it was explained in the prior chapters in more detail, the emergence of new actors in the global health governance in the 1980s and 1990s have altered the establishments of and methods in global health partnerships. This development has changed the conception of the role of the WHO as the global health leader in the GHG, as observed in the form of decrease in funding to the organization, criticism towards the organizational structure and its ability to establish efficient health partnerships. In this context, the BMGF has strengthened its influence through its internal efforts and external conditions which contributed to rapid enhancement of the authority of the foundation as a prominent global health leader. In order to explain the factors that contributed to this process, this chapter will, first focus on the historical evolution of the foundation and then important initiatives in global health conducted through the financial and normative authority of the foundation.

Bill and Melinda Gates Foundation was formed in 2000, based on the former efforts and experience of the William H. Gates Foundation which was established in 1994. The foundation has granted US$53.8 billion since its establishment for development efforts and continues to be a prominent actor in global health and poverty eradication in world with its extended efforts in many areas, which was initially only focused on the improvement of education in USA (Bill & Melinda Gates Foundation). The foundation was built upon the ideals and optimism of its founder Bill and Melinda Gates and positions itself as a mediator between the public and private sector in developing regions to provide health services and infrastructural support in low-income and middle-income countries. The foundation works through providing grants to initiatives and public-private partnerships with the focus of disease prevention, poverty eradication, and reducing inequality in the world. The foundation has five main pillars, with the existence of special programs dedicated to each problem it addresses (Bill & Melinda Gates Foundation). The United States Program is dedicated to improvement of education inequality

within the United States, and it is the initial issue area which the foundation was focused on in its initiation. The Global Development Program is dedicated to eradication of poverty and inequalities in the world's poorest regions. The Global Health Program is the pillar where the foundation takes upon important responsibilities in the global health governance. Global Policy & Advocacy Program is focused on the establishment and funding of private-public partnerships in diverse development policies and global emergencies in which joint action is in need. Lastly, the Gender Equality Program was established in 2020 to integrate gender equality perspectives in the operations of the foundation. In this chapter, the BMGF's role in global health governance will be investigated through its initiatives in Global Health Program and Global Policy & Advocacy Program.

3.2.1 Funding Allocation and Priority Setting Problems of BMGF

The most significant attribute of the BMGF, and the attribute which helped to elevate its position in the ranks of the most influential global health actors in the system, is its outrageous monetary budget and ability to utilize it in the most productive way (Birn 2014; Chung 2021; Kickbusch). Therefore, examining the funding allocation of the foundation, and the decision-making process behind it is important to understand both the motives of its donors, and the process of how the foundation became so influential in global health governance. In the years between 1998 and 2007, BMGF had contributed to funding one thousand ninety-four health initiatives, with the total amount of US$8.95 billion awarded (McCoy et al. 2009). McCoy et al. (2009)'s study is eye-opening as it provides us an informal track record of the allocation of fundings on the basis of preference of grantees by BMGF. The funding provided by the foundation in aforementioned period was primarily disbursed in a limited number of organizations as 65% of the accumulated funding was provided to only 20 institutions, which include the WHO, Global Alliance for Vaccines and Immunization (GAVI), World Bank, the Global Fund, selected universities, and NGOs (McCoy et al. 2009). Nearly half of the funding was given to supranational organizations including global health partnerships and intergovernmental organizations. The more interesting outcome of the study is that the researchers detected that of the remaining half of the fundings, 82% was allocated to grantees in the USA, and only 5% were allocated to grantees in low to middle income countries (McCoy et al 2009).

The foundation has made considerable contributions to the WHO as 69 grant arrangements were conducted between the years 1998-2007 (McCoy et al 2009). This situation can be seen as another aspect of the funding problem of the WHO, as these fundings were discretionary. Another prominent actor in global health, which was occasionally funded by the foundation through partnerships is the World Bank. BMGF contributed two grants to the International Finance Corporation under the authority of the World Bank, which primarily focuses on the improvement of private enterprises. These grants were awarded on the condition of development of better conditions for the private health initiatives in developing regions. This move of the foundation was criticized, while the responsibilities taken upon the BMGF is focused on betterment of the primary health system in developing countries, the emphasis of the fund being directed to private initiatives were perceived as clashing with the ideals adopted by the foundation (McCoy et al. 2009).

In addition, health actors who are considered to have considerable influence on global health funding have close relations with the BMGF through involvement in several global health partnerships. While officials from BMGF are part of governing structure in many global health initiatives, the foundation is also a part of the Health-8 group, which is an informal grouping of eight prominent global health actors focused on the betterment of global health system. The Health-8 group is comprised of the WHO, UNICEF, UNFPA, UNAIDS, the Global Fund, GAVI, and World Bank along with the BMGF. Therefore, it may be argued that the foundation has active presence in determination of research agenda and precedency of health problems. For example, its involvement in malaria eradication efforts were criticized by some authorities, such as the former head of the WHO, on the basis of uniformization of malaria research under the control of the foundation disabling alternative research methods (McCoy et al. 2009).

Throughout these nine years, three out of four of the fundings allocated was focused on six main categories of “HIV/AIDS, malaria, vaccine-preventable diseases, child health, tuberculosis, and other tropical and neglected diseases” (McCoy et al. 2009, p.1649). The foundation can make a significant impact on global health through changing its funding system to be directed more into neglected diseases and preventable diseases, over diseases and health research that is greatly funded (Black et al. 2009). The problem regarding the immense funding channeled to the selected and limited universities and research centers based in developed countries, primarily in the USA and in the UK, is that the health research agenda planned

according to the needs of the developing countries is conducted in more affluent countries. This situation has a negative impact on enlarging the inequality gap between the developed and developing world, while eliminating possible contributions from the researchers and administrative entities in low to middle income countries, who know the best about underlying reasons behind these health problems (Black et al. 2009). The foundation disagrees with McCoy et al. and Black's argument on disproportionate allocation of funding among developed and developing countries, as they allege that the critical article was based on a faulty research method, which disregarded the "subrecipients" disadvantaged regions of some of the programs funded through institutions in developing countries (Targett et al. 2009).

As a more recent example of criticism on this issue, a new study focused the COVID-19 pandemic suggests that since most of the COVID-19 inflicted deaths are caused by metabolic diseases such as "obesity" and "diabetes", insufficient attention given to these health problems by the WHO may have contributed to this causal mechanism (Havinga 2022, p.83). Study underlines that since BMGF influences global health actors into focusing on its own research agenda and priorities, the underinvestment in pharmaceutical research and disease knowledge generation about obesity may have caused the WHO to put less emphasis on its initiatives directed against obesity (Havinga 2022). This example illustrates that short-term fixation on specific agenda items by the BMGF may have incalculable long-term impacts on global health. In addition, channeling significant amounts of funds into certain issues can cause undermining of more prevalent health emergencies in some low- and middle-income countries (Lancet Editorial 2009).

Decision mechanism behind the grant allocation preference of the BMGF is often criticized because of the informal decision-making system based on personal ties of main founders, as this kind of mechanism is the opposite of the expected transparent methods by global health society (McCoy et al. 2009; Black et al. 2009; Kickbusch 2001; Birn 2014; Chung 2021). In its 2009 editorial, the prominent health journal Lancet has underlined that one of the most intriguing aspects about legitimacy of the BMGF as a significant global health actor might be the mandate of the foundation, which is solely based on personal ideals of the family. In the same editorial section, many recommendations were made for resolving the transparency and accountability problems of the foundation, improving its governance system, allocation of funds according to the burden of disease, supporting research and development activities in low to middle income countries, being more open to cooperation with other global health actors in

the agenda-setting and decision-making process. However, the foundation opposes this kind of criticism claiming that the funding decision process goes under technical and independent scrutiny of experts (Target et al. 2009). BMGF is criticized on the basis of perverting already existing global health programs with their massive amounts of funding, as in the example of the political corruption caused and sustained.

As cooperation between the foundation and primary dependents of the health project in developing regions is absent from the policy design and implementation process, the foundation is criticized as being undemocratic. However, Chung (2021) argues that this kind of criticism directed towards BMGF may be unnecessary as there is no authority responsible for democracy in the global health system and democracy is a concept that belongs to domestic governance. On the issue of existence and position of philanthropic foundations in global governance, Chung (2021) suggests that they emerge and attain a significant place for themselves in GHG because traditional global health structure lacks to cover all the problems within global health. In addition, they have the financial power to devote to health-related causes without any political interest. Chung (2021) argues that philanthropic foundations such as BMGF show effort to improve global health on the issues, which national governments are unwilling or unable to provide for, and the private sector do not invest because of simple cost-benefit calculations.

Some critics suggest that the provision of basic health mechanisms and equipment should be considered as responsibilities of nation-states and international organizations with main focus on health. As an actor able to generate financial and technical sources on its own, BMGF should be more focused on the scientific research and development of new health technologies (Black et al. 2009). However, the focus of the foundation should be "low-risk and high reward" improvements and inventions, rather than its current fixation on "high-risk and high-reward" health technologies (Black et al. 2009, p.1584). For instance, vaccine research and development can take decades and an increase in funding does not guarantee the success of a product, in addition even if trial results come as successful today, it will take at least twenty years to reach to decrease the targeted child mortality rates.

3.2.2 Technology-Based Approach in Global Health Governance

Through the funding channeled to primary global health actors and global health cooperation, 4% of the amount was used in provision of basic health-care services, while 37% of the amount was used in "research and development or basic science research" (McCoy et al.

