Global health philanthropy

In its ongoing response to the Covid-19 pandemic philanthropy must address economic and societal inequity if it is to have a meaningful role in changing global health for the better.
Lead article

Funding for global health: too much and not enough

Investments made by governmental and philanthropic donors in healthcare systems around the world too often reinforce arrangements that favour private interests over public provision

In March, Indian author and activist Arundhati Roy observed that, ‘historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next.’

For those of us working in philanthropy, the pandemic provides an opportunity to reflect on the complicated political and economic role we play in global health. This issue of Alliance considers what we can do to rebuild faith in the ‘public’ in public health and restore more balance to our political and economic systems.

Too much philanthropy?
Consider the following.

• In 2017 and 2018, the top 100 private foundations and grantmakers spent over $46 billion on health – representing 23 per cent of all private giving, according to Candid data.

• Governmental and philanthropic donors provide over 40 per cent of all health spending in nine African countries.

• Sustainable Development Goal 3 on Good Health and Wellbeing requires countries with poor healthcare systems to spend at least 8.6 per cent of GDP on healthcare by 2030 yet most lower income countries are spending less than half of this amount.

These data show the pre-eminence of private foundations and donor governments – each with their own geopolitical interest or niche funding area – in the health policy-making of lower income nations. This is compounded by a focus of most donors

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Guest Editors
Julia Greenberg and Aggrey Aluso
on disease-specific outcomes rather than on broader health systems. The result? The fragmentation of health systems in low- and middle-income countries, and the illusion that donors have health covered, letting governments off the hook for the provision of basic health services. It also breeds corruption, as health is increasingly seen as a cash cow for government coffers, a profit centre for national and multinational hospital chains and a market opportunity for insurance and pharmaceutical companies.

The impact of private money also risks creating an accountability ‘black box’. Susan Erikson and Leigh Johnson’s article on page 60 discusses the implications of profit-driven pandemic financing models – notably so-called ‘pandemic bonds’ – operating with little or no public oversight. The inability to see how healthcare systems are being financed is particularly damaging because it undermines the efforts of citizens to advocate for alternative healthcare models.

Donors’ support continues to be focused on the use of market-driven models, including for Covid-19. For example, at a side event at the recent UN General Assembly, Bill Gates announced an unprecedented partnership between 15 pharmaceutical companies and the Gates Foundation to expand global access to Covid-19 diagnostics, therapeutics and vaccines.

Health advocates have long documented the ways in which some of the pharmaceutical companies involved in this partnership have massively profited from drugs primarily developed with public money. These pharma companies are poised to profit once again in the race for a Covid vaccine, following the influx of public money from the US and European countries for advance purchases of vaccines for their own countries. While Bill Gates himself acknowledges that so-called ‘vaccine nationalism’ is a problem, his solution, in this case, is to forge a partnership with pharmaceutical companies to lower the prices and dictate the terms of access for lower income countries. Not only are these arrangements typically made without public oversight, but they do not change the intellectual property rules, and monopoly pricing, which prevent more systemic change over the longer term.

The high prices of drugs, including Covid vaccines, cannot be justified by the high costs incurred by companies for research and development, when so much of the R&D is funded with public funds. The US government
has invested $19 billion in the race for the vaccine for example. Indeed, this partnership of pharmaceutical companies seems to ignore calls from political leaders across the globe to consider a Covid vaccine as a public good - from the president of Costa Rica calling for all global stakeholders to share Covid-19 knowledge, data and intellectual property, to the presidents of South Africa and Ghana calling for a People’s Vaccine available to all, free of charge for all (see In Profile on page 37). The important work of the Gates Foundation has been evident since the pandemic began, from support of the WHO to efforts to build vaccine manufacturing capacity in lower income countries. But it should not be for private foundations and pharmaceutical companies to set the terms for access to vaccines for lower-income countries in a pandemic. That is the role of national governments, held accountable by civil society, and member state-driven multilateral institutions.

So where do private actors derive the legitimacy to intervene in global and national health governance?

A recent critique by Rwandan activist Paula Akugizibwe is that private philanthropy and public donors, often working together with companies, are reinforcing an extractive global health architecture in which they (not states and citizens) create the conditions for access to health and ignore the massive impacts of inequality on public health. Akugizibwe argues that policy prescriptions implicitly and explicitly attached to funding from donors even influences the ways countries allocate their own domestic resources for health, complicating the very idea of national sovereignty in health decision-making.

Private donors, ourselves included, cannot afford to ignore this critique.

In our view, funders should not subsidise the health budgets of lower-income countries – in the case of Kenya, 23 per cent is provided by external donors – nor should we use our funding to influence the behaviour of states, where we have no legitimate role.

Global health philanthropy: not enough

Consider with us instead an affirmative role for global health philanthropy in a world that will undoubtedly be shaped by this pandemic for decades to come. The fact that health systems from the US to Ecuador buckled under the onslaught of the pandemic, suggests an important role for philanthropy in supporting a transformative vision of universal healthcare. This vision resists the radical privatisation which compromised the US response to the pandemic, the politicisation against which WHO director-general Dr Tedros Adhanom Ghebreyesus so powerfully and painfully cautions in this special feature (see page 42) and the exclusion of groups whose rights are denied by authoritarian states and fundamentalist movements proliferating around the globe.

