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Master's Thesis of International Cooperation

The Effect of WHO's Funding
System in Its Responses to Ebola
and COVID-19

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The Effect of WHO's Funding System in Its Responses to Ebola and COVID-19

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Abstract

The international organizations (IOs) have been experiencing a continuous increase of voluntary contributions (VCs) in recent years. The World Health Organization (WHO), also observing this trend, serves as an extreme case with access to less than 20% of flexible funds. As leader of global health security, the WHO has played a fundamental role in responding to health emergencies by taking the leadership in the shaping of health agendas, provision of technical assistance and coordination of responses. However, the organization's limitations were prominently highlighted during the West African Ebola epidemic in 2014, which was larger in scale than the previous outbreaks. The reactive responses are attributable to the lack of flexible funds, impeding the rapid mobilization of resources during emergencies. This funding issue has been further solidified during the COVID-19 pandemic, adding onto the ongoing financial frustrations. Therefore, with the consideration of the long-persisted problem of financial stress largely accounted for by the continuous rise of voluntary funds, this research investigates the challenges to proactive WHO responses through the cases of Ebola (West Africa) and COVID-19 outbreaks, as well as the consequent trajectory of WHO financing through the path dependence theory.

Keywords : Earmarking, Financing, COVID-19, Ebola, World Health Organization (WHO), Path Dependence Theory

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List of Abbreviations

AC	Assessed Contribution
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control
CERF	United Nations Central Emergency Response Fund
CFE	Contingency Fund for Emergencies
COVAX	COVID-19 Vaccines Global Access Facility
COVID-19	Coronavirus (SARS-CoV-2)
CVCA	Core Voluntary Contributions Account
DG	Director-General
EB	Executive Board
EVD	Ebola Virus Disease
GAVI	Global Alliance for Vaccines and Immunization
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IHR	International Health Regulations
IO	International Organization
M&E	Monitoring and Evaluation
MERS	Middle East Respiratory Syndrome
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NPI	Non-pharmaceutical Intervention
PHEIC	Public Health Emergency of International Concern
PPE	Personal Protective Equipment
SARS	Severe Acute Respiratory Syndrome
SNS	Social Networking Service
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
VC	Voluntary Contribution
WHA	World Health Assembly
WHO	World Health Organization

Chapter I. Introduction

Financing is one of the foundational underpinnings of international organizations (IOs), supporting their functions and purposes. IOs are mainly financed through the core or assessed contributions (ACs) and the non-core or voluntary contributions (VCs). Throughout history, the practice of receiving VCs has not been uncommon. These VCs, which are allotted for specific and thematic endeavors, have been supporting their operations, and this type of fund has been remaining constrained over time. Last few decades, there have been two noticeable trends in the area of financing within the IOs. The trends are first, the continuous increase in the total amount of funds and second, the changes in the quality of funds (Schmid et al., 2021). An organization that reflects both of these trends is the World Health Organization (WHO). Substantially relying on the VCs by the Member States, the WHO is one of the extreme examples in the UN system (Burci & Daugirdas, 2019).

The IOs were founded with various purposes like the provision of global public goods, while upholding their independence and autonomy (Sridhar & Woods, 2013). However, the practice of earmarking funds presents a significant challenge to their autonomy, by permitting donor countries to wield direct influence through allocation of resources into specific projects and activities. This issue is salient in the WHO's response to major health crises, such as the West African Ebola Epidemic (2014-2016) and the COVID-19 Pandemic (2020-). Criticisms that have been directed at the organization for its insufficient, sluggish actions often highlight the underlying problem of financing that primarily stems from the restricted availability of flexible funds. Despite efforts to secure reliable and sufficient sources of funds, as exemplified by the establishment of the

Contingency Fund for Emergencies (CFE) following the West African Ebola Epidemic, the issue persisted, remaining unresolved. Following the COVID-19 howbeit, the WHO recognized the urgency of financial system rectification, resulting in the World Health Assembly (WHA)'s notable agreement in May of 2022 to increase ACs. Signifying signs of change in the budgetary trend, it remains to be observed whether concrete actions will be undertaken in line with this encouraging development.

As the WHO assumes the leadership role in the shaping of global health agendas, fortification of health systems, and effective responses to unforeseen health emergencies, maintaining an adequate reserve of flexible funds is of paramount importance. Despite its notability, there has been a relative dearth in academic scholarship of the topic of earmarking, which has garnered interest post-2010s (Reinsberg, et al., 2015). Although the practice of earmarking funds for specific regions or thematic areas began around three decades ago in the 1990s (Eichenauer & Reinsberg, 2017), the study of this phenomenon has been more on the UN system as a whole, rather than an individual UN entity (Mahn, 2012; Graham, 2015). Furthermore, there are also insufficient studies conducted on the effects of earmarking on these institutions, with scholars having more interest on the causes behind both the trends - increase of quantity and decrease of quality of funds (Schmid, et al., 2021). Thus, the contributions this thesis aims to make in academia are twofold. Firstly, an in-depth examination of the financing system of a specific UN organization, the WHO. Second, the scrutinization of the effects of the increasing lack of core contributions on its responses to health emergencies through the cases of the West African Ebola Epidemic and the COVID-19 Pandemic as well as of the organization's budgetary trajectory with the utilization of the path dependence theory.

Having made that establishment, the research is as follows. Chapter two conducts relevant research on the role of the WHO in the global response to infectious disease and investigates the practice of earmarking. Building on this background of this study, chapter three presents the research design, which includes the research question and the theoretical framework. With the application of the path dependence theory, this study aims to understand the responses to the critical junctures, the health crises - Ebola and COVID-19, in relation to the long-standing issue of the WHO's financial structural defect. Advancing further, chapter four explains the WHO's particular role in global community leadership and the process of coordination amongst the actors. This chapter also undertakes an examination of the WHO's budget data. This is followed by chapters five and six that illuminate the infectious diseases West African Ebola and COVID-19 respectively, and the initiatives the WHO's undertook in international responses. Lastly, the thesis concludes with a discussion of findings and concluding remarks.

Chapter II. Literature Review

II.A. The Role of WHO and Infectious Diseases

A.1. Smallpox

Epidemics and infectious diseases have been in coexistence with mankind throughout history. As emphasized by scholars such as Ruger and Yach (2009) and Meier & et al. (2020), the WHO holds great prominence in global health governance. This leadership is bolstered by the International Health Regulations (IHR), a legally binding framework implemented for global health and emergency responses, and it serves as a critical instrument in overseeing and coordinating global health efforts.

The WHO has played an indispensable role in global health security, particularly in disease eradication and prevention. One of its most successful initiatives is the smallpox eradication campaign, which has been widely recognized as an achievement (Markel, 2014). The campaign was launched in 1959 and revitalized in 1967, having incorporated improved vaccination strategies and coordination mechanisms (Heymann & Wilder-Smith, 2020). The collective efforts of various stakeholders with the guidance of the WHO, led to a significant milestone in public health history - the smallpox eradication in 1980. Henderson (1998) highlights the pivotal efforts of the WHO in coordinating a collaborative effort, contributing greatly to its success. They underscore the WHO's effectiveness in having driven an impactful global health campaign.

Contrasting perspectives exist regarding the WHO's leadership in the smallpox eradication project, with some scholars prioritizing the state-led efforts. Carroll (2016) underscores the significant contributions of the Soviet Union and the United States,

particularly when international organizations such as the WHO and UNICEF were in doubt of the feasibility of eradication and their involvement in the initiative. In fact, it was the Soviet Union that initially proposed the elimination of smallpox, and their active participation played a very crucial contribution (Henderson, 1998). The USSR not only initiated the eradication effort, but also donated a substantial portion of the vaccines (over 80%) through the WHO. Similarly, the United States made an invaluable assistance by providing extensive resources with a budget of more than \$35 million, as well as other support through the Centers for Disease Control (CDC). These states' financial input is well-pronounced considering that the WHO's annual expenditure for the Intensified Eradication Program was only \$2.4 million over a span of 13 years, representing a small portion of the total budget of \$200 million (Wickett, 1986). These observations shed light on the state-led efforts and sufficient resources in the successful implementation of the smallpox eradication project, with the WHO's role in complement.

A.2. Ebola

In the 21st century, the WHO has emerged as a recognized leader in global health policy and security, with increased attention on health security due to outbreaks such as the Ebola and COVID-19. It is widely acknowledged that national healthcare systems alone are insufficient in effectively addressing health challenges, calling on the leadership of the WHO in the global health system (Soucat, 2019). During the Ebola outbreak, the WHO was acknowledged as the primary agency responsible for developing comprehensive strategies in controlling the spread of the disease. These strategies encompassed essential aspects such as case identification, case management, laboratory services and contact

tracing (Kalra et al., 2014; Kmietowicz, 2014). The WHO cooperated with various global actors, including the CDC, the UN, the United Nations International Children's Emergency Fund (UNICEF), the National Institutes of Health (NIH), and other Member States, to devise effective strategies for combating the outbreak (Evans, 2014; McKinney, 2014). The WHO's essential role in coordinating and mobilizing resources to address public health emergencies is demonstrated by these collaborative efforts.

In contrast, the WHO faced criticisms for its handling of the West African Ebola outbreak, which resulted in a tragic loss of 11,000 lives. Following the outbreak, numerous evaluations were conducted to comprehend the failures and to identify their underlying causes. Scholars such as Moon et al. (2015) and Heymann et al. (2015), along with government officials and medical experts, referred to the shortcomings and placed at least some of the blame on the WHO for its delayed and disjointed response to the virus. Gostin and Friedman (2014) delineated the situation as "crisis in global health leadership," pointing out the need for an effective superintendence and orchestration during such emergencies. The lack of a timely and coordinated action by the WHO prompted high-income countries like the United States to assume a more prominent role by filling in the leadership gap and responding to the crisis. These critical assessments stress the challenges faced by the WHO in comprehensive response in facilitating and managing global health emergencies.

A.3. COVID-19

As a response to the COVID-19 pandemic, the WHO has undertaken a range of critical efforts that have garnered some significant recognition. The organization has been

commended for its provision of essential medical and technical guidance, with active investigation of the virus and its new variants by experts, contributing a deeper understanding of the virus and successful response tactics (CFR, 2022). Furthermore, the WHO has been instrumental in coordinating with world leaders to bolster their national responses to the pandemic, facilitating collaboration and sharing of best practices among countries (*Ibid*). Markedly, the WHO has assumed efforts in global vaccination, resource and expertise mobilization to ensure worldwide equitable access to vaccines (*Ibid*). These commendable efforts of the WHO stress its global position in guidance and formulation of responses to the pandemic.

Despite the lessons learned from the Ebola virus outbreak and the subsequent calls for reforms, the WHO has faced substantial criticisms. The COVID-19 pandemic has been widely known as a "profound tragedy and a significant global failure," resulting in a substantial damage (Sachs et al., 2022). As the central actor in global cooperation, the WHO has been held accountable for delivering an untimely and ineffective response (*Ibid*). Particularly, the organization has been criticized for issues related to independence, compliance, and financing, highlighting the need for improvement in such areas (Gostin et al., 2020; Gostin et al., 2022).

The COVID-19 pandemic has also drawn attention to the question of the WHO's dependence on its key donors, specifically China and the United States, exposing the organization to the dynamics of the U.S.-China competition (Keaton, 2021). The initial announcement by the United States to withdraw funding to the WHO (later reversed), had a profound impact on the organization due to the potential loss of substantial financial support (Gostin et al., 2020). This development carries important implications as it

undermines world solidarity during a pandemic that requires a unified and comprehensive response. The WHO's reliance on these major donors raises concerns about its autonomy and the potential influence of political factors on its operations. Limited flexible funding has emerged as a major challenge for the WHO, resulting in its underfunded state (Yamey et al., 2019) and compromised autonomy (Gostin et al., 2015). The organization's heavy dependency on VCs makes its financial resources vulnerable to fluctuations and political changes (Clift & Rottingen, 2018).

Furthermore, the practice of earmarking funds by the Member States limits the full autonomy of the WHO, as these funds are designated to align with their respective national agendas (Gostin et al., 2015). This funding approach undermines the organization's capacity for independent distribution of resources and prioritization of global health needs based on scientific evidence and public health priorities. The challenges posed by the WHO's funding model and donor dynamics emphasize the necessity for reforms to ensure its independence and capacity for an efficacious management of global health emergencies.

II.B. Funds - Earmarking

The field of global health is intricately intertwined with finances and the capacity to support international health initiatives, thereby influencing the leadership dynamics (Harman & Rushon, 2014). The ability to offer financial backbone plays a crucial role in exerting influence, especially in determining the utilization of the allocated funds (*Ibid*). However, effective management of an outbreak, whether from a normative or operational standpoint, becomes significantly challenging when the governing body faces the constraints of an exiguous and inadequate budget (Gostin & Friedman, 2014). The WHO

has grappled with substantial difficulties stemming from its vulnerable financial mechanisms (Davies, 2010), resulting in a significant decrease in the available funds to mount effective responses to outbreaks (Philips & Markham, 2014).