2009). Rather than using existing technologies to overcome challenges, investing in research and development of new scientific methods in child health research are preferred by most of the critics of the foundation as the global health initiatives of the foundation is considered to be aligned with the "technological bias" of the founder Bill Gates (McCoy et al. 2009, p.1651). BMGF has been criticized for its scientific research-oriented methods, its non-encompassing disease-driven agenda, and its unsustainable and short-term methods, which parallels the business model of many private sector actors (Birn 2014). While the WHO was criticized on similar allegations in the 1970s, some member countries – mostly the G-77 countries from developing regions – criticized the organization based on its "disease-focused" and "donor-driven approach" (Birn 2014, p.8). Through the efforts of member states from developing regions, and the exceptional efforts of the General-Director of the time, Halfdan Mahler, WHO has shifted in a more transparent, accountable, and inclusive organizational structure through reforms in the 1970s. Since most of the member states in Western bloc have recognized the WHO as one of the organizations that was under the security umbrella of the Western interests against the Soviet bloc, with the end of the Cold War the organization has significantly lost its influence over its member states. Therefore, the funding for the organization has decreased and its responsibilities were narrowed down to the role of maintaining global health security through disease monitoring and establishment of information-sharing mechanisms during global health emergencies.

As an example, in the 2005 World Health Assembly meeting, WHO introduced the Commission on Social Determinants, which focused on the objective of contributing to smallpox eradication by not only technical means but through underlining the social determinants behind the problem (Birn 2014). After two months of the inauguration of the commission, Bill Gates started to advocate for a "simple technological solution" to the problem of smallpox eradication, which came to be opposed by many global health experts based on the data that showed the problem was in need to be addressed through intervention in "fundamental structural and political factors", rather than investing more into development of health technology (Birn 2014, p.11). The BMGF has been funding scientists in various regions through the "Grand Challenges in Global Health initiative", which was founded in 2003 and expanded through the "Grand Challenges Explorations" initiative (Birn 2014). The problem regarding the funding of scientists is the conditional nature of the funds, which limit the focus-areas of the research and encourages researchers for unconventional projects that do not guarantee positive returns. In addition, most of these projects are solely based on the improvement of technological

aspects of health rather than addressing underlying socio-economic or political reasons behind the emergence of problems (Birn 2014). Generally, maintenance and strengthening of basic health systems in developing countries are hindered due to the socio-economic and political problems, which cause problems about sanitation, malnutrition, and sheltering. However, these criticism can be deflated on three basis: the foundation channels considerable amount of funding to provision of already existing health services and technologies, the foundation has a program mainly focused on the eradication on poverty and poverty-inflicted problems in developing regions, and lastly establishment and maintenance of domestic basic health systems is under the responsibility of the nation-states and prominent intergovernmental organizations such as the WHO (McCoy et al. 2009). Since BMGF is a prominent actor in shaping the trends and agenda setting in global health, their funding scheme can influence other actors in global health. The foundation's science-based approach can shift the priorities of the global health society from underlying socio-economic and political conditions in global health, especially in politically unstable regions (McCoy et al. 2009). In addition, a short-term and issue-based approach to global health may harm the efforts building sustainable and robust health systems (McCoy et al. 2009).

One important habit introduced by the BMGF into global health governance is related to the funding mechanism of the organization being dependent on the performance-based evaluation of the grantees (Clinton et al. 2017). This has created an environment in global health, in which donor countries and non-state actors become more inclined to fund activities that they can observe tangible performance outcomes in a short amount of time. Therefore, funding for international organizations with encompassing health mandates, such as the WHO, have experienced an increase in conditional funding schemes and decrease in their core fundings. In addition, the governance model of 'do your research yourself, set your agenda accordingly, and fund it' had an impact on the improvement of institutional knowledge on technical aspects of global health, narrowing the health knowledge gap between other actors and traditional actors such as the WHO.

According to Clinton et al. (2017), changing and fluctuating methods of funding in global health today constitute three risks for global health market: criticism is made on normative concern on the basis of limited organizations' role in determining health priorities and enforcing policies in developing world, criticism made on efficiency on the basis of new funding schemes pushing actors to focus on short-term and unsustainable health initiatives,

criticism on underinvestment to foundational aspects of global health governance under the responsibility of the WHO, such as global disease monitoring and pandemic preparedness. One of the main objectives of the establishment of the WHO as an international organization was to create an environment of information exchange and consensus regarding health policies in the world in accordance with a sustainable and inclusive understanding of global health. Also, as we have experienced in the COVID-19 pandemic, there is a need for an organization which is accountable to different actor in global health systems and can ensure the accountability of other actors in information sharing, and create a trustable surveillance and response system, which will contribute to convergence of differing interest in a unified pandemic response policy (Clinton et al. 2017). Through this example, we can observe the negative impact of informality around the WHO on GHG.

BMGF was previously criticized for its close relations with certain actors of the private sector which induce negative impacts on global health (*ExxonMobil* and *Chevron*), pharmaceutical companies, and private enterprises which benefit from the global health projects conducted under the scrutiny of the foundation (Birn 2014). In response to this criticism, the BMGF has cut their ties with many pharmaceutical companies they were associated with in 2009, however, the third major donor of the foundation, Warren Buffet, still owns "holdings in Johnson & Johnson, Sanofi-Aventis, and other pharmaceutical companies" (Birn 2014, p.14).

Microsoft is known to be a monopoly in the tech sector, which this character of the company was certified through fines issued to the entity based on its unfair conduct within the market. Microsoft is also an infamous advocate for intellectual property protection and undertook a significant role in acceptance of the TRIPS agreement within the World Trade Organization (WTO) (Birn 2014). As one of the major funders of the WHO, the foundation has also participated in the *Commission on Macroeconomics and Health*, which worked for the acceptance of intellectual property rights as the main pillar in development of pharmaceutical technologies. This stance of the WHO has been highly contested among the global health society, as this approach is protested among most of the low and middle-income countries based on inequalities created by the market forces in global health (Birn 2014).

3.2.3 PPPs: GAVI, IHME and PATH

Public-private partnerships (PPPs) are defined as "collaborative arrangements that involve at a minimum a corporation or industry association, and a public sector agency or

intergovernmental organizations, which are formed around specific goals and mutually agreed up division of labor" (Stevenson & Youde 2021, p.402). The first significant PPP which assists operations of the foundation in global health system is Program for Appropriate Technologies in Health (PATH), which was inaugurated with the intention of encouraging establishment of PPPs to produce medical equipment and medicines in an affordable manner to ensure their provision to low-income and middle-income countries (Stevenson & Youde 2021). BMGF is a prominent funder and partner of PATH and increasing authority of the foundation within the supervision and funding of global health PPPs arouses suspicion among the global health society on the issue of interdependence of institutions and projects of global health (Stevenson & Youde 2021).

The second significant PPP for the foundation is GAVI, which has received its initial seed funding of US$750 million from the BMGF. GAVI's main objective is providing "equitable access to vaccines for children living in the world's poorest countries" (Clinton et al 2017, p.326). GAVI was established in 2000 with the main support of the BMGF, in a relatively advantageous environment, in which health development assistance became a trend within the global health system in the same period. However, in the second decade of the alliance, BMGF's support became less important on a percentage basis of fundings to GAVI (Clinton et al. 2017). Channeling of health development assistance to entities such as the GAVI and Global Fund illustrates certain trends in global health system: funding has become more conditional and short-term, "multi-stake-holder governance" is preferred over "traditional government-centered" governance systems, and the focus of global health actors are narrowed on popular issue-areas, diverting the attention away from sustainable and embracing objectives such as universal health coverage (Clinton et al. 2017, p.328). It is claimed that the shift of organizational focus on research for vaccines in the WHO after 2009, is highly affected by the BMGF's research agenda, priorities, and funding to GAVI activities. GAVI has become the first non-state organization to gain "nation status among countries connected with the WHO", "under the new Swiss Host Act" (Havinga 2022, p.83). Since GAVI came to be on an equal status with sovereign member states of the WHO, it has acquired the rights reserved for sovereign states, such as non-interference with internal affairs, which eventually disabled the WHO to monitor and control the activities of the organization (Havinga 2022). In addition, through GAVI's involvement in global vaccine research and development efforts, under the influence of GAVI the WHO has altered "the definition relating to infection mortality", "the pandemic definition", and "definition of immunity" (Haavinga 2022, p.83).

The third prominent investment of the foundation is to Institute for Health Metrics and Evaluation (IHME), which acts as an unaffiliated program focused on health monitoring and disease surveillance through accumulation of global data (Lancet Editorial 2009). IHME is heavily reliant on the funding by BMGF, and since the initiative has become the main responsible for production of health knowledge and data in the world, its funding has become more criticized based on accountability and transparency considerations (Levine 2015). While global burden of disease (GBD) figures was gathered and announced to public by global health institutions such as the WHO and World Bank, with emergence of IHME in 2007 with "a US$105 million grant from BMGF", generation of GBD figures and sharing of health data with the world became a responsibility of the IHME (Levine 2015, p.315).

It is important to examine the operations of the BMGF in global health development by focusing on their interactions with and through these PPPs, as much of the criticism directed towards the foundation is related with the initiatives and activities of these three PPPs. In a correspondence article in prominent global health journal Lancet, the BMGF responded to a previous editorial piece in the journal, which criticized the foundation (Targett et al. 2009). First and most importantly, they argued that the BMGF is dedicated to transparency as an organization. They argued against the claim of McCoy et. al (2009) about consideration of burden of diseases on the funding decisions of the foundations. They argued that, as opposed to the claims, the foundation takes "disease burden as measured by disability-adjusted life years (DALY)" as standard while deciding on which diseases and which regions should have priority in funding. In accordance, most of the funding is channeled through the contagious and "parasitic diseases", which constitute the greater extent of "DALYs" in disadvantaged populations. However, it has been emphasized that this consideration should be "coupled with a sense of where [their] limited dollars can make the biggest difference" (Targett et al. 2009, p.2195). They reiterate the foundation's preoccupation with scientific research and health technologies once again. However, since the foundation is criticized for inclosing the data accumulation on disease monitoring through IHME, and often criticized for creating a monopoly for health knowledge, the case that is based on measurement of burden of disease through a process that is not transparent enough, and allocates its immense funding according to this data, how can it justify the transparency of its decision-making and priority designation process? Since there is no authority or mechanism that can hold the BMGF accountable for its working process, proving the justification of the foundation's defense against the criticism is not possible in today's circumstances.