The politicisation of health

Health activist partners of our East Africa Foundation, OSIEA, have warned that philanthropic funding can act as a political analgesic. Instead of treating the source of

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Geography of global health leadership: a relic of colonialism?

<table>
<thead>
<tr>
<th>Low- and middle-income countries</th>
<th>High-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>% global population: 83%</td>
<td>17%</td>
</tr>
<tr>
<td>% global health leaders: 17%</td>
<td>83%</td>
</tr>
<tr>
<td>% degrees obtained in those countries: 8%</td>
<td>92%</td>
</tr>
</tbody>
</table>

5% global health leaders who are women from LMICs

8% of global health leaders are nationals of just two countries: UK and US.
pain, philanthropy offers temporary relief that disarms potential civic action to address a lack of domestic action on health. While a massive amount of philanthropic spending goes towards research and biomedical approaches to health, we need to see more funding for the kinds of efforts and organisations showcased in this issue of *Alliance*.

**Solutions need to be local**

One example of philanthropy adopting a citizen-centred approach involved relatively modest funding from three US foundations – Hewlett, Wellspring, and Open Society. These foundations supported a coalition of 40 Ugandan civil society organisations to take the Ugandan government to the Supreme Court over its failure to provide maternal health to its citizens. In August 2020, the court ruled in the petitioners’ favour, and the right to maternal health is now enshrined in the Ugandan constitution. Significantly, in the nine years the case took to make its way through the courts, the Ministry of Health has overhauled its reporting mechanisms for maternal deaths, and rates have dropped in certain districts as the government moved to demonstrate accountability for this failure. By contrast, donor governments and multilateral health financing organisations rely too heavily on international organisations to implement programmes on behalf of ‘beneficiaries’ in low-income countries. Salaries and indirect administrative and operational costs benefit consultants and staff from outside the country and the companies with which they have procurement arrangements. A recent report by amfAR, the Foundation for Aids Research, estimated that between 2007 and 2016, the US presidential initiative on Aids spent up to $4 billion on ‘indirect costs’ which did not go directly to programmes on the ground. The continued power of these multimillion-dollar contracting organisations is one of the most vivid remnants of a colonial global health system that is extracting resources rather than redistributing them. Risk-taking and flexible philanthropic dollars could be better spent elsewhere.

A report from Uganda’s Institute for Social and Economic Rights provides another example of the problem. The report shows how a public-private partnership with USAID and the Government of Uganda, implemented by the international organisation ABT Associates, invested millions in a voucher programme to stimulate demand for maternal child health, which has not led to significant reductions in maternal deaths, especially for poor women.2 In fact, the programme in Uganda has an explicit goal of subsidising private clinics to show their effectiveness in programme delivery, thereby undercutting efforts to roll out a publicly funded national health insurance programme.

**Mind the gaps but do not fill them**

Some argue that a sweet spot for global health donors is in securing access to health for populations whose rights are denied due to criminalisation, fundamentalism and intense social stigma. But donations in this area should be focused on dismantling the systems of oppression, not on creating unsustainable parallel health systems that perpetuate them. As Ban Ki-moon of The Elders cautions in his article on universal health coverage on page 54, ‘philanthropists and the sector can complement the state but they cannot replace it’.

There is scope for donors to build on the lasting and inspirational legacy of the global HIV response. That response brought action from governments and donors to address the disproportionate impact of public health failures on women, people who use drugs, migrants, sex workers and LGBTI people. But the philanthropy in the aftermath of Covid-19 should move well beyond the limited focus of the HIV movement on the ‘marginalised’. Instead, as we witness the disproportionate impact of the pandemic on black, brown, and Indigenous bodies, donors need an enduring focus on racism as a public health crisis in its own right.

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Above: Victory celebration after a successful court-case against the Ugandan government in August this year which resulted in the right to maternal health being enshrined in the country’s constitution.

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The continued power of these multimillion-dollar contracting organisations is one of the most vivid remnants of a colonial global health system that is extracting resources rather than redistributing them.
We also see clear gaps but also opportunities when it comes to mental health and sexual and reproductive health programming. Each received just 6 per cent of philanthropic health funding in 2017 and 2018 according to Candid’s data – and both are areas where intense social stigma, criminalisation and institutionalisation make access to rights respecting services very difficult for excluded groups.

The attack on sexual and reproductive health and rights (SRHR), too – especially abortion – by fundamentalist religious groups both at the national level and exported through US government funding is compromising the ability of progressive donors such as the Swedish and the Dutch to ensure that SRHR is scaled up and included in health systems. The articles in this issue by Linda Weisert and Suzanne Petroni (page 50) and Steven Allen (page 56) provide clear guidance on where philanthropic investments in SRHR and mental health, respectively, can put communities first in defining the kinds of health services they need and advocating for government to provide them.