The increasing prevalence of earmarked contributions can be attributed for the diminishing of available funds within the UN (Schmid et al., 2021). Currently, most of the funding received by UN organizations is earmarked, with a striking 79% of funds earmarked to the UN's development pillar in 2018, in relation to its overall revenue and spending (Baumann, 2020). These earmarked funds share three key characteristics. Firstly, their provision is voluntary for both the donors and the recipient organization. Secondly, donors specify the intended purpose of the funds, exerting influence over their utilization. Lastly, the multilateral governing bodies have narrow discretion in determining the allocation of earmarked funds compared to their control over the core resources (Baumann et al., 2020). Such trends in the funding mechanisms of IOs, including the WHO, reflect the complex relationship between financial considerations and the ability to constructively address health challenges on a global scale.

From the perspective of IOs, the practice of earmarking funds presents several advantages. Firstly, while core contributions have demonstrated limited growth in the past two decades, the allocation of funds to specific purposes has led to a significant rise in the revenue streams (Baumann et al., 2020). Second, although agencies' autonomy may be reduced to certain extent, earmarking can enhance their capacity to implement programs and projects with greater effectiveness. According to interviews with insiders from the UN, earmarking provides agencies with direct political support from donors during project implementation (*Ibid*). Additionally, earmarked funds offer the potential to expand

activities and foster innovation. Although concerns exist regarding potential deviations from mandates and programs, earmarked contributions can introduce fresh ideas, concepts, and approaches from diverse donors, thereby broadening the scope of activities and solutions provided by IOs (Browne et al., 2017).

Conversely, while VCs play a significant role in funding IOs, the practice of tight earmarking is also deemed to come with several drawbacks. IOs can face increased transaction costs, unpredictability of funds, insufficient coverage of overhead costs, and intensified competition for financial resources (Schmid et al., 2021). Moreover, restricted voluntary funding rules transfer decision-making authority over financial allocations to individual actors, thereby weakening the collective decision-making processes that are crucial in multilateral governance (Graham, 2015). Consequently, it is argued that donor earmarking can impede IOs' ability to fulfill their mandates and deliver global public goods, eroding the multilateral nature of these organizations (Ruggie, 1992). This leads to many IOs to perceive core, non-earmarked funding as the preferable form of support (Schmid et al., 2021) as the core or flexible resources provide the necessary means to well-coordinate states and implement general principles of conduct, which are essential for upholding their multilateral character (Ruggie, 1992).

In conclusion, the findings from the reviewed studies underscore the notable influence financial capacity and considerations in the global health initiatives has on the leadership dynamics within IOs. While the practice of earmarking presents both advantages and disadvantages, a significant concern arises from the current imbalance between earmarked and core funding. To secure the sustained success and uphold the multilateral character of IOs, it becomes imperative to establish a healthier balance

between earmarked and core funding. Having this established, this study does not intend to negate other factors that may hamper proactive functioning of IOs, such as bureaucratic processes, political considerations, legal constraints, and governance system. With the urgency of the phenomenon – increasing VCs, and the importance of ample funding to successful working of agencies, the researcher aims to draw attention on and delve deeper into this funding issue within the context of the WHO, focusing specifically on the organization's response to health emergencies - the West African Ebola and COVID-19 outbreaks.

Chapter III. Research Design

III.A. Theoretical Framework

Path dependence theory is founded on the belief that the past history has profound effects in the future. Proposals on the definition of the theory have been raised by scholars of different fields - economics, sociology and political science, and all of them are said to have influenced the discipline of political science (Mahoney & Schensul, 2009). One distinguishing characteristic of the theory is the acceptance of the plausibility of events to have “*temporally lagged*” effects, which signifies that a particular effect doesn’t always have an immediately visible impact but may be evident at a later stage (Mahoney & Schensul, 2009). The essential features of path dependent that define the sequences within the theory are as follows.

First is the general assumption by all that the past exerts influence on the future (Castaldi & Dosi, 2005; Karl, 1997; Sewell, 1996). As Sewell (1996:263) phrased, “*what has happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time.*” Although this insight has garnered acceptance and has been found important by all, scholars view the limitation of this insight alone, requiring an integration of a complementary tool to become of practical use (Castaldi & Dosi, 2005; Sewell, 1996).

Second is the initial conditions that are of causal significance. Initial conditions are the variables at the start or even prior to a certain sequence of events (Goldstone, 1998). Built on this conception, scholars bring forth the importance of “*critical juncture*” and assert that such causal action leads to the events that come after (Collier & Collier, 1991).

Critical junctures pertain to situations wherein decisions made by influential actors are causally significant in determining the trajectory of path of institutional development among the different possible paths (Capoccia, 2016).

The path dependence framework largely maintains two types of sequences: self-reinforcing sequence and reactive sequence. Self-reinforcing sequence is characterized by the establishment and reproduction of a specific institutional pattern over time with a reinforcement of a particular outcome (Mahoney, 2000; Mahoney & Schensul, 2009). This type of sequence often involves “increasing returns,” whereby the established institutional pattern yields benefits, which make it increasingly challenging for the pattern to be transformed (Pierson, 2000; Mahoney, 2000). While the concept of “increasing returns” is usually applied by economists, many scholars argue the possibility of its application into various social and political institutions (Mahoney, 2000). On the other hand, reactive sequence denotes a series of events that are causally linked (*Ibid*), and it is “reactive” in that each event is the response to or is dependent on the preceding events (*Ibid*).

Between the two main kinds of sequence in path-dependence theory, the currently employed budget system by the WHO is understood to reflect a self-reinforcing sequence. A noticeable feature of this sequence is that first, there is a specific institutional pattern reproduced over time. Second, it involves some kind of “increasing returns.” Third, the institutional pattern becomes very rigid, being difficult to undergo changes. As such characteristics, the budget mechanism of accepting VCs in addition to ACs has been continued over a considerable duration, with an outcome of a continuous increase of VCs, in which such increment has been locked-in as a pattern. This practice involves “increasing

returns" or some benefits such as the substantial increase in revenue streams (Baumann et al., 2020) and the expansion of the range of activities and solutions offered by IOs (Browne et al., 2017). Lastly, the pattern is "locked-in" as evidenced by the rise of VCs within the WHO since its inception. Academics mostly agree that institutions are enduring entities that cannot be instantaneously or easily changed (Mahoney, 2000). Hence, such characteristic of persistence renders institutions as great subjects for the analysts interested in self-reinforcing sequences.

Within institutional reproduction, a particular pattern becomes "locked-in" or challenging to be reversed. The plausibility of the 'lock-in' of a pattern is posited in a series of events, and this term has been first conceptualized by Arthur (1994). The concept of a 'lock-in' presents the notion that entities can become trapped on particular paths of development, grappling to break free (Mahoney & Schensul, 2009). One approach to explaining an alteration to the customary trajectory is through the functional explanation (Mahoney, 2000). In this perspective, changes within the system occur in response to exogenous shocks (*Ibid*). Functional explanations are premised on self-regulating systems, thereby requiring some kind of an exogenous shock that exerts pressure on the overall system for an institutional change, and these exogenous shocks or critical junctures are understood by some academics as the opportunity to get out of such 'lock-in' (Mahoney, 2000).

The path dependence theory has been employed for this particular study for three reasons. First, to point out the persistence of a concern, the increasing VCs, in relation to the foundational belief that the past affects the future. Second, to contribute in explaining why certain patterns may persist over time, despite challenges or crises faced. Lastly, to

identify interventions or critical junctures that may shift the direction of an established pattern as the path dependence theory provides insights into the factors that can hinder or facilitate institutional changes. This theoretical tool offers an invaluable lens in understanding the dynamics of social systems with a more nuanced perspective.

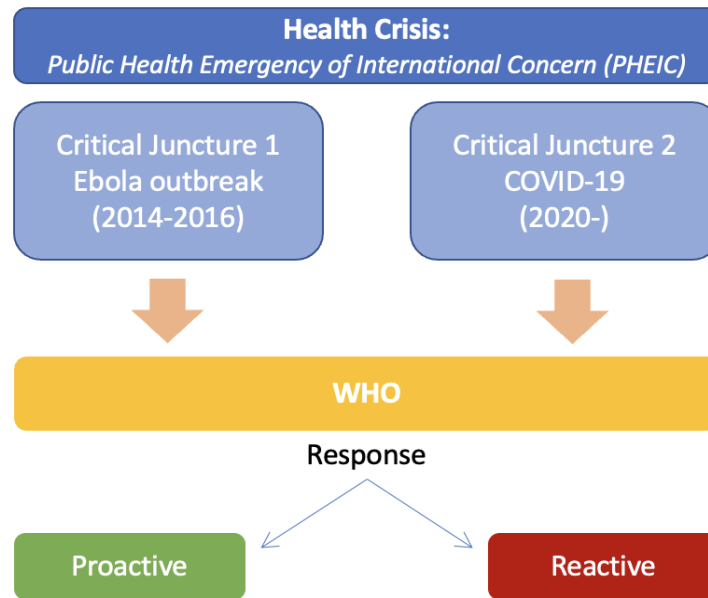


Figure 3.1. Theoretical Flow Chart

Using this theoretical framework (Figure 3.1), this thesis sought to comprehend the WHO’s reactive response (as opposed to proactive response) to a global health crisis in relation to the long-persisting concern - the decrease of the percentage of ACs (also known as the flexible, core funds). Reactive responses are those that have been primarily focused on responding to crises after they occur, whereas proactive responses include those that have been formed with prevention and anticipation of potential health emergencies. Through analysis of the two critical junctures West African Ebola and COVID-19, the

paper looked over the WHO's poor responses with the focus on the financing aspect. In addition, it reviewed whether the critical junctures served as a means of breakout from a 'lock-in' of the increasing VCs in the budget system through the path dependent perspective.

The researcher began the study, with the inquiry on the reasoning behind the WHO's inopportune, insufficient responses to the COVID-19 despite its previous criticisms from health crises like the Ebola outbreak. One recurring concern was the underfunding of the organization. As funds are the key foundation to an effective functioning of an organization, the study was designed to focus on the financing system of the WHO. Hence, the researcher proposed the following main research question and argument:

- *Research Question: What is the impact of increasing voluntary contributions on the WHO's responses to Ebola and COVID-19 outbreaks?*
- *Research Argument: Increasing voluntary contributions resulted in the WHO's reactive responses to Ebola and COVID-19 outbreaks, which failed to serve as critical junctures for change of the established financial trend.*

This research question entails three primary objectives. First, to investigate the trend of increasing VCs within the institution, the WHO. Second, to analyze the effects of such budgetary pattern in the WHO's responses to Public Health Emergency of International Concerns (PHEICS)¹, and lastly, to identify whether the PHECIS, specifically the West

¹ *Public health emergency of international concern (PHEIC) is defined in the WHO IHR (2005) Article 1 as "an extraordinary event which is determined: (i) to constitute a public health risk to other States through*

African Ebola and the COVID-19, acted as critical junctures that instigated reform of an entrenched pattern.

III.B. Research Methodology

This paper conducted qualitative research with a case study of the WHO's budget system through its effect on the responses to West African Ebola and COVID-19. Qualitative research involves the processes of describing, interpreting, verifying and evaluating (Peshkin, 1993), and a case study is a form of qualitative research that entails gathering detailed data on a specific individual, program, or event in order to gain a deeper understanding of a situation that is either obscure or inadequately understood (Hartley, 2004; Leedy & Ormrod, 2005). In line with such intentions, this research aimed to provide a deeper understanding on the budget system of the international organization WHO, which has received relatively limited attention within academia. The significance of the case-study lies in its examination of the exacerbated budgetary concerns through the WHO's poor handling of health crises. In light of such consideration, qualitative case-study was determined as the apt method to an in-depth understanding in an attempt to responding to the main research question and fostering relevant understanding.

The main research and data collection were conducted as outlined in the following. Initially, the background study was carried out by reviewing pertinent academic journals. To gain insights into the WHO and its constituent organs (Executive Board, Secretariat and World Health Assembly), the *WHO Constitution* was examined. Furthermore, the *International Health Regulations (IHR) 2005* was reviewed to identify the main functions

the international spread of disease and (ii) to potentially require a coordinated international response.” COVID-19 and Ebola are examples of PHEIC.

as well as the institution's communication procedure in response to PHEICs. An analysis of the budget system of the WHO was undertaken through the WHO's financial statements, program budget reports and existing studies of relevance. Specifically, the types of WHO funds were classified through the WHO document "*Outlook on WHO's various types of funding, their levels and its contributors,*" and the United Nations (UN) report "*Data Standards for United Nations System-Wide Reporting of Financial Data.*" For the analysis of the WHO finances, several core documents were reviewed, including the *WHO Scale of Assessments for Assessed Contributions*, *WHO Voluntary Contributions*, *WHO Programme Budget 2008-2021*, and *Contingency Fund for Emergencies (CFE) Annual Report*.

In addition, to gather background information about the health crises West African Ebola and COVID-19, scholarly journals, the *WHO Dashboard*, and the websites of Centers for Disease Control and Prevention (CDC) and the WHO were reviewed. The responses of the WHO to both outbreaks, West African Ebola and COVID-19, as well as their evaluations were garnered and examined through the external assessment reports initiated by the WHO (without its participation): *the Ebola interim assessment panel* and *Independent Panel*. In summation, the research was conducted with the objective of understanding the financial problem of the WHO and its effects on the operation of the organization, incorporating the scrutiny of academic papers, financial data, and external assessment reports.