In addition to this criticism, BMGF has faced some serious allegations regarding its investment in a project carried out by PATH in India, which was focused on vaccination for HPV infection. The Indian government accused the foundation of misconduct through "trails violated ethical standards" after the death of adolescents coming from disadvantaged backgrounds which have agreed to take on the HPV vaccines developed under the responsibility of PATH (Birn 2014, p.14). While the officials alleged that the trial process was not transparent as the subjects were not informed clearly about the possible side effects of the vaccination and the consequences that can be brought by the vaccines, PATH argued that the studies conducted were classified as "observational study of an already approved vaccine", and the studies could not be classified as "clinical trials", therefore, they were not responsible for implementing regulations that were necessary for proper clinical trials (Birn 2014, p.14). In addition, the foundation was criticized as Gates lobbied within the Indian government to introduce the "Merck's rotavirus vaccine" into the local Indian markets (Birn 2014, p.14).

As for the positive impacts of the BMGF on GHG, their effort has contributed to health improvements in neglected areas such as HIV/AIDS and universal vaccination in child health. The new funding scheme and its performance-oriented nature may contribute to constant scrutinization of newly emerged institutions such as GAVI and Global Fund, while presenting case studies to traditional global health organizations on how to improve themselves (Clinton et al. 2017). Non-states actors shifted toward initiatives such as GAVI and Global Fund as their voice seems to be unheard in the WHO (Clinton et al 2017). BMGF influence has also contributed to stimulating many philanthropic actors to channel their fundings into global health initiatives (Karlan & List 2020; Moran 2008).

3.2.4 Changing the Norms of Global Health Governance

In his 2015 study, Fejerskov argues the BMGF, which emerged as an unusual actor ready to defy the existing rules of the global health system, has embraced the institutional norms and practices within the health development field over time. While BMGF showed efforts to maintain its distinct position and understandings compared to other global health actors in its early years, through further interaction and exposure to existing practices in the system, has embraced the norms and practices of the health development field while "practicing a self-conception of difference from well-established donor organizations" (Fejerskov 2015, p.1099). In its early years, BMGF was more of a closed cooperation of private funders, which consisted

of individuals from family and friends of the main donors. Through interviews conducted with officials and employees which were present in the first years of the foundation, most of the interviewees agreed that the foundation had an understanding with "fundamental skepticism" in their relations with other actors within global health. For example, while both Melinda French Gates and Bill Gates evaluated Millennium Development Goals of the UN as unpromising and unoriginal (Gates Foundation 2013), in 2008, as a guest invited to UN to speak on "the future of development cooperation", Gates indicated his changing views about the MDG, while praising the goals and pledging to intensify the foundation's efforts to work towards them (Fejerskov 2015).

In the first years of the foundation, while they had uncertainties regarding positioning of the foundation as a global health actor in an already established system, they were skeptical towards other prominent actors, such as the UN, OECD, and the WHO (Fejerskov 2015). The foundation remained to keep a low profile while its activities were mainly concentrated in the USA, however, with its growing budgetary sources and bold initiatives, the foundation has gained remarkable interest from domestic and global actors. The historic event, which inflicted a clear transformation and restructuring for the foundation, happened when one of the wealthiest people in the world, Warren Buffet, donated US$31 billion to the BMGF and become the third biggest donor of the foundation in 2006. After the entry of such a massive amount of funding into the foundation budget, the foundational structure has been changed according to donor demands and newly emerged ability to fund initiatives which required greater funding and effort. Accordingly, the foundation's three new programs, which can be considered as the three pillars of the foundation, were introduced: *the United States Program*, *the Global Health Program*, and *the Global Development Program*. Through geographic expansion of the foundation operations by opening new offices in regions from London to New Delhi, and from Washington DC to Beijing, the foundation has increased its experience in global health partnerships. Foundation has left its isolationist perspective by expansion of the foundation in terms of employees and officials, who now constituted more than the majority of other health-donor organizations.

In 2011, Bill Gates was invited to deliver a report to the G20 countries' meeting on *Innovation with impact: Financing 21st Century Development*[13]. Gates offered three principles

[13] Further information on Innovation with Impact: Financing 21st Century Development can be found through the website: https://www.gatesnotes.com/development/g20-report-innovation-with-impact

to increase interaction between actors in global development efforts; working on initiatives that support achievement of MDGs, produce clear knowledge about development data and share it with other actors; study on the outcomes of different development projects to evaluate the efforts to come up with the optimal development projects which will be the most beneficial for all in the future. Fejerskov (2015) argues that through this report presented in the meeting, Bill Gates and the BMGF have become actors who are "directly involved in principle and norm setting" (p.1108) in the global development field.

As one of the founders, Bill Gates is infamous for being personally invested in problems in the developing world, which occasionally do not attract much global attention (Chung 2021). In 2015, the infamous article by Gates was published, which focused on the Ebola pandemic and lessons global health society has learned from it. In this article, Gates warns the global health community against a possibility of an upcoming pandemic, which may inflict far more damage to greater populations in the world. In this article, in which Gates (2015) cautioned that the upcoming pandemic may be more infectious, and the same health systems used during the Ebola pandemic might fall short to give proper response to a pandemic on a larger scale. The similarities established between health security and military security through argument of need for a global health security scheme modelled after NATO has attracted criticism on Gates after this publication (Gates 2015). While the global health security system is criticized by Gates based on its underfunding and inability to establish a proper joint response mechanism, he criticized that only few member states act accordingly to the new IHR set after the 2003 SARS outbreak. Gates iterates that the problems caused by the insufficient global response to any possible health emergency is not under the responsibility of a global health actor alone, as the likes of the WHO, but the whole global health community undertakes the responsibility. However, he does not refrain from underlining the incompetence of the WHO as the main authority in pandemic surveillance and response, by pointing out the financially and logistically inefficient structure of the WHO Global Outbreak Alert and Response Network (Gates 2015). While he argued that the WHO influence should be strengthened, the institution should position itself in an appropriate role and share responsibility with other global health actors such as "the World Bank and G7 countries" (Gates 2015, p.1384). While Gates makes demands regarding the improvement of the primary healthcare system, and disease monitoring and control mechanisms in developing regions, he also highlights the significant role undertaken by the US and UK military forces in response to Ebola pandemic in West Africa. Depending on this experience, he suggests that global health security should be institutionalized with inclusion of

an “epidemic response” system that includes “military alliances such as NATO” (Gates 2015, p.1384). Gates’ call for action strategy that involves military involvement in pandemic response was criticized by some critics as a new form of “global health imperialism” (Levich 2015, p.731-733).

In 2018, Bill Gates has written a piece on how the global health system can prepare itself for an upcoming pandemic. He called for a joint approach to possible pandemic in the future, improvement of global disease monitoring and response systems, and enhanced knowledge sharing is needed between the actors. Another important part of the article was the mention of a mechanism that will enable rapid production of “a universal influenza vaccine” was in development under the supervision of the BMGF, which the whole world eventually benefited from with the rapid vaccine production process during COVID-19 pandemic (Gates 2018, p.2058).

In his 2020 article focused on the COVID-19 outbreak and pandemic response system, Gates has underlined the importance of national governments and local health authorities for the pandemic response. He argued that while national governments should support people under their own jurisdiction, developed countries should make contributions in health in disadvantaged countries and regions (Gates 2020). Gates (2020) mentions their personal commitment to the cause by disbursing US$100 million in low to middle income countries which began the COVID-19 response process. To strengthen their primary healthcare system. Conflicting with the criticism directed towards Gates, he emphasizes that global health actors should come to an agreement on the procurement of COVID-19 vaccine and medicines to ensure that the products cannot be sold to highest buyers in the market for profit (Gates 2020).

In the March 2001 issue of Journal of Epidemiology and Community Health, prominent global health expert Ilona Kickbusch has written an open letter to Bill Gates. Kickbusch (2001, p.153) refers to the initiatives taken under the BMGF as Bill Gates “bailing out global health”. In this open letter, the expert talks about the questionable decision-making process of the priority setting of the foundation, the foundation only being a short-term remedy for problems that necessitate long-term and structural developments, transparency, and accountability problems of the foundation. While in the same piece the contradiction behind poor people being dependent on the mercy of the richest in the world is criticized, Kickbusch (2001) underlines that establishing a prominent legitimacy, accountability and transparency in global health is a time-consuming process as observed in the example of the WHO experience. A new goal for

Bill Gates to build a sustainable health system over disease-based initiatives is proposed. After 11 years, while the foundation has progressed in some respects, mentioned concerns are still relevant today, and the foundation has still a long way to go in establishing sustainable and long-term health initiatives through a more transparent and accountable decision-making mechanism.

3.2.5 Future of the Bill & Melinda Gates Foundation

After the divorce news of the two main donors of the foundation – Bill Gates and Melinda French Gates – were announced, the foundation had formation changes in its board. Critics are still unconvinced that this new board formation will have any respectable impact on the improvement of the transparency and accountability problems of the foundation, as the new board members are still consisting of individuals from financial sector and philanthropies, who do not have any at first-hand experience or expertise in global health field (Burki 2022). It has been argued that the governing board of the foundation can be more democratic and inclusive through addition of individuals from the regions that the health initiatives of the foundation is focused in, who are directly related to the health issues and effected by them on personal level.