**Don’t go it alone**

The examples throughout this issue of *Alliance* strongly suggest that we cannot play our proper role in helping to end health disparities without addressing economic inequality and racism. It follows that we cannot fund health organisations alone, nor can we fund people to work on health in isolation from its underlying social determinants. We need to address the issues that affect the health and education sectors together during the Covid crisis. It is the same populations’ people of colour, with disabilities, with lack of economic resources, who can’t access a Covid test and don’t have a tablet to access their remote schools.

The opportunities for reimagining philanthropic investments in global health which we have put forward are driven by an analysis of the ills of the legacy of colonialism in the global health system and the ways in which this legacy is playing out through privatisation, health systems fragmentation and undemocratic and non-transparent health governance. It is our hope that this edition of *Alliance* will spark the conversations that we believe need to happen if philanthropy is to play a meaningful role in changing global health for the better.

1 tinyurl.com/pandemic-profit
2 Other independent studies of maternal child health voucher programmes in East Africa show mixed results (gh.bmj.com/content/3/2/e000726) and similarly poor results for poor women (tinyurl.com/ESJ-voucher-programme)

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**Distribution of Health Grants by Subject Area, 2017-2018**

<table>
<thead>
<tr>
<th>Subject Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Diseases and Conditions</td>
<td>25.9%</td>
</tr>
<tr>
<td>Other Health</td>
<td>30.6%</td>
</tr>
<tr>
<td>Reproductive Healthcare</td>
<td>6.5%</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>12.1%</td>
</tr>
<tr>
<td>Public Health</td>
<td>20.2%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.8%</td>
</tr>
<tr>
<td>In-Patient/Out-Patient Healthcare</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

Source: Candid, 2020 Based on all grants of $10,000 or more awarded by the FC 1000 – a set of 1,000 of the largest U.S. private and community foundations by giving.
Health and healthcare has been a traditional priority for philanthropy. Moreover, the Covid-19 pandemic has stimulated activity among funders and foundations not previously much associated with it. Here is a snapshot of who is doing what in the global health arena.

### The Bill and Melinda Gates Foundation, US

The Gates Foundation aims to take a catalytic approach in its healthcare work, concerting its activities with public sector and philanthropic partners which include WHO and the UK’s Foreign, Commonwealth and Development Office. It tries to identify areas where its intervention can make crucial differences and sees itself as in effect the risk capital of the health sector. Areas of concern include malaria, Aids, tuberculosis and polio. The foundation has provided $2.9 billion in grants to combat malaria and has committed an additional $2 billion to the Global Fund to Fight AIDS, Tuberculosis and Malaria. It is also part of the Global Initiative to Eradicate Polio and with other core partners, WHO, Unicef and the World Bank, helped set up Gavi (the Vaccine Alliance, see below), to which it announced a commitment of a further $1.6 billion in June this year. Since the Covid-19 outbreak, it has provided $350 million to support global responses to the pandemic and a further $300 million from its Strategic Investment Fund which helps make it attractive for private enterprise to develop affordable and accessible health products in the service of developing a vaccine. It is the largest single contribution by a foundation and is a reflection of the priority Bill Gates is giving to the pandemic. It is also part of a partnership with the Wellcome Trust (see below) and others, called the Covid-19 Therapeutic Accelerator, to fund screening of already-approved drugs to see if they work against the coronavirus, and has secured free access from a dozen drug companies to their compound libraries.

[gatesfoundation.org](http://gatesfoundation.org)

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### Top 8 Foundations by aggregate grant dollars awarded for health, 2017-2018

<table>
<thead>
<tr>
<th>Foundation</th>
<th>Grant Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>$6,575,531,380</td>
</tr>
<tr>
<td>American Lebanese Syrian Associated Charities, Inc.</td>
<td>$1,419,099,344</td>
</tr>
<tr>
<td>Pfizer Patient Assistance Foundation, Inc.</td>
<td>$937,749,727</td>
</tr>
<tr>
<td>The Susan Thompson Buffett Foundation</td>
<td>$798,275,587</td>
</tr>
<tr>
<td>The Robert Wood Johnson Foundation</td>
<td>$659,964,744</td>
</tr>
<tr>
<td>Wellcome Trust</td>
<td>$647,682,666</td>
</tr>
<tr>
<td>Robert Driscoll &amp; Julia Driscoll &amp; Robert Driscoll, Jr. Foundation</td>
<td>$636,270,732</td>
</tr>
<tr>
<td>Bloomberg Philanthropies, Inc.</td>
<td>$562,059,267</td>
</tr>
</tbody>
</table>

Source: Candid, 2020 Based on all grants of $10,000 or more awarded by the FC 1000 – a set of 1,000 of the largest U.S. foundations by giving. For community foundations, discretionary grants are included and donor-advised grants when provided by the foundation. Grants to individuals are not included in the sample.
Bill Gates and the pandemic

*Associate editor, Andrew Milner writes:* In an interview with *The Economist* in August, Bill Gates predicted that by the end of 2021, a reasonably effective vaccine against Covid-19 would be in mass production, but that, in the meantime, many more would die, mostly in the developing world, from the effect on under-resourced healthcare systems, rather than the disease itself. In addition to the content, another interesting feature of this is that Gates, who is a philanthropist, not a politician or the head of a global health organisation, is discussing medical questions in a publication which is not a philanthropy journal but a current affairs magazine.