Chapter IV. WHO: Its Role and Funding System

IV.A Organization and Role of the WHO

The WHO is made up of 3 organs: World Health Assembly (WHA) Executive Board (EB), and the Secretariat. These organs work together with a system that holds accountability of one other. To take health emergencies for example, the EB implements urgent measures concerning the finances and operations (*art. 28*), while the WHA approves the regulations, name of diseases, and public health procedures to abide by (*art. 21*). The Secretariat, led by the Director-General (DG) communicates with the regional offices (*art. 33*) and takes the administrative and technical leadership (*art. 35*). The following table describes their specific roles within the institution based on the WHO Constitution:

World Health Assembly (WHA)	Secretariat	Executive Board (EB)
<ul style="list-style-type: none"> • holds annual meetings (<i>art. 14</i>) • one vote per member (<i>art. 59</i>) • examines and authorizes the reports and actions of the EB (<i>art. 18</i>) • appoints DG (5 year term) (<i>art. 18</i>) • elects 34 EB members (<i>art. 18</i>) • holds the authority to adopt regulations, names of diseases, causes of death, and public health practices; and standards regarding safety, purity and potency of biological and pharmaceutical products. (<i>art. 21</i>) 	<ul style="list-style-type: none"> • consists of the HQ, 147 country and liaison offices, and 6 regional offices (Lee, 2009). • headed by DG (<i>Art. 31</i>) who is the chief technical and administrative officer (<i>art. 35</i>) <ul style="list-style-type: none"> - primary responsibilities of DG: appointment of Secretariat staff (<i>art. 35</i>), preparation of yearly financial reports, and the drafting of the proposed budget of programs (<i>arts. 34, 55</i>) • informs regional offices with information regarding all subjects related to their respective areas (<i>art. 33</i>) 	<ul style="list-style-type: none"> • 34 members (<i>art. 24</i>) • meets at least 2 times a year (<i>art. 26</i>) • appoints regional directors (<i>art. 52</i>) • carries out the WHA decisions, submits a draft General Programme of Work, evaluates proposed program budget, submits advice or proposals, and implements emergency measures concerning the finances and operations (<i>art. 28</i>) • forms committees to support and aid the mission of the organization (<i>art. 38</i>)

Table 4.1. Three Organs of WHO

Under the headquarters of the Secretariat are the different departments, and the department relevant to the preparation and response to health crises is the ‘Health Emergencies, Preparedness and Response,’ which consists of three groups: *Emergency Preparedness, Emergency Response and Intelligence and Surveillance Systems*. Hence, the WHO takes the leadership in equipment and preparation of the world against various health problems, in response when they occur, and in quick detection of potential epidemics and pandemics.

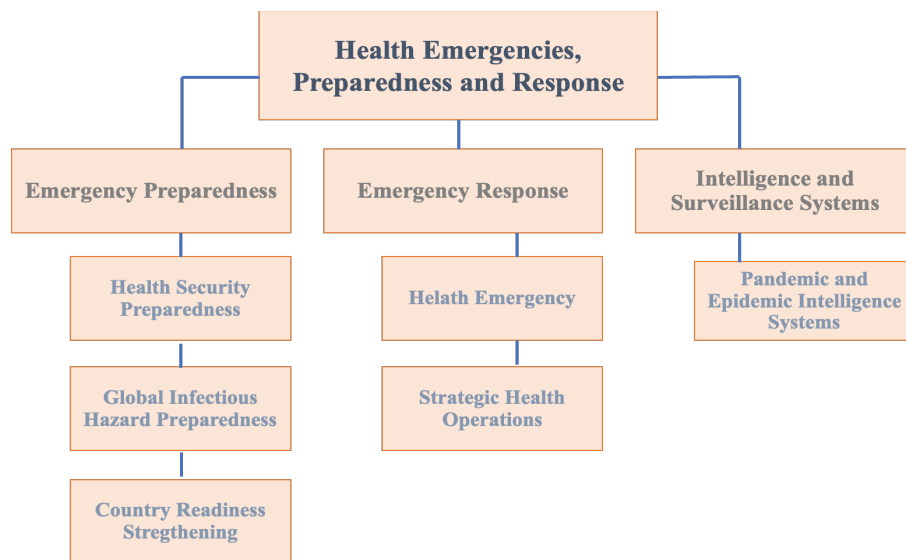


Figure 4.1. HQ’s Health Emergencies, Preparedness and Response

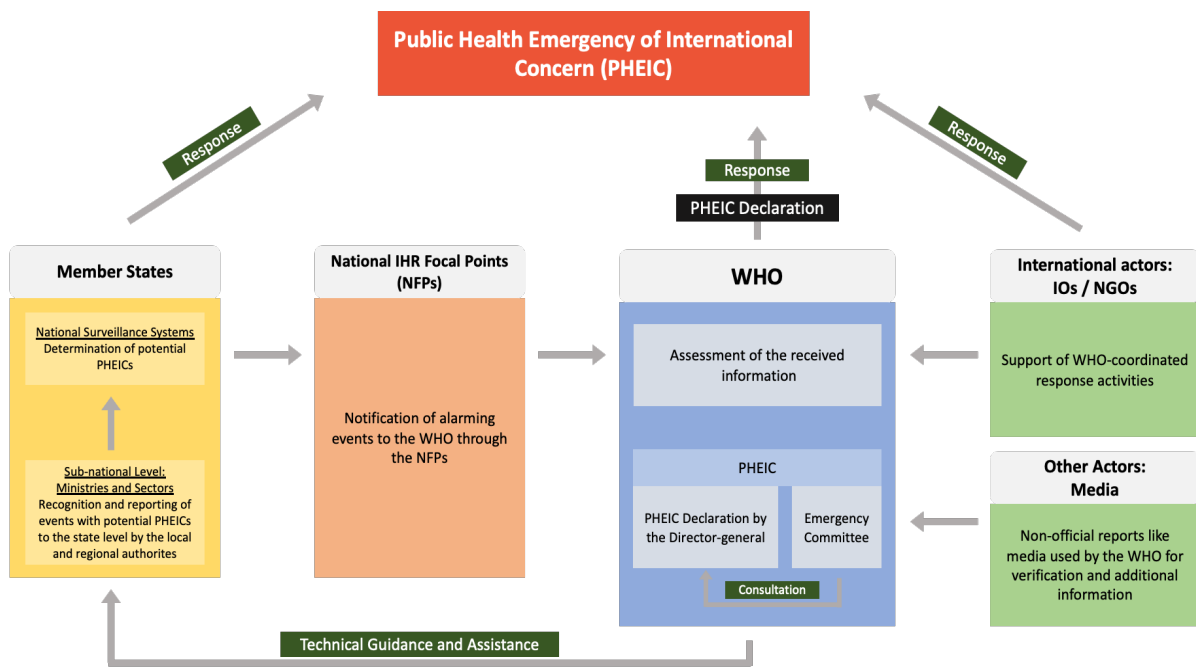
The following table shows the six main functions undertaken by the WHO according to the International Health Regulations (IHR) 2005:

Functions	Specific Roles														
1. Leadership	<ul style="list-style-type: none"> • to lead global surveillance and determination of public health risks 														
2. Partner Coordination	<ul style="list-style-type: none"> • to cooperate and coordinate agreements or arrangements with other IOs and/or international actors in implementing IHR (art. 14) 														
3. Information and Planning	<ul style="list-style-type: none"> • to disseminate health information with the state parties and other IOs (art. 11) • to identify and Declare PHEICs (with advice from external experts) (arts. 12, 48, 49) <p>-There have been six PHEICs declared since the First Emergency Committee Meeting in 2009:</p> <table border="1"> <thead> <tr> <th>Year/s</th> <th>PHEIC</th> </tr> </thead> <tbody> <tr> <td>2009-2010</td> <td>Influenza Pandemic H1N1</td> </tr> <tr> <td>2014-</td> <td>Polio</td> </tr> <tr> <td>2014-2016</td> <td>West African Ebola</td> </tr> <tr> <td>2016</td> <td>Zika and Microcephaly</td> </tr> <tr> <td>2019-2020</td> <td>Ebola DRC</td> </tr> <tr> <td>2020-</td> <td>COVID-19</td> </tr> </tbody> </table>	Year/s	PHEIC	2009-2010	Influenza Pandemic H1N1	2014-	Polio	2014-2016	West African Ebola	2016	Zika and Microcephaly	2019-2020	Ebola DRC	2020-	COVID-19
	Year/s	PHEIC													
	2009-2010	Influenza Pandemic H1N1													
	2014-	Polio													
	2014-2016	West African Ebola													
	2016	Zika and Microcephaly													
	2019-2020	Ebola DRC													
	2020-	COVID-19													
4. Health Operations and Technical Expertise	<ul style="list-style-type: none"> • to directly support the states parties through the following: <ul style="list-style-type: none"> ○ assist in strengthening core public health capacities ○ technical assistance 														
5. Operations Support and Logistics	<ul style="list-style-type: none"> • to M&E (monitor and evaluate) the IHR (2005) and its implementation • to adopt guidelines for the needs that are evolving 														
6. Finance and Administration	<ul style="list-style-type: none"> • to mobilize funds to assist and strengthen capacities of the developing countries (art. 44) 														

Table 4.2. Functions of WHO Under IHR (2005)

The WHO plays a central role in outbreak preparedness, surveillance, risk assessment and response to transnational health concerns. The WHO, with its risk management power, can declare PHEICs and adopt recommendations. At the same time,

states are to take the final measures for the protection of their own citizens. For those states that are in need of resources and/or financial assistance as well as guidance, may request them to the organization. Thus far, there have been a total of six PHEIC declarations since the inception of the Emergency Committee Meeting in 2009.



Source: WHO IHR (2005) Articles 5-17

Figure 4.2 IHR (2005): Coordination of Actors Facing Health Crises

Responding to the PHEICs requires concerted coordination of different actors: the WHO, its Member States, and other organizations (Figure 4.2). When a potential event/s of PHEIC is recognized by a Member State, it is to notify the event/s to the WHO through national International Health Regulation (IHR) focal points. Information is gathered by the WHO through the Member States and external sources like the media and then, DG’s consultations with the Emergency Committee proceeds on whether the event should be categorized as a PHEIC. The final decision of the PHEIC declaration is made by the DG, and all the international actors respond collaboratively in facing the health emergency. Technical guidance or other assistance may be requested by the Member States to the WHO if it is deemed unprepared with deficient capacity.

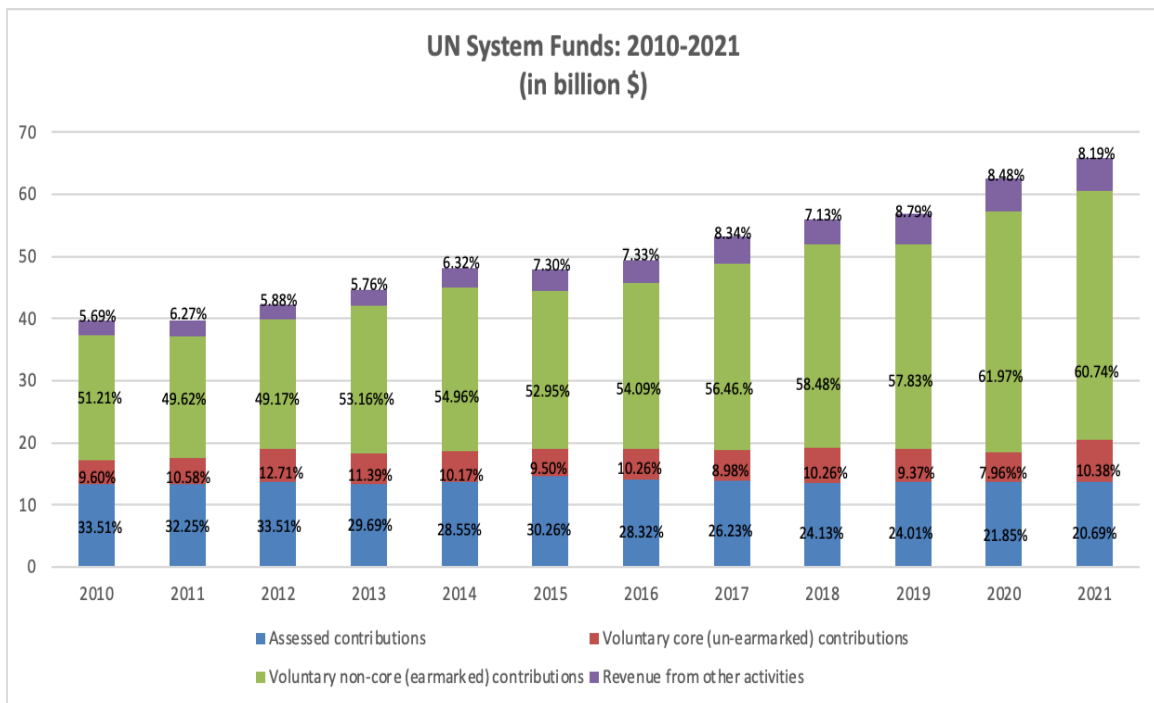
IV.B. Funding System

Type		Definition		Flexibility
1. Assessed Contributions (AC)		Fixed payments to be made by the Member States to the entity, and this is bound by treaty.		O
2. Voluntary Contributions (VC)	Program Support Costs	The costs levied on every VC for the administrative and management costs		O
	Core Voluntary Contributions Account (CVCA) (Un-earmarked)	VCs that are not earmarked; hence, are flexible and untied in terms of program budget.		O
	Non-core (Earmarked)	Thematic / Core	VCs that are earmarked for specific projects or themes. In terms of degree, there is more flexibility than specified VCs.	X
		Specified	VCs that are tightly earmarked within the outcomes and/or structure of the organization.	X
3. Revenue from Other Activities		<ul style="list-style-type: none"> Sources of funds that do not fall under ‘contributions.’ They may be from UN entity’s activities e.g. investments, exchange gains, or income generated by providing services or carrying out tasks for other UN organizations or foreign governments. 		