While BMGF has a considerable amount of impact on the agenda-setting and decision-making mechanisms of multilateral health organizations through the existence of important BMGF representatives within the governing bodies of these entities, these organizations do not have the same authority on the monitoring on the activities conducted by the foundation (Burki 2022). While Bill Gates has been criticized regarding his opposition against "waiving intellectual property protections for COVID-19 vaccines", BMGF continues to contribute for COVID-19 response and has strengthened its immense authority in global health governance during this period[14] (Burki 2022, p.508). After their divorce, Bill Gates and Melinda French Gates committed a further 15 billion to foundations 50 billion endowment (Burki 2022).

[14] "Bill & Melinda Gates Foundation Commits up to $120 Million to Accelerate Access to COVID-19 Drug for Lower-Income Countries, Calls on Other Donors to Mobilize Resources - World," ReliefWeb, October 21, 2021, https://reliefweb.int/report/world/bill-melinda-gates-foundation-commits-120-million-accelerate-access-covid-19-drug-lower.

"Bill & Melinda Gates Foundation Commits up to US$125 Million to Help End the Acute Phase of COVID-19 and Prevent the next Pandemic - World," ReliefWeb, May 13, 2022, https://reliefweb.int/report/world/bill-melinda-gates-foundation-commits-us125-million-help-end-acute-phase-covid-19-and.

While BMGF has continued to receive criticism regarding the issues it faces such as accountability and transparency problems, in the last twenty years, the foundation has contributed to a significant number of health developments through its unprecedented financial resources and deep interest of the funders in research and development of health technologies. We can observe that the BMGF has become one of the most established actors in global health governance today, and the informal practices conducted under the authority of the BMGF prove that informality can be beneficial in certain cases with the support of necessary checks and balances mechanisms.

3.3 The Illustrative Case of Global Fund in Global Health Governance

In this section, I will be focusing on the case of the Global Fund as an example of the informality of the institutions in global health governance in relation to the WHO. Examining the environment within the global health governance is important to understand the process that leads to the establishment of the Global Fund. At the beginning of the 21st century, United Nations Secretary Kofi Annan's plead for a global fight against AIDS, supported by "US$7-10 billion per years for AIDS", inspired many global health actors such as G8 countries, national governments in Africa and the UNGA (Feachem and Sabot 2006, p.537). At the G8 summit in Okinawa, Japan in 2000, country representatives came together to discuss the necessity for "a new global health partnership" to overcome the deficits in the existing global health governance (Brown 2009). The existing deficits in the multilateral global health governance were framed as: insufficient local expertise in global health governance, lack of local inclusivity in policymaking process, accountability and transparency problems of UN institutions responsible from global health, politicization of global health initiative led by UN organizations, non-existence of joint financial assistance systems that would provide the source for response against urgent health problems; HIV/AIDS, tuberculosis (TB) and malaria (Brown 2009). In its essence, the Global Fund was established to work around the existing global health governance system overlooked by the UN-affiliated global health organizations. Therefore, the proposal for the new institution was designed to include partners from different sectors to create a more effective funding mechanism.

The G8 meeting in Japan created a chain effect in establishment of new institutions for overseeing and implementing global health assistance for these three diseases. In 2001 *UN Special Session on AIDS* was conducted, and a *Transnational Working Group* was founded. As

a result, the Global Fund was launched in 2002. Two important principles were set in *the Framework Document of the Global Fund*. The first principle emphasized on the need to establish a "multisectoral partnership between governments, civil society, the private sector and affected communities" (Brown 2009). The second principle underlines that "highest priority should be given to countries and regions with the greatest need, based on highest burden of disease and the least ability to bring financial resources to address these health problems" (The Global Fund 2001, p.96).

The administrative structure of Global Fund was designed according to these fundamental principles to overcome the global health problems caused by the three-target disease. To provide an effective multisectoral cooperation mechanism, the Global Fund board consists of "20 voting members, with equal representation by implementers and donors. Non-governmental organizations: communities affected by HIV, TB, and malaria; the private sector; and private foundations are also represented as voting members. In addition, there are eight non-voting members, including the Board Chair and Vice-Chair; representatives of partner organizations including the World Health Organization and World Bank; as well as the Additional Public Donors constituency" (The Global Fund n.d.).

3.3.1 Funding Structure of The Global Fund

A novel aspect of the Global Fund is its funding strategy being dependent solely on voluntary contributions from donors. For example, the "de-facto permanent Board members" of the Fund which consists of prominent global health actors such as the US, China and BMGF have no obligation to make recurring donations to the organization (Clinton and Sridhar 2017, p.326). One of the most important contributors, and the kick-starter of the Fund is BMGF, who contributed "US$1.1 billion…in its first 13 years" which made up a significant amount of its initial fundings (Clinton and Sridhar 2017, p.327). In the same period, bilateral donors have carried the load of donations with a 94.3 percent contribution rate. According to Clinton and Sridhar (2017), the increasing influence of global health actors as the likes of the Global Fund and GAVI Alliance have inflicted a transformative process in global health development assistance. Global health development assistance has changing characteristics in which the actors' preference shifted towards arbitrary funding habits and short-term remedies, cross-sectoral methods are preferred over methods that require state control, and specific-disease-

focused and short-term health objectives became dominant in global health assistance (Clinton and Sridhar 2017).

The multi-stakeholder approach of the Global Fund is unique due to its focus on "sector-wide approach" to global health governance (Brugha et al. 2004 p.96). One characteristic that makes the Global Fund mechanism distinguished among other global health organizations like the WHO is its "hands off approach" in funding and implementation policy process (Feachem and Sabot 2006, p.537; Radelet 2004, p.4). First, the primary recipients must submit their proposals to demand funding for eradication of the three focused diseases. *A principal recipient* is the governmental or non-governmental entity which receives the fund and is responsible for its implementation. As an organization, the Global Fund does not keep employees in partner countries which are responsible for monitoring the implementation process of the funds. *Country Coordinating Mechanisms* (CCM) are a focal point in the multi-stakeholder structure of the Global Fund operational mechanism. CCMs are designed to establish a local multisectoral cooperation system through maintaining "national ownership and respect for country-led formulation and implementation processes" (Brown 2009, p.171). The Global Fund Framework Document defines CCMs as where various stakeholders are to collectively create grant proposals, to design locally sensitive health programs, and to facilitate a corresponding implementation strategy (The Global Fund 2001). After the proposal is submitted by the respective CCM to the Fund, the proposal is reviewed by the *Technical Review Panel* (TRP) composed of medical experts. In the last step, the Global Fund Board considers the proposals approved by technical experts for decision of funding approval. The monitoring process of the implementation of fund disbursements in planned health initiatives is conducted under the supervision of a Local Funds Agent. A Local Funds Agent is an unaffiliated organization, who is responsible for monitoring the fund implementation process and the financial amenability of the program, contracted by the Global Fund.

3.3.2 Criticism of the Initial Funding Structure

During the first years of the Fund's operation, the CCM structure was contested as the mechanism was accused of being unable to amplify the local voices (Brugha et al. 2004). According to the study conducted by Brugha and colleagues in 2004, which focuses on four cases of funding early operation experiences in Sub-Saharan Africa, local representatives expressed their concerns regarding the constrained national capacities of low-income recipients

might hinder their ability to satisfy the funding conditions determined by the Global Fund. While NGOs and governmental authorities were mostly content with the Fund's activities, representatives of bi-lateral donors from previous health assistance schemes were critical of the disease-focused approach of the Fund and claimed that Fund's approach disturbed the long-term-focused improvement within their countries' health systems. The Global Fund has faced obstacles within the CCMs regarding "representation" and "participation" issues (Brugha et al. 2004, p.97). It was often alleged that the communication between members of the CCMs and local population was inefficient, and lack of technical infrastructure of health systems interrupted the inner workings of the CCMs. Among the four case studies, only in Mozambique the national actors were content with the working of the CCM and fair representation within the system. In other three cases, the CCM was considered as insufficient by the national-level entities as due to excessive governmental control within the decision-making process (Brugha et al. 2004).

Another prominent problem in the first years of the operation was caused due to clashes between "national AIDS councils" and CCMs (Brugha et al. 2004, p.99). In some countries, national AIDS councils overtook the responsibilities of the CCMs, and this certainly had a negative impact on the multi-stakeholder nature of the process. The tension between existing health authorities within countries and national AIDS councils over designation of responsibilities and who is to decide on the management of funds have slowed down the health initiatives. The indispensable significance of "national financial autonomy" for fund receiving governments may limit the extent of health development assistance in some cases (Cometto et al. 2009, p.1501).

Global health assistance programs with aims of fighting HIV/AIDS are distinct among other health initiatives, as they manage to overcome these limitations due to the urgency of the situation. Multisectoral approach in response to AIDS is exceptional, as this method allows a more robust response system in global health governance. In most of the low-income countries, which consist of the main recipients of Global Fund funding, basic health systems lack the necessary capacity to overcome certain challenges due to problems in "governance, health financing, procurement, human resources, and information systems" (Cometto et al. 2009, p.1501). Inefficient use of funding and disturbance of the already existing health system due to specific-disease-focused health programs. In order to create an effective and quick global response mechanism against AIDS, the unique "rights-based approach" of the Global Fund

should be embraced in global health governance (Cometto et al. 2009, p.1501). However, this may conflict with national financial autonomy in some cases.

In 2004, the initial funding commitment made by some donors fell short of the recommended amount by *the WHO Commission on Macroeconomics and Health*. The most vital problem of the mechanism seemed to be the "delay of disbursements of funds" and "managing evolving global fund process" (Brugha et al. 2004, p.98). In later years, the 2007-2008 world financial crisis and following sovereign debt crisis in Europe have impacted the funding pledges from developed donor countries. Due to these problems, many countries had to seek alternative funding methods to overcome these deployment problems. These alternative health partnership programs which are focused on eradication of HIV/AIDS can be exampled as World Bank Multi-Sectoral AIDS Program (MAP), the Clinton Foundation, and notably the US President's Emergency Plan for AIDS Relief (PEPFAR) (Brugha et al. 2004; Hanefeld 2014).