In fact, the Covid-19 outbreak has thrust Gates more clearly into the spotlight than usual. ‘He’s been everywhere,’ notes an article in the *Seattle Times*, ‘on television, in medical journals, in online Q&As.’ A long-time advocate of better preparedness for pandemics, Gates has spoken of the need for expanded testing and equitable distribution of vaccines and criticised the US government’s response to the outbreak. He – or the Gates Foundation – has also been the object of groundless rumour-mongering and conspiratorial thinking.

There are a number of things to note here. First, the high profile of the Gates Foundation generally, second, and given the long involvement and the billions of dollars the foundation has invested in combatting disease, the status of Gates in the international health community. Third, the politicisation of the pandemic, deplored by Gates himself. It is more than a health crisis, it has called into question the nature of social and political arrangements everywhere. And this is also true for philanthropy. At times when its activities become most prominent, both champions and detractors also come to the fore. While many have praised the rapid and generous response of donors like Gates, others have taken the opportunity to suggest that big philanthropy is too big for its boots.

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**Wellcome Trust, UK**

Wellcome funds research to tackle the big health challenges and raise the public profile of scientific research especially in regard to health. Announcing a new strategy in late 2020, its grants will increasingly focus on infectious diseases, mental health and global heating. Prior to the pandemic, it already had a special interest in epidemics, co-funding the development of a new Ebola vaccine, training health workers and developing research leaders in regions most affected by infectious diseases. Its spending in support of these objectives is around £900 million per year, according to its 2019 annual report and financial statements.

[tinyurl.com/wellcome-new-strategy](tinyurl.com/wellcome-new-strategy) | [wellcome.ac.uk](wellcome.ac.uk)

**Open Philanthropy Project, US**

Part of its Global Catastrophic risk stream of funding, OPP has focus areas including global health and development, and biosecurity and pandemic preparedness. In the former, it has made grants to the tune of $452 million, mostly to organisations recommended by non-profit monitoring platform, GiveWell, with whom it has a close relationship. Its interest in biosecurity and pandemic preparedness is based on OPP’s belief that pandemics, whether natural or engineered, represent ‘one of the biggest current risks to global welfare and stability’. It also sees ‘relatively little philanthropic support in this area’ but believes that philanthropy could have an important role to play in it.

[openphilanthropy.org](openphilanthropy.org)
The Gavi Alliance

A cross-sector alliance, involving foundations, INGOs and multi- and bilateral funders, Gavi, or the Vaccine Alliance, has helped to vaccinate over 760 million children in the world’s poorest countries since it was set up in 2000. It has supported campaigns to immunise children against rotavirus, meningococcal meningitis A and pneumococcal disease, yellow fever and Japanese encephalitis. Its partners bring a range of expertise to bear on the immunisation question, including policy-setting, advocacy, fundraising, vaccine development and procurement, country support and immunisation delivery and, in 2018 (the latest date for which a figure is given) it was working with 73 low-income countries. More recently, it has become one of the leaders of the COVAX Facility to provide equitable access to Covid-19 vaccines. The idea behind this is to pool the buying power of participating economies (at the time of writing, there were 172 countries expressing interest in the facility) and to provide volume guarantees across a range of promising vaccine candidates so that their manufacturers can go ahead with their production.

gavi.org

Michael Bloomberg and Johns Hopkins health initiatives

Bloomberg Philanthropies have been instrumental in the health elements of Johns Hopkins University. Having funded the establishment of the Johns Hopkins Bloomberg School of Public Health, Bloomberg has also resourced the Bloomberg Fellows Program to the tune of $300 million, the largest gift ever made to the School of Public Health. This is to provide public health training to individuals engaged with organisations tackling critical challenges facing the US in the following areas: addiction and overdose; adolescent health; environmental challenges; obesity and the food system; and violence. Johns Hopkins has been a leading source of global data on the prevalence of Covid-19.

americanhealth.jhu.edu

UN appoints Dr T

The UN has appointed Dr Tlaleng Mofokeng as its special rapporteur on the right to health. Part of the Commission for Gender Equality in South Africa and a member of the boards of Safe Abortion Action Fund, Global Advisory Board for Sexual Health and Wellbeing, and Accountability International, Dr Mofokeng is a champion of universal health access, HIV care, youth friendly services and family planning. Popularly known as Dr T from her broadcasts and magazine columns, she has taken on the role, she says in an article in the South African news publication, Daily Maverick because ‘it’s about being able to raise questions about accountability, be it from governments or global funders, and to make sure patients’ rights and needs are what drives agendas and funding models.’
Freethevaccine is a philanthropically-backed movement of 300 self-styled activists spread around the world campaigning for free access to a Covid-19 vaccine once it is developed. The movement is led by two non-profits, Universities Allied for Essential Medicines and the Center for Artistic Activism. Its primary targets are university faculties, who can put pressure on their institutions to be socially responsible in patenting and licensing publicly funded medicines like vaccines developed in university labs, ministers of health and CEOs of pharmaceutical companies. The movement runs weekly online courses on innovative advocacy featuring assignments ranging from ways to use social media to encourage health officials to pledge support for equal access to treatment, to social distancing performances that urge people to pressure their governments.

freethevaccine.org

Globally Health 50/50 emerged from University College London in 2017 with funding from the Wellcome Trust, and an aim of using a gender lens to tackle global health inequalities. It does so through its Gender and Health Index – the single-most comprehensive analysis of gender equality and diversity in the global health system today.