Source: UNSDG (2022), WHO (2021) Color Code: Flexible Funds ■ / Non-flexible Funds ■ / Both ■

Table 4.3. Types of Funds

Within the UN system, there are largely two sources of funds, which are the *assessed contributions (ACs)*, *voluntary contributions (VCs)*, and the non-core VCs can be further differentiated through *thematic* or *specified*. Additional income may be derived from *revenue from other activities*. Although the classification of funds is primarily similar throughout the UN organizations, specific terminologies may differ according to the UN entity. Therefore, Table 4.3 indicates the classification of funds to be referred to in this study.

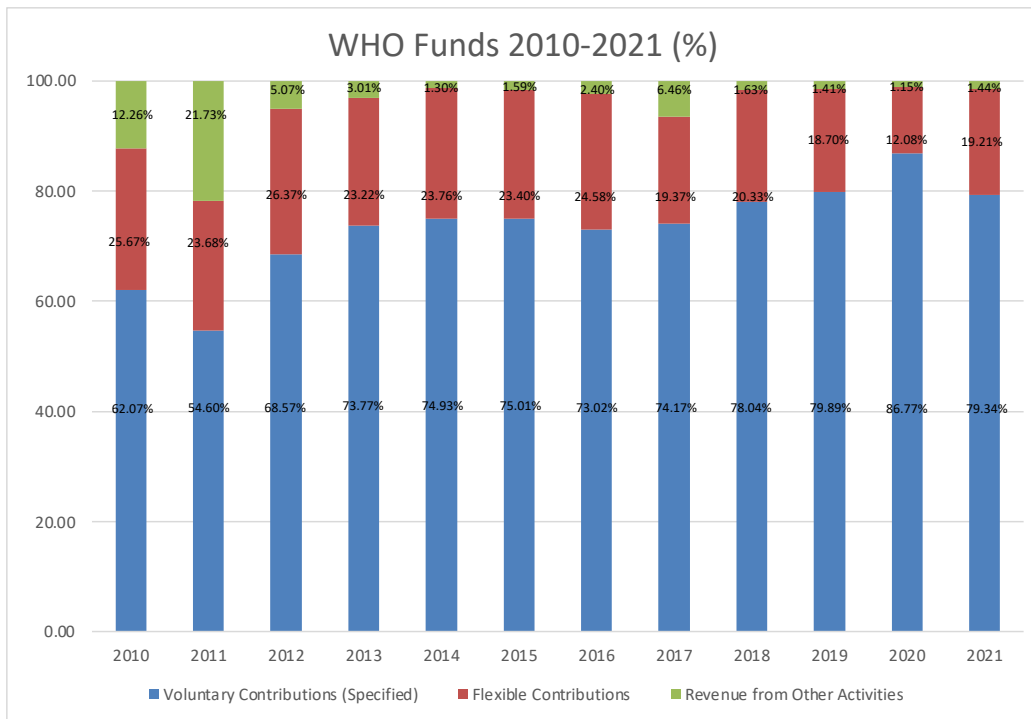


Source: UN CEB Database

Graph 4.1. United Nations (UN) System Funds

One of the alarming issues revolving around funds is the increasing VCs, which predominantly lack flexibility. This can be seen also in the UN system as depicted in Graph 4.1, in which the data were drawn from 43 UN entities. What can be collected from the changes over around a decade (2010-2021) is the increase of the percentage of VCs

(earmarked) from 51.21% to 60.74%, while the percentage of ACs decreased from 33.51% to 20.69%. The VCs that have flexibility, remained quite constant throughout the period. This increase in VCs has been called out to be an alarming issue for its lack of flexibility, hence undermining organizations’ autonomy, and capability to carry out their work. One representative example is the WHO.



Source: UN CEB Database

Graph 4.2. WHO Funds 2010-2021(%)

The WHO’s percentage changes from 2010-2021 of the flexible funds and the VCs – specified (earmarked) are depicted in Graph 4.2. Over the period of a decade, the percentage of earmarked funds increased by 17.27 % from 62.07 % in 2010 to 79.34 % in 2021, leaving a decreased amount of flexible funds from 25.67 % to 19.21 %. As denoted previously, the concern of the VC percentage increase is concurrent with the decrease of flexible funds, hindering organization’s quick financial access and utilization. This

immediate access and deployment of funds are especially more critical in dealing with unprecedented health emergencies.

	Countries	WHO Scale for 2008–2009	Countries	WHO Scale for 2020–2021
1	United States of America	22.00	United States of America	22.00
2	Japan	16.63	China	12.01
3	Germany	8.58	Japan	8.56
4	United Kingdom of Great Britain and Northern Ireland	6.64	Germany	6.09
5	France	6.30	United Kingdom of Great Britain and Northern Ireland	4.57
6	Italy	5.08	France	4.43
7	Canada	2.98	Italy	3.31
8	Spain	2.97	Brazil	2.95
9	China	2.67	Canada	2.73
10	Mexico	2.26	Russian Federation	2.41
	Total	76.11%	Total	69.06%

Source: WHO Scale of Assessments

Table 4.4. Top Assessed Contribution Donors (Scale of Assessments)

According to the WHO's *Financial Regulation V*, ACs and VCs finance the WHO's budget funds. ACs are predictable and stable sources of funds, which are collected based on the Health Assembly's determined scale of assessments. The WHO members' sole financial obligation is the ACs as stated under the WHO Constitution Article 56, and they are to be given in two yearly installments as stated in the *Financial Regulation VI*. Table 4.4 shows the top donors of ACs for two bienniums 2008-09 and 2020-21. For the years 2008-09, the top 10 donors account for 76.11 % of the total ACs, signifying that few

countries are the main sources of flexible funds. Some noteworthy points are that the United States remained as the top AC donor and that there has been a great increase of ACs by China from 2.67 % to 12.01 %, equating to the second highest contributor.

2008-2009					2020-2021			
	Contributors	% of VC - Specified	Contributors	% of VC - Thematic	Contributors	% of VC -Specified	Contributors	% of VC - Thematic
1	United States of America	19.18	Spain	24.62	GAVI	22.11	Germany	17.30
2	Bill & Melinda Gates Foundation	15.52	Norway	19.07	Bill & Melinda Gates Foundation	15.37	Saudi Arabia	9.99
3	Rotary International	7.33	Luxembourg	10.83	United States of America	10.34	Norway	6.34
4	United Kingdom of Great Britain and Northern Ireland	5.98	United Kingdom of Great Britain and Northern Ireland	10.21	European Commission	3.43	France	5.95
5	European Commission	4.32	Netherlands	8.28	Japan	3.28	European Commission	4.02
6	GAVI	3.99	Ireland	6.3	India	2.47	Luxembourg	1.40
7	Hoffmann-La Roche and Co Ltd.	3.95	Australia	4.06	Russian Federation	2.09	Spain	1.36
8	Canada	3.82	Sweden	3.61	Bloomberg Family Foundation	2.08	Japan	1.31
9	United Nations Central Emergency Response Fund (CERF)	3.12	Denmark	3	United Nations Development Programme (UNDP)	2.05	Republic of Korea	0.72
10	United Nations Development Programme (UNDP)	2.54	France	1.52	United Kingdom of Great Britain and Northern Ireland	1.91	Sweden	0.23

Source: WHO Voluntary contributions by fund and by contributor

Table 4.5. Top Voluntary Contribution Donors: Non-flexible Funds

2008-2009			2020-2021	
	Contributors	% of CVCA	Contributors	% of CVCA
1	United Kingdom of Great Britain and Northern Ireland	22.47	United Kingdom of Great Britain and Northern Ireland	46.01
2	Norway	18.74	Sweden	12.18
3	Netherlands	14.38	Australia	11.09
4	Sweden	9.70	Netherlands	5.42
5	Australia	8.89	Denmark	4.61
6	Finland	5.61	Finland	4.13
7	Belgium	5.08	Qatar	3.40
8	Denmark	4.83	Belgium	2.95
9	Spain	4.54	Switzerland	2.87
10	Switzerland	2.79	Australia	2.82
11	Ireland	1.93	France	2.46
12	China	0.55	Spain	1.53
13	Italy	0.47	Ireland	0.53

Source: WHO Voluntary Contributions by Fund and by Contributor

Table 4.6. Top CVCA Donors: Flexible Funds

Year	CVCA Budget	CVCA% of Total VC Budget
2008-2009	160.42	6.14
2020-2021	293.69	4.20

Source: WHO Voluntary Contributions by Fund and by Contributor

Table 4.7. CVCA: 2008-09 & 2020-21

As stated in Article 57 of the WHO Constitution, “*The Health Assembly or the Board acting on behalf of the Health Assembly may accept and administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable to the Health Assembly or the Board and are consistent with the*

objective and policies of the Organization.” The gifts or bequests stated in Article 57 refer to the VCs. There are three types of voluntary contributions - *specified, thematic* and *core voluntary contributions account (CVCA)* (Table 4.3 for classification of funds). The VC specified and thematic are non-flexible, and the top donors are shown in Table 4.5. Most of the top VC thematic funds are accounted for by the Member States, whereas the majority of the VC specified funds are derived from foundations, UN agencies and other institutions. This indicates the notable role that foundations and other institutions play in financing specific projects, which are to specifically meet their vision and needs. As opposed to the earmarked funds, there is also the flexible VC - core voluntary contributions account (CVCA). However, as shown in Table 4.6, there are only 13 Member State donors, and the CVCA budget only holds 6.14 % in 2008-09 and 4.2 % in 2020-21 (Table 4.7). This is to mean that roughly only 6 % and 4 % of the VCs are flexible.

B.1 World Health Organization (WHO): Program Budget 2008-2021

The WHO launches five-year strategies, which state different health objectives, categories and strategic priorities. Hence, the following program budget data have been accordingly grouped into three: *2008-2013, 2014-2019, and 2020-2021.*² As stated in the Financial Regulation II, program budgets have a two-year financial period, with the beginning year being even-numbered. Thus, the program budgets are indicated in biennium.

² *The last group is for two years 2020-2021, following the latest available data.*

In million US\$

Strategic Objectives		Approved Total from 2008–09	% 2008-09 Budget	Approved Total from 2010–11	% 2010-11 Budget	Approved Total from 2012–13	% 2012-13 Budget
1	Communicable Diseases	894.04	21.15	1268.35	27.94	1278.13	32.28
2	HIV/AIDS, Tuberculosis and Malaria	706.93	16.72	633.88	13.96	540.30	13.65
3	Chronic Noncommunicable Conditions	158.10	3.74	145.95	3.21	113.76	2.87
4	Child, Adolescent, Maternal, Sexual and Reproductive Health, and Healthy Aging	359.83	8.51	332.70	7.33	218.31	5.51
5	Emergencies and Disasters	218.41	5.17	364.02	8.02	382.03	9.65
6	Risk Factors for Health	162.06	3.83	161.68	3.56	122.26	3.09
7	Social and Economic Determinants of Health	65.91	1.56	62.65	1.38	42.79	1.08
8	Healthier Environment	130.46	3.09	114.36	2.52	86.83	2.19
9	Nutrition, Food Safety and Food Security	126.93	3.00	120.39	2.65	54.90	1.39
10	Health Systems and Services	514.05	12.16	474.20	10.45	348.09	8.79
11	Medical Products and Technologies	134.03	3.17	115.13	2.54	137.28	3.47
12	WHO Leadership, Governance, and Partnerships	214.34	5.07	222.72	4.91	257.57	6.51
13	Enabling and Support Functions	542.37	12.83	523.89	11.54	376.74	9.52
Total		4227.48		4539.91		3958.98	

Source: WHO Programme Budget 2008-2013

Table 4.8. Approved Program Budget 2008-2013

For the period 2008-13, the program was outlined by 13 strategic objectives (Table 4.8). The budget was mostly allocated to strategic objective 1 all throughout the 3 bienniums, and it aimed to ‘*reduce the health, social and economic burden of communicable diseases.*’ The WHO tackled specific diseases such as the neglected tropical diseases, Ebola virus, cholera, Middle East Respiratory Syndrome Coronavirus (MERS-

CoV), yellow fever and more, and gave assistance through technical cooperation, provision of guidelines and resources. On the other hand, strategic objective 5 is about emergencies and disasters, aiming to ‘*reduce the health consequences of emergencies, disasters, crises and conflicts and minimize other social and economic impact.*’ SO5 supported the Member States to develop norms and standards as well as to strengthen their national emergency preparedness blueprint and capacity. SO5’s budget allocation out of the total program budget increased from 5.17 % in 2008-09, to 8.02 % in 2010-11 and to 9.65 % in 2012-13.