Another challenge would be the overseeing of financial implementation of disbursements through monitoring of different NGOs with little amount of technical expertise and resources within these low-income countries (Brugha et al. 2004). The critics argue that the recipient low-income countries might suffer from a lack of "absorptive capacity", which meant that the local health work force in these countries would be incompetent and would not be able to compensate the needs of the monitoring requirements (Lu et al. 2006, p.483) Many critics argued that this situation would lead to large funds becoming inefficient due to health systems not having the capability to adapt to the programs prepared by the Fund. As a response to this criticism, studies show that the low-income countries can manage the funds and channeling more funds in politically stable low-income countries would create greater positive outcomes in health systems (Lu et al. 2006). Though, existing literature does not provide concrete support for improvement of "country stewardship of HIV programs", some studies underline the positive impacts of the Global Fund on "capacity building of local health leadership" in management of local disease-focused health programs (Atun and Kazatchkine 2009, p.68).

3.3.3 Multisectoral Approach of the Global Fund

Even in the earlier years, the Global Fund was criticized by different parties because of differing disputes about its structure. The composition of the board members was criticized as some recipient countries claimed that the interests of representatives from wealthier countries

have prevailed over the interests of the poorer countries and this created a power-struggle within the board. On the other hand, the representatives from donor countries have criticized the inclusion of medical experts as board members, based on the claim that the institution should be accountable solely to donor countries. NGOs contested on the issue of accountability as they were not represented within the board, therefore there was no formal mechanism that would ensure accountability of funds towards implementing NGOs (Brown 2009). However, Brown (2009) argues that exertion of political and economic power is prevalent in bilateral health development assistance and naturally results in arbitrary and fragmented funding schemes. Therefore, without a hierarchical system that oversees all actors from exerting their power arbitrarily in health development partnerships, global health financing is prone to misuse of asymmetrical power by wealthier countries. Therefore, the claims of power-struggle in the Global Fund mechanism are not a unique problem of the institution itself, but a general problem of the global health system (Brown 2009). In addition, while the Global Fund evolves over time and respects the criticism from its partners, the cooperation problems within the fund's system are often caused by internal discord between the board members and people they are responsible to answer to.

The primary criticism regarding CCMs is about the lack of formal rules set by the Global Fund to maintain the multisectoral model of the CCMs. Until 2009, as a precaution, Global Fund had introduced six requirements for CCM grant eligibility. While the Global Fund has made suggestions for a minimum of 40 percent of the CCM members should be NGOs, there is no formal requirement to ensure this. In response to criticism on this problem, the Global Fund asserts that since it is "a non-political organization", and its immediate focus is creating channels for health funding, and since in some low-income countries there is no sufficient capacity to establish ties with the local NGOs, a strict requirement for CCM would hinder these countries' ability to apply for health fundings (Brown 2009, p.172). In addition, the multisectoral approach of the Global Fund embraces "informally organized members of civil society such as academic, spiritual leaders, and independent medical professionals", and since putting strict constraints on the NGO inclusion requirements would limit the multisectoral approach to formal NGOs, and force Western understandings of civil society on recipient countries would limit "a sense of local ownership and self-direction (Brown 2009, p.173).

However, as a result of this policy, in some recipient countries CCMs are governed by political elites. As of 2009, half of the recipient countries could not meet the suggested

requirement of 40 percent NGO inclusion in CCMs. NGOs inclusion in health partnership is significant because most of the local NGOs have direct connection with the people affected by these diseases and know the existing environment at the domestic level. However, according to studies, implementation processes conducted under the scrutiny of CCMs which lack multisectoral cooperation also are relatively insufficient and vulnerable to corruptive activities (Brown 2009). As a response to the claims of the Fund to being a non-politicized agency, the eligibility requirements are considered have political aspects by scholars, as they contain principles such as "democratic accountability, transparency, the reduction of conflict of interests, and the inclusion of people living with the disease" (Brown 2009, p.173). Brown (2009, p.174) certainly disagrees with the non-political claim of the Global Fund, as the foundational principles of the institution are "political inclusiveness" and "economic distributive prioritization".

The Global Fund's funding scheme is designed to be a *performance-based financing* program. In their 2013 article, Fan et al. investigates the internal and arbitrary factors which play a role in the designation of grant ratings used to assess the performance of recipient countries. In addition, they argue that the performance-based funding scheme of the Global Fund does not necessarily create incentives for recipients (Fan et al. 2013). In the initial financing model, the fundings process consisted of two rounds of fundings which were named as *phase-1* and *phase-2*. While the grants were usually provided for five years, the funding for phase-2 is dependent on the performance of the grant implementation by primary recipients during the phase-1. The study conducted by Fan et al. (2013, p.164) illustrates that "at least 42% of grants had final phase-2 amounts that were outside the expected indicative disbursement range derived from the grant rating, suggesting manual adjustment by Global Fund staff". The Global Fund explains this outcome by highlighting that the funding mechanism is not solely based on financial factors but also on different factors such as disease burden and local conditions in the recipient countries (Fan et al. 2013).

The Global Fund has proved itself as an institution open to structural change, and development through its rapid learning process stimulated by its early activities in different countries. However, new structural mechanisms were hard to incorporate into the system due to a lack of guidelines for recipient countries. Especially in the first years of the initiative, many recipients suffered from changing flows of funding due to under-performance of the funds in the first phase of the funding period. This has resulted in an unexpected consequence for

receivers, who were desperately in need of funding to fight against diseases that created huge distress on populations. From this aspect, we can observe the difficult, yet important responsibility put on the Fund to balance the need for immediate response and limited time to build a solid ground for a new funding scheme (Brugha et al. 2004). Even the funding mechanism of the Fund has been evolving through time and experience, the urgent need to respond to these fatal diseases create a dichotomy for the Fund to this day, even the other side of the balance seems to be changing through time and external factors.

One constant criticism of the Fund was related to fears regarding underrepresentation of local and disadvantaged groups, and possibility of funding schemes controlled by donors and governments in receiving countries (Radelet 2004). While the fund has attained significant success in its first years of operation, there was still room for improvement. There was an ongoing contradiction for the Fund to choose between amplifying voices of local populations to designate local priorities and creating adequate methods to safeguard that these priorities are addressed in the most efficient way (Feachem and Sabot 2006). While the CCM mechanism had been criticized by many, as the system could serve countries with better income more in the proposal process, governments might have dominated the operational mechanism to direct the funds in specific issue areas while disregarding needs of marginalized groups.

Firstly, “long-term sustainability” of the funding system is crucial for most of the recipients, and in the future due to lack of funding the board might have to choose among the proposals approved by the Technical Review Panel (Radelet 2004, p.48). CCM process should be monitored and strengthened through regulations, “hands-off approach” should be reconsidered, and the Fund should pull in by introducing clear guidelines on how CCMs should operate (Radelet 2004, p.48). The fund disbursement process should be sped up, and the performance-based system should be restructured.The question of whether the global health community should be focused on vertical or horizontal health systems developments has been an ongoing debate in the global health system (Feachem and Sabot 2006). Opponents of horizontal support for local basic health systems argue that, while disease-specific initiatives cause reformation of health systems in a way that will provide maximum return for specific-disease-eradication efforts, the existing health systems will weaken and the probability that these initiatives will have positive outcome in first place is significantly low. Vertical support for basic health systems would strengthen the system and increase its ability to respond against

health problems including the targeted three diseases by the Global Fund program (Feachem and Sabot 2006).

The supporters for the establishment of the vertical developments in the health system criticize the Global Fund, while they disregard the effort of the organization which can be classified as vertical assistance for basic health systems. For example, nearly half of the funding provided by the Global Fund until 2006 was channeled into improving the basic health care systems within the recipient countries through "constructing and outfitting health centers training health professionals and strengthening monitoring and assessment systems" (Feachem and Sabot 2006, p.540). The contradiction between choosing a disease-focused approach and a health system approach is contested in global health society. In his report concentrated on the comparative case study of the Global Fund and World Bank's HIV/AIDS programs, Shakow (2006, p.5-7) proposes that the responsibilities in the global health governance should be shared, and two different authorities should be responsible from these focus-areas in global health according to their "comparative advantages". For example, the report proposes that while the Global Fund can oversee disease-specific health initiatives focusing on AIDS, malaria and tuberculosis, the World Bank can be responsible for the improvement of basic health systems in needed regions to make a sustainable contribution to the global health system. In the upcoming sections, I will concentrate more on this issue by explaining why this kind of proposal is inefficient within the existing structures in global health governance.

3.3.4 Restructuring of the Funding Mechanism and Organizational Structure

Unfortunately, over years, the funding mechanism of the Fund was abused by some of the recipients. With the corruption allegations in the use of fundings in two projects, in November 2014, the Global Fund declared that it would halt its funding mechanism until 2014 (Hanefeld 2014). During this period, the Fund has focused on the restructuring and improvement of its funding methods and established the new funding model. *A New Funding Model* was introduced in 2012, which prioritized more strategic investments and reaching the best possible outcome with the few resources. The new funding model was praised for its "iterative process of grant making" (Davis 2014, p.136; Hanefeld 2014, p.56).

This new repetitive grant making process has created an opportunity for reconsideration and restructuring of the proposals by recipients according to the recommendations proposed by the Secretariat and TRP after a primary examination process. After the recommendations are

conveyed to recipient country CCM, it is expected for the CCM to create a "concept note analyzing country context, the proposed response, the available funding, the programmatic gap, and proposed implementation arrangements" (Davis 2014, p.136). Later, this concept note is considered by the TRP and if necessary, can be readjusted by the TRP and a new iterative process can be started. After the concept note passes the TRP approval, an internal *Grant Approvals Committee* examines the note and states their opinion to the Board on whether the proposal should be accepted or not. The new funding model aims to strengthen the multisectoral approach of the funding mechanism and increase its efficiency. Supporting the new funding model, the Global Fund also went through a restructuring period which resulted in changes in leadership and staff throughout 2012 to 2014.