More recently, as part of its efforts to promote Covid-19 responses that promote gender equality, GH5050 tracks official sex-disaggregated data from 175+ countries to reveal how men and women are affected differently by the epidemic. For this Gates Foundation-backed study, GH5050 has been joined by two research institutes – the Washington and Delhi-based International Center for Research on Women and the Kenya-based African Population and Health Research Centre.

globalhealth5050.org

At a meeting of the UNAIDS Programme Coordinating Board in June 2020, new executive director Winnie Byanyima (pictured below) urged countries to learn the lessons from a history of unequal access to HIV services and apply them to the fight against Covid-19. She also called for a people’s vaccine for Covid-19, with an international agreement that any vaccines and treatments discovered for Covid-19 be made available to all countries. The same call was voiced in May by over 140 world leaders and public figures who signed an open letter to all governments to unite behind a people’s vaccine. The letter demands that all vaccines, treatments and tests be patent-free, mass produced, distributed fairly and free.

Applying the lessons of Ebola to Covid – page 48
Philanthropy’s response to Covid-19

In October 2020, Alliance magazine conducted a survey to learn more about how the global philanthropy sector was reacting to Covid-19. We received 250 responses from readers in 59 countries around the world.*

Some key findings:

In your opinion, since the onset of Covid-19, has the mental health and well-being of people in your organisation:

Become worse: 58%
Stayed the same: 34%
Improved: 13%

Have your funding priorities changed this year? Are you giving more to the following:

Health (including mental health): 39%
Gender equality: 28%
Racial justice: 19%
Climate change: 12%
Democracy education: 9%

Some key findings:

Have you made more of your funding unrestricted?

Yes: 60%
No: 40%

On a scale from 1 – 5, is there more willingness to work with other foundations to combat this pandemic?

5: (Absolutely): 48.9%
4: 13.8%
3: 27.7%
2: 6.4%
1: (Definitely not): 3.2%

On a scale from 1 – 7, do you believe the crisis has made philanthropy more relevant to solving society’s problems?

7: (More relevant than ever): 32.4%
6: 18.5%
5: 19.4%
4: 15.7%
3: 6.5%
2: 5.6%
1: (Not relevant at all): 1.9%

“The pandemic was a huge opportunity to the organisations of civil society to show their power, their capacity to face complex problems, to react fast, to raise funds and to help people everywhere.”

“We fear that we are rushing into a ‘new normal’ without reflecting on the deep questions about how abnormally we’ve been operating for quite a while.”

“We tackle FGM cutting increasing hugely due to lockdown under Covid-19.”

“In addition to addressing immediate need, the pandemic has mainly served to highlight some long-standing issues with funding that otherwise would not have been at the forefront.”

“Many foundations have shifted their giving to responding to the immediate public health challenge. Very few are focused on addressing the root causes of the problem.”

“Our evidence-based research and advocacy has increased people’s awareness of more hidden violence against women.”

“Build back better’ doesn’t just apply to the things foundations fund – it should also apply to foundations themselves.”

*For the full survey, check out our coverage on the Alliance website. tinyurl.com/2020-alliance-survey
Alliance exclusive

A sharpened focus in the eye of the storm

In the Covid-19 response, why are some high-income countries being outperformed by countries with fewer resources? What are the merits of a multilateralist approach in a crisis like Covid-19? What is it like being in the eye of the storm as head of the World Health Organization through a global health crisis? These are some of the questions Dr Tedros Adhanom Ghebreyesus, director-general of the WHO discusses with Professor Senait Fisseha, director of Global Programs at the Susan Thompson Buffett Foundation.

Senait Fisseha: We’re approaching a year since the first cluster of Covid cases were reported to the World Health Organization. On this and on other major global health issues, how is the WHO using its experience of working with philanthropy?

Tedros Adhanom Ghebreyesus: Even before Covid, philanthropic organisations were committed to contributing to global health, so I was not surprised when many scaled up their response in very flexible ways, not only in building up the health systems of individual countries, but also investing in global and regional institutions like WHO and Africa CDC. The response of philanthropic organisations in general has been very encouraging. Their flexibility has helped them move quickly to change their priorities.

SF: In recent years we have seen a growing trend for private foundations and donors to contribute to the WHO alongside member states. What are your thoughts on that shift and what are some of the benefits and challenges of working with philanthropists along with member states?

TAG: There is a growing trend of private foundations and donors contributing to WHO and this is very important as it broadens our donors base. We welcome this. There is great potential, and great need, for the philanthropic sector to partner with WHO and health organisations around the world. And this is possible if you agree on the objectives, especially at country level, then you can cooperate with anyone because your interests are aligned.

But there have been challenges. For instance, they can come when a donor member state or a donor philanthropic organisation has their own priorities, which may not be fully aligned with those of the country. If the priorities are not aligned, then any assistance will not remedy the problems that country is facing.
This lack of alignment comes for two reasons: one, when a donor country or philanthropic organisation says, ‘I know their problems so I can help them’. But it is the country itself which knows its own challenges best.