In million US\$

Category		Approved Total from 2014–2015	% 2014-2015 Budget	Approved Total from 2016–2017	% 2016-2017 Budget	Approved Total from 2018–2019	% 2018-2019 Budget
1	Communicable Diseases	840.8	21.14	783.5	18.05	805.4	18.22
2	Noncommunicable Diseases	317.9	7.99	376	8.66	351.4	7.95
3	Promoting Health Through the Life-course	388.5	9.77	381.7	8.79	384.3	8.69
4	Health Systems	531.1	13.35	594.5	13.70	589.5	13.33
5	Preparedness, Surveillance and Response / WHO Health Emergencies Program	287	7.22	485.1	11.18	554.2	12.53
6	Corporate Services/Enabling	684	17.20	733.5	16.90	715.5	16.18
Polio Eradication / Special Programs		927.9*	23.33	986.1	22.72	1021.2	23.10
Total		3977.2		4340.4		4421.5	

Source: WHO Programme Budget 2014-2019

*This includes event-driven ‘outbreak and crisis response’ funds of US\$ 227.5 million, following the West African Ebola outbreak.

Table 4.9. Approved Program Budget 2014-2019

For the period 2014-2019, the health programs have been designed to work, adhering to six categories (Table 4.9). In addition to these six categories, were the polio eradication and other special programs withal, having been earmarked in the program budget. Just like the previous period, the highest percentage of budget allocation is to the category 1 communicable diseases. The category that deals with health disasters and emergencies is category 5, which is Preparedness, Surveillance and Response or the WHO Health Emergencies Program. Category 5 supported the alert and response capacities of Member States to deal with the epidemic or pandemic diseases. It also strengthened the national capacities in crisis management, as well as worked to prevent food safety. The biennium 2014-15 decreased budget allotment for health emergencies, in comparison with the previous years; however, with the Ebola outbreak in 2014, the funds increased to 11.18 % the following biennium, and by 2018-2019 the number reached 12.53 %.

In million US\$

Strategic Priority		Approved Total from 2020–2021	% 2020-2021 Budget
B.1	One billion more people benefiting from universal health coverage	1358.8	28.07
B.2	One billion more people better protected from health emergencies	888.8	18.36
B.3	One billion more people enjoying better health and well-being	431.1	8.91
B.4	More effective and efficient WHO better supporting countries	1090	22.52
	Polio Eradication	863	17.83
	Special Programs	208.7	4.31
Total		4840.4	

Source: WHO Programme Budget 2020-2021

Table 4.10. Approved Program Budget 2020-2021

Lastly for the latest years 2020-2021, the programs were guided by four strategic priorities (Table 4.10) and additional programs of polio eradication and other special programs. The budget was mostly assigned for B.1, which holds the goal of reaching one billion people benefiting from universal health coverage. The goals were to increase access to quality health services, to enhance availability of necessary medications, immunizations, diagnostic tools, and equipment for primary healthcare and to decrease individuals with financial difficulties. B.2 had three aims, which are to prepare the Member States from health emergencies, to prevent epidemic or pandemic, and to have a quick detection of and response to health crises. The budget assignment for health emergencies has reached the highest to 18.38 % with the COVID-19 outbreak.

B.2 Funds for Health Emergencies

In million US\$

Biennium Year	Approved Program Budget For Health Emergency	% of Total Program Budget
2008–2009	218.41	5.17
2010-2011	364.02	8.02
2012-2013	382.03	9.65
2014-2015	514.5	12.94
2016-2017	485.10	11.18
2018-2019	554.20	12.53
2020-2021	888.80	18.36

Source: WHO Programme Budget

Table 4.11. WHO Health Emergency Program Budget

Biennium Year	Category / Program Area	Budget (in million US\$)	Total Health Emergency Program Budget (in million US\$)	% of Total Program Budget	
2008–2013	Strategic Objective 5: Emergencies and Disasters				
	To reduce Health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.		218.41	5.17	
				364.02	8.02
				382.03	9.65
2014–2015	Category 5. Preparedness, Surveillance and Response				
	- Alert and response capacities	98	287.00	12.94	
	- Epidemic and pandemic prone diseases	68.5			
	- Emergency risk and crisis management	88			
	- Food safety	32.5			
	Others				
	-Emergency and Outbreak Response (event-driven)	227.50	227.50		
2016–2017	Category E. WHO Health Emergencies Program				
	- Infectious hazard management	107.2	485.10	11.18	
	- Country health emergency preparedness and the International Health Regulations (2005)	138.1			
	- Health emergency information and risk management	59.8			
	- Emergency operations	120.7			
	- Emergency core services	59.3			
2018–2019	Category E. WHO Health Emergencies Program				
	- Infectious hazard management	93.8	554.20	12.53	
	- Country health emergency preparedness and the International Health Regulations (2005)	146.8			
	- Health emergency information and risk management	63.5			
	- Emergency operations	154			
	- Emergency core services	96.1			

B2. Strategic Priorities / Outcomes				
2020-2021	- Countries prepared for health emergencies	231.1	888.80	18.36
	- Epidemics and pandemics prevented	380.4		
	- Health emergencies rapidly detected and responded to	277.3		

Source: WHO Programme Budget 2008-2021

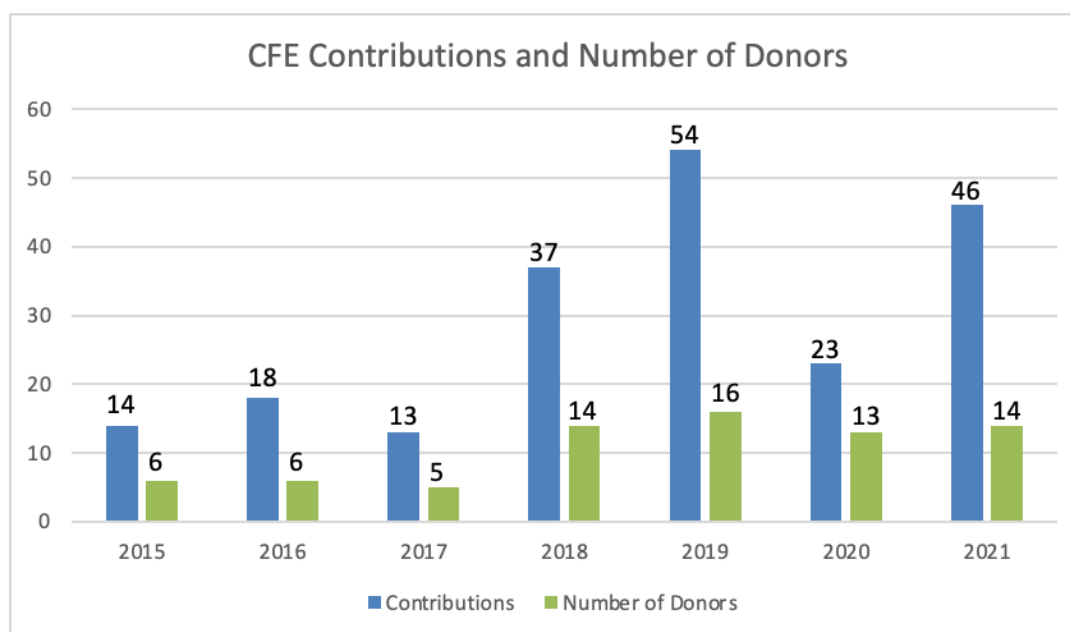
Table 4.12. Summary of Health Emergency Funds from Program Budget 2008-2021³

The WHO's program budget for health emergencies have been in a continuous growth (Table 4.11). The percentage of budget allocation has simultaneously been growing, which signifies an increased awareness of the importance of sufficient preparedness for potential epidemics or pandemics. There have been a total of six PHEICs⁴ from 2009-present, and they have been alarming the severity of viral diseases and their impacts on human beings. Drawing from the categories and priorities for health emergencies (Table 4.12), although budgets are used to prevent these health crises, they mostly focus on surveillance and development of national response systems. This raises the need for an adequate financing for preparedness prior to a healthy emergency, as well as for a rapid, needed response capacity post-outbreak. In centrality, flexible funds must be available to give opportune assistance and guidance to the members.

³ Although the specific areas/focus under emergency response may not be exactly the same according to each five-year objectives, the comparison across them was deemed sufficient to prove the increased importance placed on health emergency strategies.

⁴ The 6 Public Health Emergency of International Concerns (PHEICs) since 2009 are of the following: Influenza Pandemic H1N1, Polio, Ebola (West Africa), Zika and Microcephaly, Ebola DRC, and COVID-19

*Contributions in US\$ millions



Source: CFE Annual Report 2021

Graph 4.3 CFE Contributions and Number of Donors

Contributor	2015-2021	Contributor	2015-2021	Contributor	2015-2021	Contributor	2015-2021
1. Germany	83.19	7. Canada	6.05	13. France	1.70	19. Estonia	0.35
2. Japan	32.89	8. Denmark	4.40	14. Luxembourg	1.59	20. Austria	0.34
3. United Kingdom	27.00	9. Australia	3.40	15. Kuwait	1.50	21. Philippines	0.06
4. Netherlands	12.57	10. New Zealand	3.07	16. India	1.00	22. Portugal	0.03
5. Sweden	10.79	11. Republic of Korea	3.02	17. Finland	0.74	23. Malta	0.02
6. Norway	8.48	12. China	3.00	18. Switzerland	0.58	24. Georgia	0.02
TOTAL							205.77

Source: CFE Annual Report

Table 4.13. CFE Contributors and Amount 2015-2021

The WHO's lack of access to flexible funds has been raised as a concern over a significant time, especially with the previous experiences of health crises in the 2010s.

Following the 2014-2016 West African Ebola Outbreak, the problem led to the efforts of increasing flexible funds. One such effort is the establishment of the Contingency Fund for Emergencies (CFE) in 2015 through the WHA Resolution to procure access to reliable and rapid sources of funds during health emergencies. CFE has a US \$100 million target capitalization, but the figure is yet to be reached; and the number of donors is 24 as of 2021, necessitating improvements in order to successfully actualize the goal of the CFE. Although the CFE has been releasing funds to different disasters and is a meaningful effort to increase flexible funds, the amount itself and the number of donors has yet to be further enhanced.

Chapter V. Ebola Virus Disease (EVD): West Africa

The present and the subsequent chapters delve into the cases of disease outbreaks, focusing on the West African Ebola and the COVID-19. The investigation also entails the analysis of some of the key issues that arose with the WHO-led responses to these crises. Disease outbreaks can broadly be differentiated into three groups: epidemic, pandemic, and endemic, and this categorization lies on the span of propagation not the severity of the disease itself (Columbia MSPH, 2021). The Ebola virus has been classified as an epidemic, denoting an increase of reported cases confined to a specific geographical region. On the other hand, the COVID-19 outbreak has been declared as a global pandemic, indicating its wide scope of dissemination across regions and states.

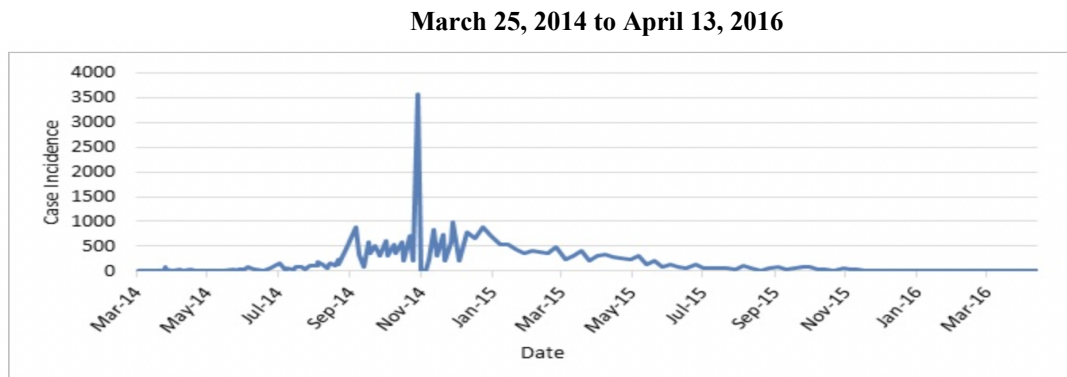
This present chapter conducts an analysis primarily based on two prime reports: the *Report of the Ebola Interim Assessment Panel* and the WHO Secretariat's response to the report. These reports were undertaken by external experts (not affiliated with the WHO) to ensure a partial, truthful evaluation and recommendations. Having been established by the DG in March 2015, a panel of experts were assigned to carry out a thorough, unbiased investigation of the WHO's response to the outbreak (WHO, 2015).

V.A. West Africa Ebola Virus Disease (EVD)

March 23, 2014 marks the genesis of an epidemic, in which the West Africa Ebola Virus Disease (EVD) cases were officially registered by the WHO in Southeastern Guinea. This emergence became a significant turning point as it turned out to be the most extensive and fatal Ebola outbreak (CDC, 2019b), surpassing all previous EVDs since its first 1976

identification (WHO, n.d.). Having lasted from 2014 to June 2016, the 2014 EVD stands as the seventh Ebola outbreak to be recorded.

The first Ebola case was witnessed in Guinea, and the virus quickly spread to Sierra Leone and Liberia, the neighboring states. Within the period of three months, the epidemic had reached all three of the capital cities. In recognition of the gravity of the situation, the WHO officially declared the West African Ebola as a PHEIC in August of 2014 (*Ibid*). In total, the outbreak impacted ten countries, with Guinea, Liberia, and Sierra Leone having experienced the most widespread and severe transmission. Other countries that were also affected include Italy, Mali, Nigeria, Senegal, Spain, the United Kingdom, and the United States (CDC, 2019a).