In addition to the structural change in administrative side of the Fund, and reformed funding mechanism, the institution also went through a normative improvement process by further integration of basic human rights into decision-making process for funding. As a result of the Fund's efforts towards embracing human rights principles in its funding mechanism, in 2008 a *Gender Equality Strategy*, and in 2009 a *Sexual Orientations and Gender Identities Strategy* was accepted. However, these efforts could not be effectively reflected in the grant decision-making process until 2011 (Davis 2014).

The year 2012 was a turning point for evolution of organizational mandate, since this year marks the significant efforts made by the Fund to introduce human rights "systematically across its grant-making process" (Davis 2014, p.135). Traditionally, while nation states are responsible for protection of human rights, in the case of developing countries, external agents such as global aid organizations can influence normative perspectives within these countries (Davis 2014). In the case of the Global Fund, the inclusion of human rights in its funding requirements has been perceived as a challenge against the state sovereignty in some of the recipient countries. As I mentioned earlier, the Global Fund's hands-off approach disallows the organization to hold staff in the recipient countries and overseeing of the grant implementation process is conducted under the authority of an independent Local Fund Agent.

The Fund has accepted a new strategic plan for the 2012-2016 period. The first objective of the new strategy focused on "protection and promotion of human rights" (Davis 2014, p.137). The incorporation of human rights in the grant-making process was supported by the efforts of local communities, who had first-hand experience with the disadvantaged people living with AIDS, malaria, and tuberculosis, and often lacked the necessary attention by the governmental

authorities who are responsible for health projects funded by the organization. For instance, sex workers, those who are dealing with drug addiction, LGBT+ communities, religious or ethnic minorities, migrants and incarcerated people were left out of the health policies funded by the Global Fund from time to time because some of the implementing primary recipients had traditional normative understandings that discriminated these people from society and denied their right to access public health (Davis 2014).

Human rights are enshrined in the mandate of the organization as the fund expects the partner countries to undertake their responsibilities under *the International Covenant on Economic, Social and Cultural Rights* and *the Universal Declaration of Human Right* in providing equal access for health services without discrimination based on ethnic and religious identities or gender and sexual orientation of the people. In alignment with its focus on creating a multi-stakeholder approach in global health partnership, the Secretariat created a platform for exchange of ideas between technical partners and *Human Rights Reference Group* to establish a course of action for implementing the human rights into grant-making process in a more effective way (Davis 2014).

Davis (2014) suggests that the Global Fund should be meticulous to detect the programs which do not respect the human rights requirements set by the organization during the approval and monitoring process of the funding scheme. The Fund should especially pay attention to three aspects: where the partner country is composed of "closed societies with a record of systematic human rights abuses, when the receiving section of population is "criminalized populations" Fund should ensure the security of these populations against police violence, arbitrary apprehension, and abuse by local authorities (Davis 2014, p.141). Lastly, the Fund should continuously monitor the aid implementation process in environments where the receiving population is under supervision "institutional settings where abuses are routine", for example, in prisons, detention centers, and rehabilitation centers (Davis 2014, p.141).

In respect to the previous conversation about the *non-political* nature of the Fund, we can argue that the inclusion of human rights into decision-making process indirectly gravitates the Fund's mandate towards a political context, because while making grant decisions according to preservation of human rights, the fund must protect the rights of disadvantaged groups who are in dire need for external health assistance (Davis 2014). At the end of the day, the Fund cannot deny the needs and demands of people who suffer from these diseases based on formal requirements that need to be met by the recipient agents who are not willing to

undertake responsibility for these populations. In this sense, the Fund has caught between the devil and the deep blue sea. In addition to efforts made in the formal rules and requirements of the global health partnership process, the Fund has actively mobilized its technical resources to inform the local workers, CCMs and civil society organizations in recipient countries to encourage the strengthening of human rights-based approach of the operations (Davis 2014).

As for the accountability principles of the Global Fund, the institution has been working under a "zero tolerance for corruption and fraud" policy (Kohler and Bowra 2020, p.5). Compared to other active participants of global health governance, the Global Fund distinguishes itself from other actors with its sophisticated system to provide accountability and transparency for its partners. Especially, after the Fund had drawn attention to its operation system after corruption scandals came to light in early 2010s, it has been working towards betterment and strengthening of the checks and balances within its partnerships.

The Office of the Inspector General (OIG) was founded to oversee the financial interaction within the programs conducted by the Fund. While the office has closely scrutinized each allegation regarding any possible corruption and fraud, the reports prepared by the institution are open for public access on its official website. In addition, a campaign named "*I Speak Out Now!*[15]*"* had been led by the office to include every stakeholder in the process, even whistle-blowers who do not have authoritative power over CCMs, to uncover any corruption claims through a direct reporting system (Kohler and Bowra 2020, p.6). Through investigation of *Prohibited Practices* under the authority of the OIG, the Fund can freeze the funding and even sanction the recipients under any corruptive incidents. In 2014 *the Ethics and Integrity Framework* was established, and in 2016 *the Ethics Office* was established to solidify the accountability of the funding mechanism.

Lastly, I want to enlighten the readers about the process followed in the case of detection of unruly use of the fundings. The institution interferes with the recipient who mingles with corruptive activities and fraud through its *Agreed Management Actions* (AMAs). AMAs are a blueprint of actions, decided by the Secretariat and OIG, to determine the cause of the unruly activity and warn the recipients against conspicuous operation, or when necessary, sanctions the primary recipients according to Fund regulations. In the case of off-course with initial

[15] "Report Fraud & Abuse," Office of the Inspector General - The Global Fund to Fight AIDS, Tuberculosis and Malaria, accessed July 1, 2022, https://www.theglobalfund.org/en/oig/report-fraud-and-abuse/.

agreement or lost disbursements, AMAs are used to create a recovery plan for the Fund. *Recoveries Reports* are prepared by the Board and published annually to strengthen the transparency of the Fund through a report of liabilities and assets that should be provided through recovery plans. Until June 2018, "2-1 allocation reduction penalty" was used seven times to recover an amount of "US$12.7 million" from the recipients (Kohler and Bowra 2020, p.6).

3.3.5 To which extent the Global Fund is Multisectoral?

In her 2010 study, which examines "multisectoral deliberation" in the Global Fund mechanism, Brown argues that despite the institution's aspirations to take on a multi-stakeholder approach there is a clear "deliberative deficit" within its inner workings (p.512). The author suggests that the existing system of the Fund does not support the voices from different actors equally, and there is an "asymmetric power relationship" which we can generally observe in practices of multilateral global health governance (Brown 2010, p.512). As it is defined by Brown (2010, p.513), "deliberation denotes a process of public reasoning geared toward generating decisions or opinions about how to resolve shared problems". So, the main objective of deliberative policy making is to create an environment of consensus between actors and find an optimal solution to problems in a way which will benefit the maximum number of participants.

The envisioning and establishment processes of the Global Fund was a product of deliberative politics, which went through a problematization and settlement on adequate responses process in the G8 Summit in Japan as it was previously mentioned. Therefore, it is no surprise that the Fund aspires to maintain its characteristic as a multi-stakeholder institution, which creates an environment for deliberation among several actors in global health. Although Brown's (2010) study gives credit to the Global Fund mechanism which inherently includes deliberative consideration processes in its funding scheme, the author also highlights the shortcomings of the institution.

The main argument in this critique is the domination of the Global Fund mechanism by traditional power structure which is dominated by the wealthier countries over the low-income ones, which is supported by responses from the first-hand experiences of non-donor Board members (Brown 2010). While it is well known that the donor member countries conduct prior meetings and engagements among themselves before official Board meetings of the Fund to

deliberate their moves, non-donor members do not have the equal conditions. To eliminate this unfair situation, they have demanded extra resources from the Fund in order to conduct their own group meeting before the official Board meeting. However, this request was immediately declined, and since they do not have economic capabilities to conduct such meetings, they believe that this unequal power distribution impacts the deliberation process within the Fund in a negative way (Brown 2010). Furthermore, unequal distribution of economic power between the partners causes a disadvantage of parties from low-income countries. For instance, under the Bush administration, the US has used its veto power to freeze its donation flows with the condition of annulment or altering of certain global health initiatives conducted by the Fund. This again brings us back to the problem of the non-political nature of the institution.

In addition, the problem of accountability arises to be a concern for the non-donor countries, as the respondents allege that "there is no consistent idea of who the Global Fund is accountable to, and it seems to change depending on who the Global Fund is addressing" (Brown 2010, p.523). Unfortunately, the most excess repercussions of this kind of power struggle in deliberative processes within the funding mechanism affect the local stakeholders who are not formally represented within the Board. While the chance of local representatives to contact formal authorities is small, the incident where these types of communications come into existence is generally in informal settings. The only formal platforms which allow the local representatives and civil society to voice their demand and grievances are the *Global Partnership Forum* and the *Global Fund On-line Forum*. There is a visible and acute problem regarding the under-representation of local voices, and more significantly the representation of voices who are in the target group of the projects initiated by the Global Fund. As it was previously mentioned, the lack of formal requirements for the composition of CCM members also creates an accountability deficit between the representative authorities and the people they are representing. Therefore, CCM, which is baptized as the cornerstone of the Fund's multi-stakeholder approach, does not necessarily provide a deliberative environment that would amplify all voices equally.