The second problem is when the donor has a deep attachment to something they want to do. That passion is very important but it is essential that action reflects the needs on the ground, in the country. This is why flexibility in funding is important.

Whatever the challenge, the solution is the same: if we are interested in saving lives, then we have to listen to those who are seeking support and provide it based on their interests and their priorities.

SF: I agree. I think listening to the voices of affected communities or countries and putting them in the driver’s seat is still a big gap in global health and development. One of the things you’ve done as director-general is to open up WHO to wider public interaction and donation, both through partnership with the UN Foundation and the WHO Foundation. How do you see that developing?

TAG: Generating more flexible funding is part of WHO’s transformation so it can be fit for the future. One of the challenges we first identified was that WHO is dependent on a few major donors, and if any of them change...
It’s very strange to see that the death toll and infection rates are higher in high-income countries... the reason is that they have invested in medicine but neglected public health and primary healthcare.
This year will be forever defined by the pandemic, and you have had a front-row seat for the entire journey. Covid-19 has exposed the stark weaknesses of national health systems as well as the incoherence and insufficiency of health financing, the state of unpreparedness of many countries and the disproportionate impact of the pandemic on the poor, the uninsured and historically marginalised communities. You’ve made it very clear that national governments should be leading coordination of their country’s response, but what is the role of philanthropy in helping to mobilise political will and contribute resources to ensure an equitable response?

TAG: Losing more than a million people is a disaster. As you rightly said, many of these deaths could have been averted if we had a strong primary healthcare and strong public health. It’s very strange to see that the death toll and infection rates are higher in high-income countries. The reason for that is they have invested in medicine but neglected public health and primary healthcare. That’s where we can do better in emergencies or even prevent an emergency from happening. WHO has been warning about this. Maybe many Asian countries performed well and listened because of their own experience from SARS. That’s why Vietnam did well, South Korea did well – these are neighbours of China that should have been affected more than countries further away.

SF: You mention strong public health systems, and even low-income countries like Rwanda that have a very strong primary healthcare system have fared very well in this pandemic.

TAG: Yes. There is a view in some quarters that primary healthcare is for low-income countries. That has led to some high-income countries not prioritising it. I am convinced it’s the other way round, because WHO’s knowledge and experience is the sum of all approaches and countries. We developed a test kit with Germany, it worked very well, it’s still working. Such collaboration, between WHO and high-income countries, produces dividends for the world. WHO does not work only for low-income countries. It is in the interests of all countries, high, middle and low income, to collaborate among themselves and with WHO and the multilateral system. Philanthropic organisations can also invest in high-income countries, not just in developing countries to create awareness of the need to strengthen primary healthcare.

SF: You said in April that if you politicise the virus, you’ll end up with many more people losing their lives, and you’ve reminded us to focus on values like solidarity and love and resilience.

TAG: When I remarked in April about people unnecessarily dying, there were 84,000 deaths, now it’s October 15, the numbers are 1,087,000, and we have 1,003,000 more dead. I still believe the politicisation was a key reason behind all these deaths.

In WHO, we saw it coming. It’s just like when you feel something, when you see something, when you’re worried about something, when you see the trends, you develop this fear inside, ‘Oh we’re heading this way’. We could see that trend. It’s not without reason by the way, it’s not without evidence. We could see the trend. The only thing you need to do is to connect the dots.

When you look back now, and consider the number of deaths we see today, this was actually a very insignificant representation of this situation now, so what we said was true, we wish it wasn’t true. And it’s very sad and it could have been prevented.

SF: Among the many downstream effects of this pandemic, the impact on the health and rights of women and girls around the world is of particular concern. Women represent the vast majority of frontline health workers, and political and religious leaders who are hostile to women’s bodily autonomy have used the pandemic as an excuse to categorise sexual and reproductive health services as non-essential. What is at stake here and what kind of guidance is WHO providing in this area?

TAG: Sexual and reproductive health and rights (SRHR) were a contentious issue in
global health even before this emergency. For me, the health of women is central to the family and to society. I am a very strong believer that by guaranteeing sexual and reproductive health and rights you can even bring countries into the path of prosperity because that’s how you release the energy of the women to contribute to the economy and the focus on women and girls is more important than ever. So when people say ‘we’re in an emergency, this is not the right focus’, my answer is that the crisis aggravates the situation, and this is actually when we should do even more, not less. With philanthropic organisations, I think the thing we need to do is push, push, push. We now meet regularly virtually with civil society and we’re also installing a youth council. We need to leverage those contributions. But it should start from WHO. WHO should focus on doing the right things based on science and evidence, and SRHR should be at the centre. I hope you will support those civil society and youth initiatives so they will be more active and add their voices.

SF: I agree that philanthropy can help drive positive impact on global health, but we also have to grapple with the reality that there is a colonial and often very paternalistic history in global health and philanthropy. Many funders are based in the Global North, trying to solve ‘health issues’, concentrated in the Global South without the wisdom and the perspective of those most affected. How can we harness the power of private philanthropy to address some of these imbalances?