Source: (CDC, 2019b)

Graph 5.1 The Incidence Rate of New Cases: Guinea, Liberia, and Sierra Leone

Graph 5.1 presents the number of cases in the primarily affected countries - Guinea, Liberia, and Sierra Leone. Specifically, within the borders of these three nations, a total of 28,616 cases and 11,310 deaths were reported; while beyond the borders of the mainly affected areas, there were 36 cases and 15 deaths recorded (CDC, 2019b).

In determining efficacious and appropriate response measures, it is of paramount importance to have an accurate understanding of the nature and characteristic of each virus. For the EVD, the fruit bats are widely known to be the natural hosts of the virus (WHO, 2023), and the transmission to humans occur through a close, direct contact with blood, secretions, organs, or other bodily fluids of infected animals (*Ibid*). Having been introduced to the human population, the virus mainly propagates through direct contact, which also includes the exposure to blood, secretions, organs, or other bodily fluids of an infected person (*Ibid*).

V.B. Issues that Surfaced During Ebola Responses

B1. Surveillance and Alert System & Information Sharing

The Ebola epidemic exposed several challenges within the WHO system, including the realm of surveillance and information sharing. The report indicates that the Ebola crisis not only exposed organizational weaknesses within the WHO but also revealed deficiencies in the implementation of the International Health Regulations (IHR 2005) (2015a; 5). One key example is the poor fulfillment of core capacities by the Member States, particularly in the areas of surveillance and data collection as mandated by the IHR.

Another critical concern lies on the delayed declaration of the PHEIC. Despite the Ebola virus having been officially detected on March 23, 2014, it was not officially declared as a PHEIC until August 8, 2014 (WHO, 2015; 12). This resulted in a delay of 134 days from the initial detection of the Ebola virus. Several factors contributed to this delay, including a belated understanding of the distinct nature and context of the outbreak compared to those of the previous occurrences, unreliable reporting on the virus's

transmission, and challenges in information dissemination and decision-making processes within the WHO (WHO, 2015; 13). Moreover, the outbreak highlighted the WHO's lack of preparedness in management of large-scale, long-term, and multi-country emergency responses (*Ibid*). Additionally, despite the declaration as a PHEIC, the international community failed to take the situation seriously (*Ibid*).

The Ebola crisis also exposed issues pertaining to information sharing and communication processes. It was evident that there were inadequate and delayed notifications of public health risks to the WHO, leading to the recommendation to incentivize prompt reporting by countries (WHO, 2015; 6). Innovative financing mechanisms, such as insurance policies to mitigate economic consequences, were proposed as potential incentives (*Ibid*). Additionally, the WHO faced difficulties in establishing itself as the authoritative source of information during the crisis. Despite the implementation of an emergency media team, the organization's communication strategy struggled to counteract critical reporting of the WHO (WHO, 2015; 21). The delayed declaration of the PHEIC, coupled with misleading messages on Twitter and leaked documents, further complicated the situation (*Ibid*). Irresponsible messaging by politicians and the media regarding the risks and transmission of the disease also exacerbated the problem (WHO, 2015; 13). Consequently, the Ebola epidemic disclosed critical weaknesses within the WHO system, encompassing deficiencies in surveillance and information sharing, delays in declaring a PHEIC, and limited capacity to manage complex, multi-country emergencies.

B.2 Other Responses to Ebola

Several critical problems have been accentuated in the report, including the WHO's deficiency of capacity for a complete, comprehensive emergency health response. In the advent of a health crisis, the organization must possess the capability and capacity to make the according adjustments, allocate resources, and organize immediate responses through decision-making (WHO, 2015; 6). The panel assessment evaluated the organization to have failed to operate with such practices, and the one underlying reason is the lack of technical and financial potency to deliver this coordination (*Ibid*). What aggravated the WHO's shortage of capacity, was the concurrent insufficient Member State preparedness. The core capacities required under the IHR were conveyed not to have been achieved by 129 states, with only 64 states having equipped the core capacity (WHO, 2015; 10). The investigation of this section concluded with the note that this current core capacity rate is "*not acceptable*." For rectification of this unacceptable predicament, the WHO has been recommended to secure core funds with specific allocation for outbreaks and health emergencies as well as to invest in the WHO's operational capacity (WHO, 2015; 6).

The outbreak additionally revealed the lack of humanitarian resources or the necessary staff who support various operations onsite, with two particular issues having surfaced: the delayed and/or short deployment as well as the shortage in number. There were criticisms of the severely belated humanitarian assistance in response (WHO, 2015; 20), and numerous concerns have been conveyed over the short deployment of these staffs, which resulted in quick turnovers and instability (WHO, 2015; 8). The imprudence of the WHO regional office for Africa, the primarily affected area, heightened the organization's ineptitude for competent actions in handling a wide-scale epidemic. There are some

justifiable criticisms that the regional office received; however, the dearth of the core outbreak emergency team remains unjustifiable. The team was formed with fewer than ten staff members, and this has been yielded by staff reduction due to significant budget cuts.

V.C. WHO Funding

Various issues within the WHO system and the Member States hindered successful undertakings of the organization against the Ebola virus. As indicated in the chapter, there were poor operations in the areas such as the core capacities of both the WHO and the Member States, global health humanitarian workforce, and communication process of PHEIC declaration and information sharing with the public. A major contributing factor to these deficiencies come from substantial financial constraints. There was a great hurdle in resource mobilization due to the challenges such as aligning donor priorities and engaging new contributors and partners (WHA, 2015; 2). Therefore, the Panel made two fundamental recommendations in regard to securing sufficient, flexible funds that can be immediately accessed during emergencies.

The first recommendation is to increase ACs from the Member States by 5 % (WHO, 2015; 7). Majority of the program budget remains restricted, having been earmarked for specific purposes, with less than 25% coming from ACs. Consequently, the lack of flexible funds and the allocation of funds for emergency response placed the WHO with great frustration (WHO, 2015; 16), having been obstructed from extending appropriate and quick actions. The WHO, in great agreement with the need for flexible funds, proposed an external source of reliable funds in addition to the increase of ACs, but the increase of ACs were not able to be achieved.

In consideration of the difficulty with collection of necessary budgets during the initial stage of a disease outbreak, the WHO explored a sustainable financing mechanism and made the decision to establish a specific, replenishable contingency fund (WHO, 2015; 17). As an effort to reform the WHO's response mechanism, the WHO Contingency Fund for Emergencies was founded to better finance epidemics, pandemics and other health concerning issues. This contingency fund targeted the capitalization of US\$ 100 million to be sourced by VCs in its entirety. The Ebola outbreak and the lessons it presented, is a critical juncture for the WHO and the international community to enhance their capacities to prevent and successful administration of a large-scale health crisis as such.

Chapter VI. COVID-19

In December 2019, Wuhan, China, there were reports about unknown pneumonia cases. Having been alarmed, the Wuhan Municipal Health Commission alerted two pressing notices to the hospitals within the city. These unknown cases are what we know as the SARS-CoV-2 or the COVID-19.⁵ The novel virus spread rapidly, and it eventually was declared as a PHEIC in January 30 of 2020 and a global pandemic on March 11 of 2020 by the WHO's Director-General Tedros Ghebreyesus (WHO, March 2020). Despite the previous experiences of epidemics like the West African Ebola, the world was yet taken unaware by the global Coronavirus. Despite the collaborative efforts of preparing for potential pandemics, COVID-19 once again disclosed the lack of the required systems and resources of the WHO.

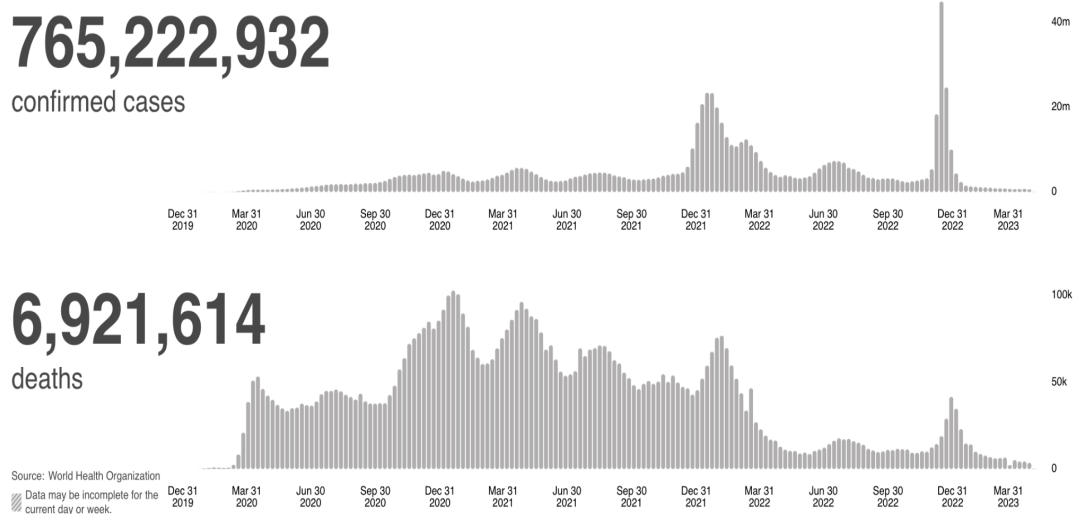
Many hold a consensus on the insufficient responses, drawing from the great number of deaths, health impacts, and other consequences that resulted in across different fields from the pandemic. As the responses made by the states and the global actors shape the direction and effects of the pandemic, this chapter briefly looks into the Coronavirus and mainly reviews the Independent Panel reports that focus on the WHO's responses to the pandemic outbreak. The Independent Panel is a review panel established by the DG, following the COVID-19. It consists of thirteen external members - two co-chairs appointed by the DG himself, and 11 members selected by the co-chairs. The group was

⁵ World Health Organization. (n.d.) Naming the coronavirus disease (COVID-19) and the virus that causes it. World Health Organization. Retrieved March 13, 2023, from [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it)

established with the purpose of carrying out a thorough evaluation of COVID-19 responses that is unbiased, autonomous, and comprehensive.

VI.A. Coronavirus (SARS-CoV-2)

It has been recognized that the Coronavirus is of a zoonotic origin with bats as the most probable host. The majority of the newly discovered pathogens originate from animals, raising the urgency to develop worldwide monitoring systems that keep track of the rapid growth of infrastructure, depletion of the environment, and the condition of animal health for prevention of future viral diseases. The transmissibility of the Coronavirus is through either symptomatic or asymptomatic transmissions as well as airborne transmissions. Another characteristic is the continuous viral mutations (*Delta*, *Alpha*, *Beta*...). These facets signify great difficulty and uncertainty in stopping the spread, opportune responses, and preparation for the mutating variants.



Source: WHO Dashboard

Graph 6.1 COVID-19 Cases and Death Rates

With its inception in December of 2019, COVID-19 cases have continuously and rapidly escalated in number. As of May 3rd of 2023, the WHO reported that there has been a total of 765,222,932 confirmed cases and 6,921,614 deaths. These numbers are alarming and strikingly high compared to previous disease outbreaks, and the pandemic's impact has been truly global with myriad cases across all continents.

VI.B. Issues that Surfaced During COVID-19 Responses

Responses to health emergencies include the governance and policy of national and international health systems. The role of an international system like the WHO is overseeing the preparedness of national governments and coordinating with countries that lack capacities to give the assistance they need. The specific responses can be broadly divided into three categories: governance and policy (e.g., containment policy - travel restrictions or border control) and health measures (e.g., medications or vaccinations) and the Non-pharmaceutical Interventions (NPIs) (e.g., social distancing and mask wearing). They are to be implemented, adhering to the necessities drawn from the nature and characteristics of the virus.

B1. Surveillance and Alert System & Information Sharing

There are two issues when it comes to surveillance and alert systems. Firstly, the surveillance and alert system was not quick enough to catch up with the speed of the virus spread. The first reported pneumonia cases were in late December 2019, and this concern was first notified to the WHO Headquarters on December 31st of that year (Independent Panel, 2021a; 21). On January 13 of 2020, the first case outside the Chinese border was confirmed, and with cases arising outside China, the WHO held the IHR Emergency

Committee meeting on January 22nd and 23rd (WHO, 2020a). The Committee did not have a concerted opinion on PHEIC declaration. Thus, the Committee held another meeting after a week, and the DG declared COVID-19 as a PHEIC on January 30, 2020. It took a month after the first reported cases in China for the outbreak to be announced as a PHEIC. In the period of a month, there were already 98 cases, spread across 18 countries. The Independent Panel (2021a; 12-16) pointed out that the alert system did not function as quickly as the rapidly spreading pathogens and critiqued the IHR (2005) to be an instrument that fails to instigate quick responses during health emergencies. The WHO also failed to apply the precautionary measures during the initial alarming stages when it should and could have (Independent Panel, 2021a; 21).