3.3.6 An Obstacle Ahead: Strengthening of Basic Health *Systems*

For an adequate implementation of disease-targeted health initiatives in recipient countries, the primary obstacle the Fund is facing is the lack of capacity of basic health systems at the domestic level. There are two elements which hinder the improvement of these systems

under the influence of the Global Fund. The first one is the limited funding provided by the Fund which is used to achieve primary objectives related to eradication of the three-target disease. The second one is the coordination problem caused by the difficulty of balancing the conditions stipulated by the fund agreement and existing national health strategies.

Regarding the problem of limited resources for improvement of national health systems, first and foremost, the Global Fund clearly declares that its efforts are concentrated in the fight against HIV/AIDS, malaria, and tuberculosis in low-to-middle-income countries. Although the effort of the organization is not primarily focused on improvement of basic health systems, scholars argue that for the most efficient implementation of the funds, a strong and sustainable health system is necessary, and the health workforce comprises the focal point of a sufficient system (Drager et al. 2006). Since the report on the track record of the Fund in its initial five years have illustrated existence of shortcomings due to lack of robust basic health systems in some recipient countries, the Fund have established a partnership with the GAVI Alliance, World Bank and the WHO for long-term development of basic health systems in certain regions (Hanefeld 2014).

Experts such as Ooms et al. (2007) suggest that the Global Fund should utilize its successful operation system to create fundings for development of local health work forces, since in dire cases as the likes of Mozambique, the domestic health system is not capable of restructuring itself without external help. In countries where HIV prevalence is immense and the governance system suffers from serious mismanagement due to economic and political upheavals, a global response system is needed to help these countries restructure their basic health systems through economic assistance provided to the health workforce. Ooms et al. (2007) criticize the suggestion that was previously mentioned in this section by Shakow's (2006) report on repurposing and a clear distinction of mission between the World Bank and the Global Fund. They suggest that the World Bank lacks the novel approach of the Global Fund in the global health governance, and underlines that the Fund is possibly the only actor in global health governance who has the capacity, experience, and ethical values to shoulder the responsibility of a funding mechanism, which will contribute to establishment of robust and sustainable basic health systems in the countries who are much in need of it (Ooms et al. 2007).

The 2013 study of Warren and colleagues (p.5) shows that 37 percent (US$362 million) of the Global Fund Round 8 funding was used in development of basic health systems in receiving countries. While the study illustrates that a remarkable amount of the donations is

channeled into health responses other than procurement of medicines and vaccines, the researchers have detected a trend in fundings spending which shifted to a more equal distribution of funds between disease-specific interventions and health system improvements. The study iterates those improvements that satisfy the needs and necessities of basic health systems in low-income countries through the funding mechanisms that can be consolidated through the multilateral cooperation and commitment of all actors in the decision-making process. Therefore, the Global Fund can create an environment which will promote a collective support system for amelioration of basic health systems through supporting knowledge sharing, training and renumeration for health work forces through its funding capability (Warren et al. 2013).

As for the problem of strategy coordination, while to some extent Global Fund persists in its efforts for improvement of local health systems, the disease-specific approach of the projects may distract the national health strategies, which are directed towards a more sustainable and long-term development in domestic health systems (Bowser et al 2014). While some scholars (Brugha et al. 2004) suggest a principle of complementarity should be undertaken by the Global Fund initiatives to not disturb the ongoing health developments within countries and support the existing mechanism through pooling of funds into a joint funding pool, others argue (Cometto et al. 2009) that the funding mechanism of the Fund can be redesigned to support different fields of global health development, therefore, expanding the agenda of the institution to be more compatible with existing domestic health strategies.

Chapter 4:
CONCLUSION

In this thesis, my main objective was to unpack the informal practices in global health governance through an analysis of three illustrative cases in a framework based on a three-way typology on informality. Through this analysis, I wanted to answer the questions of how informal practices emerged in global health governance, how do they impact the global health governance and functioning of the WHO, and what kind of implications the competition WHO faces will have on GHG in a post-pandemic world. Increase of informal practices in global health governance, illustrates an example for a general trend of increase in informality in global governance since the 1990s. This increase of informality is evident in global governance of various issue areas such as security, global trade, environment, human rights, and global health. The reason behind the increase in the use of informal practices by state and non-state actors is explained as increasing multipolarity in international environment, which resulted in de-globalization phenomenon and Great Powers conflict. Since the existing formal intergovernmental organizations are insufficient to meet the demands of increased numbers of emerging non-state actors, rising powers who aspire for an alternative governance structure in a multipolar world, and founders of the liberal international order who now aspire for an isolationist policy direction in a multilateral global environment; informality increased in global health governance.

The increase of informality in global health governance has resulted in the establishment of informal trans-governmental institutions which rose to prominence in the global health system as influential actors in a short period of time. This naturally resulted in a relative decline of the WHO influence and authority in global health governance. In this respect, informality in GHG has a negative impact on the prestige of formal health governance organizations, and this results in a decrease of trust for formal organizations in the global health community. In the case of the WHO, this lack of trust resulted in budget cuts from its contributors, and this situation has limited the already insufficient financing capacity of the organization for its operations. In addition, this has created an environment in which the lack of trust for the WHO has hindered the organization to undertake its important disease surveillance and disease control responsibilities during the recent COVID-19 pandemic.

In the illustrative case of China, I have observed that the objectives of the country as a rising power, create an incentive to engage in informal practices in global health both within its

involvement with the WHO as a member state, and through its use of informal governance networks to create alternative platforms for global health governance. In the case of China's aspiring pioneer role in global health as a WHO member, I have observed that the Chinese interference in WHO decision-making process aims to alter the existing rules and norms of the organization in order to conform the governance structure to Chinese norms and ideals, which prioritize an authoritarian capitalistic form of governance. At the same time, China shows significant effort to expand its informal governance networks to the field of global health to create an alternative for the existing international order, in cooperation with other Great Powers from the Global South. Since China's use of informality limits the capabilities of the WHO, and its interference with the internal structure of the organization hinders the smooth functioning of the WHO, the global health governance is restrained from a healthy functioning because of informality within the WHO. The illustrative case of China shows us that informality within institutions has a negative impact on both the formal global health governance organizations and global health governance.

In the illustrative cases of Bill & Melinda Gates Foundation and the Global Fund, while informality of and around institutions have negative impact on the influence of the WHO in GHG, these two institutions have a positive impact on the global health systems through introduction of new mechanisms, revitalization outdated governance structures, and through modern health development initiatives which show commitment to inclusivity, sustainability, and protection of basic human rights. Informality of and around institutions, as illustrated in the cases of BMGF and the Global Fund, can be seen as complementary to the governance structure set by the liberal international norms and values embraced by the WHO. In my analysis, I have observed that informality around and of institutions have a positive impact in global health governance to a certain degree. However, this outcome is heavily dependent on the fact that the two institutions I have examined are willingly abide to the rules and norms of global health governance set by the WHO. Therefore, in different cases focusing on different actors which aim to create an alternative governance structure, informality around and informality of institutions may also have a negative impact on global health governance. As long as informal practices abiding to the rules and norms of global health governance, which prioritize individuals' right to health and wellbeing and principle of human security, informal practices have a higher chance to have a positive impact on global health governance.

In the case of China, we can observe the dramatic change in the domestic health care system, which transitioned from its initial traditionally insufficient condition to a health care

system that serves as an example for the others. China's active involvement in global health governance began in the early 1960s, with dispatch of medical teams in developing countries, and its initial project-based approach for foreign health initiatives transformed into a wide range of health assistance projects. The geopolitical considerations of China, and the Chinese regime's desire to establish strong relationships with the like-minded governments around the world have contributed to the earlier positioning of China in global health governance during the Cold War period. The decolonization movement had inspired the Chinese government to establish international relations with the help of its health assistance initiatives in the African continent and neighboring countries. In this period, Chinese national interests were given priority over the benevolence of the aid receiving countries, and mostly bilateral relations were preferred over multilateral cooperation. Investments made in bilateral health aid as a part of the Chinese foreign policy, helped China to secure the votes of sufficient number of members in the UN to be recognized as the legitimate Chinese state, as opposed to its rival Taiwan. While initial Chinese efforts in the global health scene were mostly motivated by the geopolitical conditions brought by the fixation of the government on the anti-capitalist policies in its international relations, in the early 1950s China experienced a turn towards prioritization of universal primary health care in its involvement in GHG.

China put effort towards improvement of domestic primary health care systems, through unprecedented initiatives such as the barefoot doctors. China's experience in strengthening the local health system in such a short amount of time had inspired other global health actors, such as its influence on the Health for All by the Year 2000 plan in the 1977 World Health Assembly, and its influence in the agenda setting of Alma-Ata Declaration of primary Health Care. Starting from 1979, a period of reconfiguration for Chinese health policies was observed with the weakening influence of the country in Africa, until the 1990s. As a result of this process, the 2003 White Paper on China's African Policy has provided a new approach to health development, which focused on both bilateral and multilateral relations with other actors. This new era of partnership between China and African countries in the early 2000s introduced a form of health development initiatives which entailed projects by Chinese firms in order to promote Chinese exports.

The 2003 SARS pandemic was a watershed moment for the WHO and China. The pandemic has resulted in the altering of the International Health Regulations, and improvements in disease surveillance, and global health emergency response mechanisms. Criticism regarding China's attitude towards the WHO, and other global health actors during the SARS pandemic,

and critical weakness of China's domestic health system had damaged the global reputation of China in the global health scene. While as an outcome of the crisis health security became an important aspect which impacts China's decisions in GHG, the pandemic had immense influence in recognition of the WHO's political relevance as a primary actor in global health governance by the Chinese government. After this experience, China aspired to undertake a more assertive role in the GHG, and within the WHO. The efforts of the Chinese government for the election of Margaret Chan as the director-general of the WHO is a prominent example of the shift in Chinese approach to the WHO and multilateral global health initiatives.