TAG: As you say, only communities know their problems and support should be tailored to them, but they’re also ready to listen. Something that they see is important, like family planning, they accept. The issue is how can we discuss this honestly with funders. When it comes to addressing global health problems, it’s better to align with the needs at the country level, listen to those who should be supported and tailor the support based on that. But as you rightly say, there is the power imbalance and those who have the power, whether it’s political or financial, try to dictate.

SF: This issue of Alliance is also covering mental health as a key part of the global health agenda and we are enormously grateful for how much emphasis the WHO has given this issue. I just want to ask: how do you personally stay calm and maintain your own mental health given the challenges and the pressure of leading the WHO in the middle of a global pandemic?

TAG: I don’t know if I have advice! I can tell you one story though. One of our colleagues was asked how WHO kept going in the midst of a crisis and he said, ‘we do what we do in good faith, and we have faith in each other’. If you say ‘in good faith’ it means internally you are at peace. When you have faith in each other, it means there is trust and good relationships that emanate from everybody doing things in good faith. I have seen WHO’s worth, because it’s tested now, and through this very difficult time I have seen how my colleagues actually work and behave. Another thing about good faith is that it keeps you in balance. Of course, we were affected, because we’re human beings. But the most important thing was we were focused on the pandemic and the people dying. So you have a bigger agenda; you cannot confront those who are trying to distract you, you focus on the most important thing which is saving lives. We need to think about each other, to really help each other. That’s how we can finish this pandemic.

SF: Finally, what message do you have for the philanthropists who want to do more to support your efforts but are struggling with the complexity of the current context?

TAG: I have already mentioned things that philanthropic organisations can do to help us to advocate for countries to focus on public health and primary healthcare. As you know, after I became director-general in 2017, we have been designing the transformation of WHO, which we officially launched in March 2019. But even before then, while designing WHO to make it fit for the world’s current needs, we were already
implementing changes – the low hanging fruit – side-by-side with the design.

It is true that the agenda was influenced by a threat that a pandemic may happen and, when we look back, many of the new additions were very relevant to prepare WHO for this and future situations.

We established the independent Global Preparedness Monitoring Board to ensure preparedness for global health crises. We created a division focused on improving emergency preparedness in countries around the world, especially the most vulnerable. We appointed the first-ever chief scientist to drive research and development on emerging diseases, and established the WHO Academy, which is now training five million medical personnel for emergencies. The WHO Foundation is a new addition to mobilise resources. So one more thing I would like to ask philanthropic organisations is to help us ensure that these transformation ideas are implemented properly.

Second, I call on philanthropic organisations to please help us ensure sustained investment in primary healthcare and emergency preparedness.

Third, our aim is to make WHO a learning organisation. We have a transformation implementation unit which we want to drive continuous improvement, because change is a constant, so helping us strengthen that unit would be really great. We need support from philanthropists to implement these chances and to help prepare better for the future, so what happened never happens again.

You cannot confront those who are trying to distract you, you focus on the most important thing which is saving lives. We need to think about each other, to really help each other. That’s how we can finish this pandemic.

10 December 2020 – 15:00 GMT
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Applying the lessons of Ebola to Covid

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The devastating Ebola outbreak of 2014 taught us a great deal, but donors still need to maintain their commitments if the human cost of future health crises is to be kept as low as possible.

No one would deny that the challenge to end this Covid-19 pandemic is considerable. Yet, when I think about the future, I’m optimistic. The speed and scale of the research response to date has been remarkable and it was made possible only because of progress and global collaboration on epidemic preparedness. The global response to the west African Ebola epidemic, more than six years ago, was the turning point.

In 2014, the task facing Guinea, Liberia, Sierra Leone was mammoth. Each had very limited health infrastructures, dealing with a fast-growing outbreak and the number of cases rising constantly. Ebola is by no means a new disease, but there was limited vaccine research underway and for the most part, it had suffered from a lack of global will to invest further. The scale of the tragedy unfolding in 2014 prompted Wellcome and others to push for a different, more urgent response, bringing global researchers, governments, NGOs, industry and funders together.

The question was asked: what if we put research at the heart of the response? What if we ran clinical trials of a new vaccine in the midst of an epidemic? Vaccine development, and the clinical trials to test them, are astronomically costly and can take decades. The only time we can assess a new vaccine is within an active outbreak, but Ebola vaccine candidates had never been humans before. The case was made to richer nations that tackling this outbreak would require all of our scientific effort. After all, infectious diseases don’t respect borders and pose a global threat to international trade and travel.

There was huge will from all involved, from Wellcome’s £10 million in fast-tracked grants, to surveillance systems set up by the World Health Organization and Gavi, the Vaccine Alliance, as well as an incredible and determined commitment from all health responders in the affected countries, in some of the world’s most challenging settings. The pharmaceutical company Merck played a

The case was made to richer nations that tackling this outbreak would require all of our scientific effort. After all, infectious diseases don’t respect borders.
A pivotal role, investing considerable resource, with no expectation of a return.

Eventually this became the deadliest Ebola epidemic in history, leading to more than 11,000 deaths. The global response had averted many more deaths and made rapid advances. But it was clear we needed a more sustainable strategy to ensure the world is better prepared for threats from emerging infectious diseases.