The second concerning issue is that the PHEIC declaration did not have the alarming power, sending out the sense of great urgency. Some countries with previous experiences of disease outbreak like the SARS or MERS took the WHO's early alerts very seriously, and issued response mechanisms (Independent Panel, 2021a; 17). Some examples include the countries Vietnam and Thailand. Vietnam activated action plans on January 16 (Pollack, T., et al., 2021), and Thailand reacted even earlier on January 4, which is 10 days before the first case outside China (Hinjoy S., et al., 2020). In contrast to these states, many governments only perceived the virus as a serious threat when the cases started increasing in an uncontrollable speed. This reveals a fatal issue, which is the inability of PHEIC working as a serious, loud alarm. The PHEIC is supposed to convey the highest level of global health concern; however, the declaration itself was not able to muster an opportune, global coordinated action (Independent Panel, 2021b; 24). With the great speed of the virus spread and the inactive responses from the actors, the WHO

declared the outbreak as a global pandemic on March 11, 2020, when there was already a total of 114,000 confirmed cases across 118 countries (WHO, 2021). Hence in the span of a month and 11 days, the cases increased from 98 cases to 114,000 cases and from 18 countries to 118 countries. February is considered as a lost month that missed the opportunity to effectively curtail the transmission and manage the disease.

Access to information is pivotal during these kinds of emergencies, and the world of today mainly utilizes the digital platform in such doing. This shapes an environment with fast access to information and spread of messages, and the WHO leverages this opportunity presented by the platform by posting news and information through its official website and social networking sites (SNS) - Facebook, Instagram and Twitter. This fact raises two concerns. First, although over 12 million people follow each account, it also means that a significant portion of the population remains uninformed. Second, the internet is saturated with misinformation and disinformation (Independent Panel, 2021a; 35). The *Lancet Infectious Diseases* (2020) described these kinds of false and misleading information to have circulated as quickly as the virus, which often surpasses the reach of reliable sources like the WHO and governments. For example, an area of concern is the proliferation of fake news and myths surrounding vaccination, which is a pivotal measure for individual health protection. Therefore, there is a pressing need for concerted efforts to effectively communicate accurate information to the global community and help individuals identify trustworthy sources. Thailand serves as an exemplary case, in which the government implemented a comprehensive all-hazards risk communication system that includes the dedication for national and provincial coordination (Independent Panel, 2021a; 35).

B.2 Other Responses to COVID-19

As previously stated, response to health crises can be seen through three groups: governance and policy, the Non-pharmaceutical Interventions (NPIs) and health measures. The responses to COVID-19 revealed several grave problems such as the unpreparedness of many national health systems, and the difficulty in production and distribution of the NPIs - masks and Personal Protective Equipment (PPE) as well as vaccines.

It is imperative for both the governments and the international community to have pandemic preparedness planning as a central responsibility. In consequence, the WHO is to equip national health systems that lack capacities to effectively respond to plausible epidemics or pandemics. One of the programs that the organization committed throughout the years has been preparation of the national health systems as they vary in great extent across countries. Despite these efforts, an annual report by the WHO in 2019 prior COVID-19 reported that a significant number of national governments did not possess comprehensive preparedness strategies, essential public health capabilities, or well-structured multi-sectoral cooperation with a clear dedication from their highest officials (GPMB, 2019). In 2019, the global average score of 64 out of 100 was obtained through the self-reported evaluation of essential preparedness capacities that countries are obligated to submit to the WHO (2019) under the IHR (2005). The number increased from 61 in the previous year, but the world was unprepared to effectively manage COVID-19. The devastating effects of the Coronavirus reinstated the importance of a joint global response hence, the need of every state's solidness of national health capacity.

Non-pharmaceutical Interventions (NPIs) are an integral part of responses to diseases. Albeit they alone are insufficient to stop the spread, NPIs play a crucial role in

slowing down the speed and protecting people from contracting the virus. Globally implemented measures are the wearing of masks (recommendations of the N95 respirators and surgical masks) and of the Personal Protective Equipment (PPE) such as gloves, and protective suits that are mostly used in medical institutions. The DG of the WHO cautioned in February 2020 that there could be significant global scarcities of face masks and protective suits, leading to potential delays in supplies of up to four to six months (WHO, Feb 2020). There were two leading causes to these delays in supplies. First, is the lack of manufacturing capacities. In March 2020, the WHO projected that 89 million masks, 76 million gloves, and 1.6 million pairs of goggles would be required every month, which was 40 % more than what manufacturers were then capable of producing (WHO, 2020c). Second lies on the trade and border restrictions, which inhibited a smooth, prompt flow of supplies. Limitations on borders had an impact on both trade and transportation of goods, whether by land, sea, or air (Independent panel, 2021a; 27-30).

The delay in transportation of masks and PPEs produced unwanted effects, which are an increase of fraud supplies and the surge of prices. In numerous countries, there were instances of hoarding and fraudulent activities. As the European Anti-Fraud Office discovered, more than 340 firms engaged in the sale or exchange of fake or subpar face masks, medical equipment, disinfectants, sanitizers, and testing kits (Olaf, 2020). Moreover, the prices skyrocketed during the pandemic. By the start of March 2020, N95 respirators prices tripled, surgical masks cost six times more than their pre-pandemic prices, and surgical gowns prices doubled (Independent panel, 2021a; 27-30). In summation, the lack of manufacturing capacities and the trade and border restrictions led to the impediment of sufficient distribution of NPIs, and this also brought upon undesired results such as the

markets of fraud supplies and increase in prices. They resulted in even more difficulties for the global community to have access to sufficient and reliable protective products, and there weren't a lot of things that IOs like the WHO could do in the midst of the outbreak.

The last category of responses is the health measures, which comprise the matter of vaccination. In hopes of eradicating the virus, COVID-19 vaccines have been developed and approved in a significantly short amount of time. Consequently, this novel production engendered the problem of unequal distribution of vaccines, stemming from vaccine nationalism by the high-income countries (Independent Panel, 2021b;12-14). High-income nations such as the United States, Canada, the United Kingdom and New Zealand acquired vaccine doses with a population coverage exceeding 200 %, primarily through bilateral agreements made with manufacturers to ensure access to both current and future supplies (*Ibid*). Low- and middle-income countries have been excluded from these agreements in many instances, resulting in limited access to vaccines. As of April 2021, less than 1 % of the population received a single dose of the vaccine in the poorest nations (*Ibid*). The effective allocation and distribution of vaccines based on public health requirements have proven to be unsuccessful.

In response to this concern, the WHO with its partners established the COVID-19 Vaccines Global Access Facility (COVAX) in April 2020 as a fundamental strategy to tackle the worldwide challenge of ensuring widespread access to vaccines (Independent Panel, 2021a; 55). Despite striking advancements, COVAX encountered obstacles in its mission due to scanty financial resources, as well as the emergence of vaccine nationalism (Independent Panel 2021b; 14). For the year of 2021, COVAX obtained 2.07 billion doses, aiming to provide a minimum of 2 billion doses by the end of the year. According to

COVAX projections, approximately 1.8 billion doses were anticipated to be accessible to 92 low- and middle-income countries (Independent Panel 2021c; 24). However, there were considerable uncertainties regarding vaccine effectiveness and safety, funding, capacity, and country preparedness. If these uncertainties were to be addressed, COVAX had the potential to cover around 27 % of the population in low- and middle-income countries by the end of 2021 (*Ibid*). While signifying a significant progress for COVAX, it failed to achieve herd immunity in these countries. This urgent matter of slow and unequal distribution of the vaccines against the SARS-CoV-2 virus has been further exacerbated by the emergence of new variants (Independent Panel, 2021a; 58) because the timing of vaccination becomes even more critical.

VI. C. WHO Funding

Different problems have surfaced within the WHO system through the organization's responses towards the COVID-19 pandemic. As previously identified in the chapter, the surveillance and alert system, as well as the information sharing methods require further development, and numerous national health systems were unprepared. The difficulty of an equitable and rapid production and distribution of goods also emerged through the utilization of NPIs and administration of vaccines. An indispensable aspect with these deficiencies is that in centrality, they all come down to the issue of funds. As the Independent Panel (2021a; 56) concluded, the COVID-19 pandemic has uncovered two specific difficulties regarding the worldwide need for efficient readiness and reaction to pandemics. Firstly, there was the lack of adequate funding for pandemic preparedness at national, regional, and global scales prior to the outbreak. Secondly, there was a delayed

and insufficient allocation of funds for the response efforts after the declaration of a Public Health Emergency of International Concern (PHEIC).

With the shortage of resources in the WHO country offices, adequate provisions of resources and finances are called to effectively address technical requests made by national governments in relation to pandemic preparedness and response (*Ibid*; 45). The deficiency in manufacturing, regulation, and procurement of the essential tools such as vaccines, therapeutics, diagnostics, and supplies resulted in a slow, unequal access to them. Therefore, it would be pivotal to establish robust funding mechanisms and strengthen regional capabilities to ensure equitable and effective access to these resources.

Another integral aspect are the vaccines, which are an indispensable response measure, and the establishment of COVAX denotes the gravity of adequate financing. According to experts interviewed, there was a substantial underestimation of the challenges associated with financing vaccines on a global scale (Independent Panel, 2021c; 28). This lack of foresight was evident at various stages of the vaccine value-chain, which encompassed securing initial funding, acquiring capital for at-risk manufacturing, ensuring equitable access, and managing COVID as an endemic disease during the post-pandemic period. Insufficient funding has had a detrimental impact on the capacity to incentivize and negotiate agreements with prominent pharmaceutical companies, hindering efforts to achieve equitable access to vaccines. The overall lack of financial resources has been highlighted as a principal challenge by participants in the Vaccine Roundtable discussions and by numerous experts interviewed on the topic (*Ibid*).

The preparations prior to health crises and the responses post-outbreak are effectuated through finances, and more funds would permit better equipment of response

systems and faster mobilization of measures. Ensuring access to financial resources is important, both for investment in preparedness measures and for prompt injection of funds when a potential pandemic emerges (Independent Panel, 2021a; 45). To be equipped with such financial capability, the Independent Panel underscored the WHO's financial autonomy, which could be achieved through reliance on the flexible funds. The report's recommendation suggested the organization to increase the Member States' ACs, which should cover two-thirds of the budget allocated for the WHO's core program (*Ibid*, 49).

To address the mounting concerns of financial instability, particularly in light of the advent of COVID-19, the WHO Executive Board established the Sustainable Financing Working Group during its 148th Session in January 2021 (WHO).⁶ The main objective of this working group was to resolve the significant disparity between the global expectations placed on the WHO and its financial resources. Chaired by Björn Kümmel of Germany and constituted by the Member States, the working group convened on seven occasions from March 2021 to April 2022 (*Ibid*). During these sessions, the group sought to identify sustainable and long-term financing solutions of the organization.

Following the conclusion of the working group's seventh meeting, the Seventy-fifth World Health Assembly in 2022 reached a pivotal agreement to improve the WHO's financing model (WHO, May 2022). This decision adopted the recommendations put forth by the Sustainable Financing Working Group in its entirety (WHO, A75/9). Two of the key recommendations presented to the Health Assembly were to first, Member States to aim for a gradual increase of ACs to constitute 50 % of the WHO's core budget by budget

⁶ World Health Organization. (n.d.). Sustainable financing. World Health Organization. <https://www.who.int/about/funding/sustainable-financing>

cycle of 2030-2031(by the latest); and second, to request the Member States and other donors to provide fully unearmarked VCs.

In the following Seventy-sixth World Health Assembly in 2023, more specific deliberations were made for the implementation of recommendations. It was proposed that the WHO financing mechanism would be executed through the WHO investment rounds, and the first investment round would begin from the year 2025 to 2028 (WHO, A76/32). The pledging event for this first round is planned to be held in the second half of 2024, and the objectives, structure and outcomes of the first round would be developed, in close collaboration and consultation with Member States, emphasizing their engagement and input. Therefore, the WHO has been taking actions through the working group and discussions during the WHA to move towards the trajectory of financial system reform.

Chapter VIII. Conclusion

VIII. A. Summary and Discussion of Findings

A.1. WHO Funding System

This research sought to observe the budgetary trend and its entailing concerns of the WHO. The data suggest that the earmarked VCs of the UN as a whole, have been on a steady rise. In 2010 and 2021, the earmarked VCs made-up 51.21 % and 60.74 %, respectively. Consequently, the proportion of ACs decreased from 33.51 % to 20.69 %. This trend was also found to be reflected by the WHO. The amount of flexible funds (inclusive of CVCA) available for the WHO decreased from 2010 to 2021 - from 25.67 % to 19.21 %, while the VCs-specified observed increase from 62.07 % to 79.34 %. This trend alarms the necessity of change, as the lack of flexible funds equate to disruption of the effective functioning and autonomy of the institution.

Assessed or core contributions are the type of funds that are of the organization's preference. From 2008 to 2021, the top one AC donor remained to be the United States, and it is worthy to mention that the second highest donor has changed from Japan to China. The top two donors combined, occupy one-third of the total AC, and the top ten contributors held 76 % in 2008-09 and 69 % in 2021-21. With the decrease of its percentage, the ACs have become to hold more importance than that of the previous years, which indicates the subsequent significance of the top AC contributors. In such a situation wherein the flexible funds are valued more, although the authority that the top contributors cannot be gauged, it can be implied that their influence or opinions would not be taken lightly. This may partly explain the accusation made by the former President Donald

Trump, for the WHO to be a “puppet of China” (BBC, 2020) and other criticisms towards the WHO for being submissive and lenient to China (CFR). Whether this argument stands true or not, the fact that this received much attention and support proves the amount of influence that comes with monetary potency.