In the early 2000s, China shifted its efforts in global health governance to establish multilateral cooperation with prominent regional actors and multilateral institutions. With the impact of the dominance of the health development concept in the global health system, China has changed its foreign aid-focused perspective on GHG to a focus on multilateral development cooperation. The Health Silk Road initiative under the BRI continues to be an important pillar for China's health diplomacy with the objective of strengthening South-South cooperation under the scrutiny of China. BRI can be perceived as a platform of international cooperation which is officially ruled under the norms and values embraced by China.

In addition to BRI, China has demonstrated willingness to be a part of multilateral health initiatives under regional or global governance institutions such as BRICS, ASEAN, and Greater Mekong Six-Nations. The change in Chinese policies is not restricted to the issue of global health. Chinese policy objectives in various issue areas, from economy to environment, have directed towards increasing Chinese influence in order to attain a level of authority which is uncontradictable. Within this context, we can argue that China has an assertive approach in global governance as the Chinese foreign policies are directed towards the aspiration of becoming a hegemon in the global regime. As a response to the increasing influence of international organizations in global health governance, China makes an effort to increase its leverage in GHG. However, compared to its endeavors for becoming a hegemon in other issue areas within global governance, its efforts within the global health governance remain insufficient.

The constant criticism received based on its prioritization of national sovereignty over multilateral cooperation, and historic opposition to collective decision-making hurts China's reputation and normative influence on a global level. Furthermore, China's misuse of its influence in the WHO and GHG is criticized by many prominent global health actors and health

experts. For example, China's role in the negotiation process of the New International Health Regulations is often criticized, as the insistence of the Chinese government on the exclusion of the universality principle from the new IHR resulted in the exclusion of Taiwan from the WHO. While China takes pride in its active involvement in various multilateral global health initiatives, its positioning against Taiwan in the WHO is based on its national ambitions rather than a proper multilateral and inclusive approach in GHG.[16]As a result, China is capable of exerting its influence through informal practices within the WHO and has a respectable influence in global health governance.

The increasing influence of China in global health governance had a significant impact on the relation between China and the WHO. The change in the WHO response towards China, which did not condemn China's unruly practices, during the H1N1 outbreak can be considered as a corruptive result of the increased Chinese influence within the WHO. We can observe a pattern, in which as China's influence increases within the WHO, less criticism it attracts from the organization. However, many prominent global health actors and member states of the WHO continue to criticize this situation. When these actors prefer alternative governing methods within the global health system, this situation eventually damages the reputation of the WHO and diminishes its influence as a prominent global health actor. During the recent COVID-19 crisis, we could certainly observe the impact of this diminished role as sufficient multilateral response mechanisms could not be established under the authority of the organization.

As for the case of BMGF, it is a foundation that takes on a multilateral approach in GHG through facilitating public-private sector cooperation in health initiatives in low- and middle-income countries. As one of the members of the influential global health cooperation Health-8 group, the BMGF exercises informal practices around the WHO in addition to being a primary contributor of the WHO. BMGF is criticized for its disease-focused approach to health assistance, due to the impact of this approach within the global health governance, which resulted in concentration of global health efforts in limited areas. Through enormous financial resources and remarkable social reputation within the global health community, the BMGF have attained significant authority within the global health governance through its use of informal practices around the WHO system.

[16] Reuters, "Taiwan Fails in Bid to Join WHO Assembly after China Pressure," *Reuters*, May 23, 2022, https://www.reuters.com/world/asia-pacific/taiwans-efforts-join-who-assembly-fail-2022-05-23/.

While the foundation suffers from criticism concentrated on its transparency and accountability problems, its research and development activities heavily focused on high-risk ventures raise questions regarding its priorities. Here, the important question we should answer is that the BMGF is accountable for whom? In the absence of an authority which regulates the operation of such a foundation according to the rules and norms of the global health system, the BMGF has no obligation to adhere to these rules and norms. However, it is fortunate that the foundation makes considerable effort to show the transparency and accountability of its activities to its donors and general public. In this respect, while informality around the WHO established by the BMGF had remarkable impact in the improvement of global health systems, implementation of the norms and rules which protects human rights in an equal manner are so important for the maintenance of global health systems that it should not be left to the mercy of few wealthiest individuals in the world.

I believe that we are extremely fortunate since Bill Gates and other board members of the foundation happen to be generous and righteous people with the aim of eradication of HIV/AIDS, malaria, preventable diseases, and improvement of child health in low-income countries. While I have observed that the foundation started to embrace the norms and practices of the existing and prevalent global health assistance understanding in the later years of its operation, I believe that the monitoring of grant-making decisions and health initiatives under the responsibility of BMGF should be closely scrutinized by the global health community. In order to institutionalize the norms and practices adhered to by the foundation, a checks and balances system should be introduced with involvement of other global health actors.

Despite the criticisms, the BMGF continues to impact global health governance through its influence in the changing habits and practices such as a transition towards implementation of issue-based and short-term health programs through use of performance-based funding schemes. As one of the limited organizations who set the funding trends in the global health governance, the increasing authority of the BMGF has a considerable impact in the underinvestment to the WHO. This was significantly observed in the inability of the WHO to undertake its focal responsibility of disease surveillance and pandemic response under the budgetary constraints. However, rapidly enhanced influence of the BMGF is only one of the many reasons behind the underinvestment in the WHO, and the diminishing global influence of the organization.

Additionally, BMGF has expanded its authority in global health governance through its involvement in private-public partnerships such as the PATH and GAVI. While the foundation made significant contributions in vaccine and health technologies development, its efforts within the GAVI was even recognized by the WHO. These PPPs have become an alternative for the non-state actors and local populations who believe that these partnerships would amplify their voices more compared to their long-experienced underrepresentation in the WHO structure. Therefore, in the case of BMGF, we may argue that informality has a positive impact on expanding the inclusivity within the global health governance.

While Bill Gates made comments about the need for strengthening of the WHO's position in the global health system, he reiterated despite its significance, WHO is now one of the many influential global health actors like the World Bank and G7 Alliance. Here, Gates acknowledges the influence of the WHO within the GHG, and the need for the WHO to be a part of GHG in a way which it can contribute more to it through a multi-lateral approach. In this context, we can argue that while informality has a negative impact on the authority of the WHO, informal structures established by the BMGF impact on the improvement of the global health system overall.

For the case of *informality of* institutions, the Global Fund is a transnational health-partnership initiative established through an international call by the G8 countries to meet the need of a new partnership mechanism which will allow the global health actors to work around international organizations under the UN system. While multisectoral approach is one of the founding principles of the Fund, highest priority is given to the poorest populations in the world. The Global Fund system has changed the habits of many participants of global health governance, while main focus shifted onto short-term and disease focused programs where cross-sectoral funding and arbitrary funding methods were preferred. Another unique approach of the Global Fund to health development partnership was its hands-off approach which was consolidated through the multilateral decision-making process of CCMs. However, Global Fund structure was criticized on its different aspects such as communication problems between CCMs and local populations, underrepresentation of local voices in decision-making process in CCMs, and lack of technical infrastructure in the recipient countries to ensure a long-term improvement in basic health systems.

The limited time to respond to the urgent health problems caused by HIV/AIDS, malaria and tuberculosis weighs a responsibility on the Fund to find alternative approaches which will

work around the constraint caused by national sovereignty principles in recipient countries. Even though the Fund's efforts for establishing a rights-based approach in its funding mechanism conflicts with the financial autonomy of the nation state, the Fund mechanism is praiseworthy for its accountable and transparent system which prioritizes equal rights for all. The funding system brough to global health systems by the Fund is a remarkable example of positive contributions of informality to global health governance. While the practices of Global Fund can be improved through adopting a health plan focused on the long-term sustainability of basic health systems, its funding mechanism can inspire new initiatives in other aspects of health development. In this respect, the example of the Global Fund shows us that the informality of institutions in global health governance can have a positive impact in good governance of global health.

Informality has brought both positive and negative outcomes in global health governance. In my honest opinion, informality in global health governance should be monitored and controlled by a mechanism to minimize possible negative impacts of informal practices which can be considered harmful for proper functioning of the global health system. In this way, informality can be held under a loose check to overall enhance its positive impact on global health governance, while withholding its negative outcomes. Today, global health governance is structured as a multipolar system in which different actors have different capabilities and different degrees of influence in various fields of the global health system. The WHO, which continues to be a significant actor in global health governance, has lost its once indisputable leadership role in global health due to structural problems and its inability to timely respond to the changing demands of its member states and health development partners. In addition to these internal problems, the increase in the number of new non-governmental institutions in the global health systems has attracted attention to alternative methods for improvement in the global health system. However, I believe that the unique mandate and historical position of the WHO makes the organization the perfect candidate to create a controlling mechanism which will ensure protection of individual rights and equality of all in global health governance through monitoring informal practices.

Despite its diminished authority considering the developments brought to the global health system through institutions such as the Global Fund and BMGF, the WHO is still a focal actor in global health especially in the issue of disease surveillance and health emergency response. After the COVID-19 pandemic, the world has experienced the problems caused by lack of an authority responsible for disease control and response. Therefore, the disease

surveillance duties of the WHO should be improved through the support of the global health community since the unique mandate of the WHO provides it the capability to act as a higher authority over its members. In the post-pandemic world, the focality of the WHO in pandemic preparedness is well understood, therefore, the organization has gained the unique opportunity to build upon its existing mechanism to improve its structure and enhance its influence in disease surveillance and health emergency response. COVID-19 have exacerbated the existing increase in de-globalization trends and antagonism between Great Powers in the multipolar world order. However, these phenomena outdate the recent pandemic, therefore, it may be too early to write disaster scenarios regarding the impact of increased informality caused by multipolarity in a post-pandemic world. However, one can expect to see even a sharper increase in informality in GHG compared to last decade, and this situation will certainly push existing institutions such as the WHO to consider serious reforms and organizational restructuring.

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