Another type of funds are the VCs, which can be further categorized into flexible and non-flexible kinds. The flexible VCs are the Core Voluntary Contributions Account (CVCA), which occupied 6.14 % of total VC budget in 2008–2009 and 4.20 % in 2020-2021. Thus, out of the total VCs received, 6.14 % in 2008-09 and 4.20 % in 2020-21 were flexible funds and the percentage itself decreased as well. For the donors, UK was the top donor of CVCA for the years 2008-09 and 2020-21, having contributed 22.47 % and 46.01 %, respectively. This is followed by Norway in 2008-09 and Sweden in 2020-2021. What is noticeable is the total number of CVCA donors, which are thirteen for both bienniums. Hence, not many donors shared finances through CVCA, a fully flexible fund.

On the other hand, are the earmarked VCs, which come in two types: specified and thematic. The difference between these two lies on the degree of flexibility, with thematic having slightly more flexibility. What is worthy of attention in the top VC - specified and thematic donors is that aside from the Member States, other international actors such as foundations, and other IOs actively participate as well. For example, the top two VC-specified donors for the years 2020-21 are GAVI alliance and the Bill and Melinda Gates Foundation. Although their contributions are integral and are great a addition to the total amount of budget funds, this highlights the need of the WHO to find ways to increase the stream of flexible funds.

From the total program budget of the WHO, the funds allocated for health emergencies has been on an increase. As the data suggest, the percentage designated for health emergencies grew from 5.17 % in 2008-09 to 18.36 % in 2020-2021. This evidences the enlarged investment the area of health crises, along with the importance of copious funds for better response. The expansion of budget allocation for the health crises category was prompted with specific PHEICs such as Ebola and COVID-19. Through the Ebola, the WHO was presented with the opportunity to witness the consequences of deficiency in accessible funds in order to provide proactive responses in outbreaks larger in scale. Accordingly, the Contingency of Fund for Emergency (CFE) was established to fill in the monetary shortage. The CFE aims the goal of US \$100 million target capitalization, but the data show that it is yet to reach that figure, and the number of donors is 24 (accumulated) as of 2021, which stresses the struggles the WHO continues to face in gaining access to sufficient funding.

A.2. Responses to Health Crises: Ebola (West Africa) and COVID-19

The research investigated whether the WHO carried out its responsibility in leading proactive responses for global health emergencies, in relation to its financial capacity. The WHO, having been organized by three organs of Executive Board (EB), World Health Assembly (WHA) and the Secretariat, holds the role of leading the members, coordinating, informing necessary messages and information, and giving technical and operational assistance to the states of need (i.e. the developing states). When it comes to health crises, the main goals of the organization are to prepare for potential events, give immediate and effective responses in the advent of a crisis, and lead the individual global community

states to be equipped with good surveillance system for quick detection of the potential PHEICs. To reach these goals require a great, interactive coordination and communication of the Member States, WHO, IOs, NGOs and other actors like the media.

With the role of the WHO and the procedure of responses when confronting a global health threat discussed, the following are the issues that surfaced in the WHO-led responses to Ebola and COVID-19:

	Ebola (West Africa)	COVID-19
Surveillance and Alert System & Information Sharing	<ul style="list-style-type: none"> • Member States' lack of capacity to areas of surveillance and data collection • delayed declaration of PHEIC (134 days since detection) • PHEIC declaration's shortfall of alarming power • dissemination of misleading messages and information throughout online and media 	<ul style="list-style-type: none"> • not quick enough surveillance and alert system • PHEIC declaration's shortfall of alarming power • dissemination of misleading messages and information throughout online
Other Responses	<ul style="list-style-type: none"> • insufficient Member State preparedness: dearth of technical and financial potency with the lack of core capacity, as mandated by IHR • dearth of humanitarian resources 	<ul style="list-style-type: none"> • insufficient Member State preparedness with the lack of core capacity, as mandated by IHR • difficulty in production and distribution of the NPIs - masks and PPEs • challenges in the initial stages of vaccine production and unequal production and distribution of vaccines

Table 7.1 Summary of Issues Surfaced from Ebola and COVID-19 Responses

There were issues that continued to persist in both outbreaks, which are the Member States' insufficient capacities to carry out rapid surveillance and data collection, the shortfall of alarming power the PHEIC declaration holds, the spread of misinformation

in platforms such as SNS and media, and the delayed speed of PHEIC declarations. In regards to this PHEIC declaration, which relies on the Member States' capacities of quick detection and reporting as well as the WHO's rapid assessment, both crises revealed the need for amendments in the process. Although the COVID-19 PHEIC declaration was much faster than that of Ebola, it still was assessed to be not quick enough to catch up with the speed of the virus spread. In terms of resources, Ebola reported to have a fault in humanitarian resources while there were problems that arose in production and distribution of the NPIs (masks) and PPEs (gloves, bodysuits, and etc.) and vaccines during the COVID-19. With the continuation of certain issues and the addition of new problems, the reports pointed to the WHO's financial capability and autonomy.

A prominent cause to these weaknesses come from the dearth of access to an ample amount of flexible funds. For example for the Ebola epidemic, budget cuts resulted in the lack of human resources in the Regional Office of Africa. Financial challenges were also evidenced through the process of COVID-19 vaccine production to distribution, in which there were unforeseen hurdles such as the securing of initial funds, procurement of capital for at-risk manufacturing, and ensurement of equitable distribution. The insufficient budget ultimately led to high-income states like the United States and Canada to procure vaccines through negotiation with pharmaceutical companies, in quantities much higher than needed, obstructing equitable access to vaccines. This engendered the efforts like the COVAX for improving access, but it alone was meager to ensure global equity. With all of the key issues, the Independent Panel underscored the need of the WHO's budgetary autonomy and recommended securing sufficient, flexible funds that are of expeditious, immediate access during emergencies. First, is to increase other sources, and with financial

strains as such, the WHO established the CFE as a source of external flexible funds for health crises. Second, the most determining change would be to expand the collection of ACs from the Member States.

	Ebola (West Africa)	COVID-19
Cases	28,652	765,222,932 (As of May 3, 2023)
Death Cases	11,325	6,921,614
Affected Countries	10 countries (Guinea, Sierra Leone, Liberia, Italy, Mali, Nigeria, Senegal, Spain, United Kingdom, United States)	All, except Turkmenistan (no officially confirmed cases) ⁷

Table 7.2 Ebola (West Africa) and COVID-19: Cases and Affected Countries

Table 7.2 depicts the numerical figures of the cases, deaths, and affected countries Ebola Epidemic and COVID-19 Pandemic brought about. Although there are different facets that have been affected by COVID-19, the number of cases, casualties and the areas impacted reflect the level of influence health crises had on the population. The cases of deaths from both outbreaks are especially disturbing.

⁷ World Health Organization. Turkmenistan: Who coronavirus disease (covid-19) dashboard with vaccination data. World Health Organization. <https://covid19.who.int/region/euro/country/tm>

A.3. Discussion: Research Question and Argument

- Research Question: *What is the impact of increasing voluntary contributions on the WHO's responses to Ebola and COVID-19 outbreaks?*
- Research Argument: *Increasing voluntary contributions resulted in the WHO's reactive responses to Ebola and COVID-19 outbreaks, which failed to serve as critical junctures for change of the established financial trend.*

In consideration of the issues that surfaced as aforementioned, in totality, they indicate the responses to have been plodding, hence *reactive*. Addressing the research question, the limited financial resources imposed constraints in employing and allocating funds to timely and sufficient responsive measures to global health crises - West African Ebola and COVID-19. The research argument was proven to be partially right. The greater pool of VCs resulted in reactive responses, and Ebola failed to initiate substantial reform in the budgetary pattern as a critical juncture; but, the COVID-19 may plausibly be marked as critical juncture, prompting efforts of reversal to this financial trend entrenched over a considerable time frame. Whether these movements of reversal will actually result in changes are yet to be further observed; but regardless, the attempts themselves are momentous.

The question that surfaces is why COVID-19, unlike the West African Ebola, became the catalyst for transforming a persisting budgetary direction. Kapur (2002) explains how IOs undergo changes and posits factors such as the organizational learning, which involves deriving lessons through e.g. failures, competition, change of norms, and

etc, as well as the exogenous sources, which are in the form of certain disasters or crises. Drawing from the ‘failures’ that the exogenous shocks brought in, the West African Ebola resulted in the formation of the Contingency Fund for Emergencies (CFE) and the COVID-19 founded the Working Group of Sustainable Financing. What distinguishes the effect of the COVID-19 shock from that of Ebola lies on the type of exogenous change or the variations in degree and characteristics (Kapur, 2002).

The nature of the virus strikingly differs in that transmission across humans occurs primarily through direct contact for Ebola, while airborne transmission is plausible for COVID-19, causing a faster spread. Consequently, the type of crisis also vary, with Ebola being an epidemic that impacted 10 countries with 28,652 cases, and COVID-19 classified as a pandemic that officially impacted all countries except Turkmenistan with over 765,222,932 cases. Given the increasing severity of concern regarding the long-standing issue of financial sustainability, the decrease of flexible funds to a figure around 20 %, and the incompetence revealed in a global-scale crisis, COVID-19 may plausibly signal as the starting point of a reform as agreements are being made to increase ACs from the Member States.

VIII. B. Conclusion

To conclude, this thesis investigated the WHO’s responses to health insecurities - the Ebola (West Africa) and COVID-19 outbreaks. It highlighted the reactive measures, with the key contributing factor of financial problems being the deficiency of ample, core funds. As the WHO is an IO tasked with responding to unpredictable and unforeseen health crises, it is necessitated for an abundant source of flexible funds, arguably more than most

organizations. Unfortunately, the WHO has been recognized as a dire example of the lack of flexible funds, having undergone a continuous rise of VCs, which resulted in a decline of flexible funds that the WHO could utilize during emergencies.

The case of Ebola instigated external endeavors to mitigate the problem, such as the establishment of the CFE and COVAX in response to West African Ebola and COVID-19, respectively. Despite the seriousness of financial constraints revealed through these examples, the power to catalyze changes in the trend of increasing earmarked funds remained insufficient. However, an indication of a shift to this trend was witnessed through the creation of the Working Group of Sustainable Financing in January 2021 and the agreement reached by the World Health Assembly (WHA) in May 2022, which was concluded to increase ACs. Therefore, the findings of this thesis underscored the need for a sufficient pool of flexible budget for proactive and adequate responses to global health emergencies, along with the recognition of critical junctures as potential catalysts for transformative change in the path-dependent nature of structure that IOs hold.

With the steps being taken for the implementation of the agreement to increase ACs, the following are some policy recommendations. First, the WHO should actively advocate for increased global health financing to substantially support its programs. As warned by Bill Gates, the worst of COVID-19 could still be ahead (CNBC, 2022), and with the looming possibility of other health crises, global health funds should be bolstered. Second, the commitment of the Member States must be strengthened. The unexpected decision to increase ACs and the different financial situation of the Member States may be burdensome albeit their alignment with its intention. Therefore, there requires a compliance mechanism along with efforts to assist and arrangements tailored to the

different conditions of developing countries. Additionally, given the magnitude of reformation, there should be an effective monitoring and evaluation mechanism to review progress, identify challenges, and make necessary adjustments to ensure its success.

Lastly, the researcher recognizes the limitations of study in such as the reliance on financial data that are only publicly accessible, the selection of key responses by the WHO, and the absence of interviews with the WHO insiders due to limited network connections; however, the researcher believes that this academic work still holds significance to make contributions to the scholarship despite such constraints. By discerning the limitations and building upon this research, it is hopeful that future studies on this area can further contribute to enhancing global health governance led by the WHO, and to strengthening the capacity of IOs (not limited to the WHO) in addressing future threats to global health security.

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Abstract in Korean

국문 초록

세계보건기구의 자금조달 시스템이 에볼라와 코로나 19 대응에 미치는 영향

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경민경

국제기구는 최근 몇 년 동안 자발적 기여(Voluntary Contribution)의 증가를 경험하고 있다. 이러한 추세를 보이고 있는 세계보건기구(WHO)는 유연한 기금(Flexible Funds) 20% 미만의 접근만이 가능함으로 극단적인 사례로 작용되는 바이다. 세계 보건 안보의 리더인 세계보건기구(WHO)는 보건 의제 형성, 기술 지원 제공 및 대응 조정을 통하여 보건 응급 상황 대응에 중대한 역할을 수행해 왔다. 그러나 이전 발병 사례보다 큰 규모였던 2014년 서아프리카 에볼라 유행 당시 유연한 자금 부족으로 긴급 상황 시 자원의 신속한 동원을 방해함으로써 조직의 한계가 두드러지게 부각되었다. 이러한 자금 문제는 코로나-19 팬데믹 기간 동안 더욱 확고해지면서 지속적인 재정적 어려움이 이어져왔다. 따라서 본 연구는 자발적 자금의 지속적인 증가로 인한 재정적 한계의 장기성을 고려하여 에볼라 및 코로나-19의 발생 사례를 통해 세계보건기구(WHO)의 사후 대응에 대한 어려움을 조사하고자 하였으며, 경로 의존성 이론을 통한 자금 조달의 궤적을 탐색하고자 하였다.

주제어 : 지정 예산, 자금 조달, 코로나-19, 에볼라, 세계보건기구(WHO), 경로 의존론 (Path Dependence Theory)

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