**After the outbreak**

In 2016, the Coalition for Epidemic Preparedness Innovations (CEPI) was founded and formally launched at the World Economic Forum in Davos 2017 by Wellcome, the Gates Foundation and the governments of Norway, Germany and Japan.

Aiming to fill the financing mechanism gap directly, and designed to develop vaccines to stop future epidemics, CEPI’s work in the last four years has been far-reaching. It has accelerated research into emerging infectious diseases, such as Lassa fever and Chikungunya that afflict low- and middle-income countries.

Six years on from the beginning of the 2014-16 Ebola epidemic, we see the fruit of that collaboration to accelerate research. When Ebola returned to the Democratic Republic of Congo (DRC) in 2018, local health systems were already better prepared. Licensed approval for two vaccines has been gained in little over five years, an astonishing achievement. Thanks to an incredible effort by local healthcare workers, more than a quarter of a million people have since been protected by Ebola vaccination in the DRC.

From the very start of this year, the Covid-19 pandemic has highlighted the value of epidemic preparedness. As a result of previous investments, CEPI has been central to the research response from the very outset, pivoting its existing ‘Disease X’ programmes and work on MERS-CoV to Covid-19, accelerating vaccine development.

This response was so rapid in fact, that together with the US National Institute for Health, CEPI co-funded pharmaceutical company Moderna, which was able to enter Phase 1 trials – testing the safety of a new vaccine – just 63 days after the new coronavirus was first genetically sequenced. CEPI is now responsible for the funding of a total of nine vaccine candidates currently in late-stage clinical trials at the time of writing in October 2020.

The coronavirus pandemic has highlighted significant questions about the distribution of any successful vaccines and treatments. To address these, the Access to Covid-19 Tools (ACT)-Accelerator was launched in April, to unite international development and production of, and equitable access to, Covid-19 tests, treatments and vaccines. The vaccines pillar, COVAX, is convened by the WHO, CEPI and Gavi. Wellcome is working with Unitaid to lead the pillar for the development of and equitable access to treatments.

Global support for the ACT-Accelerator has been growing but it still urgently needs an additional $35 billion to realise the goals of producing two billion vaccine doses, 245 million treatments and 500 million tests.

To ensure we stay on the right path, there must be sustained investment and global collaboration. To bring this pandemic to an end as quickly as possible and prevent future tragedies on this scale again, we must invest in our future now.
The pandemic has highlighted the urgency of self-care as a means of gender-transformative reproductive health. The Covid-19 pandemic has affected nearly every aspect of life, including women’s sexual and reproductive health. A recent study by the Guttmacher Institute predicts deadly consequences for women and girls resulting from limited access to contraception and safe abortion services. But there is a way to avoid these potentially catastrophic outcomes. Self-care – empowering women and girls to effectively manage their own health – can help meet their sexual and reproductive needs, while simultaneously advancing gender equality.

Let’s start with what we know. Sexual and reproductive health services are among those suffering the most due to the strain put on health systems by the pandemic. Many clinics have shut or face supply chain interruptions compounding a situation where women and girls – particularly the poorest and most marginalised – often cannot afford services, or are denied them because they are unmarried or considered ‘too young’. As a result, we now face the daunting prospect of reversing the tremendous gains made in preventing HIV infections over the past two decades.

This is happening just as the need for contraception, HIV prevention and safe abortion services may be more important than ever. Cases of domestic violence and rape appear to be increasing during the pandemic and Guttmacher anticipates an additional 15 million unintended pregnancies in low- and middle-income countries due to the Covid crisis. Combined with limited access to care, this could mean an additional 3.3 million unsafe abortions, 28,000 maternal deaths and 168,000 newborn deaths in the next year alone.

These numbers are alarming, but they are not inevitable. The pandemic has forced a rethink of service design and delivery in many areas, and the Children’s Investment Fund Foundation (CIFF) and other partners have already begun to do this in sexual and reproductive health, through investments in self-care. Working with the Self-Care Trailblazers Group and in support of the new WHO global guideline, CIFF supports high quality, safe and affordable interventions, including oral, emergency, and self-injectable contraception, self-managed abortion care, and self-testing for HIV. All of these tools can be made more accessible by being provided prescription-free, in multi-month distributions, and/or with remote medical engagement and follow-up care, reducing the need for health facility visits.

CIFF’s investments and strategies leverage its agility and risk appetite as a foundation. Through deals with manufacturers, support for product registration, equitable distribution and diversity of suppliers, CIFF has contributed to reducing prices and expanding the accessibility of HIV self-tests and self-injectable contraceptives for even the most marginalised. CIFF also supports digital platforms like In Their Hands, which aims to put critical information and services within the reach of millions of women and youth. These investments improve the quality of self-managed abortion medication, make service delivery person-centred, and prevent death and injury from unsafe abortion.

Enabling women to control their own health decision-making and care supports their bodily autonomy and realisation of their reproductive rights. These are essential elements of gender equality, a goal that has become increasingly important for foundations like CIFF, particularly at a time when it is experiencing a backlash in many countries. Indeed,
in its co-leadership role within the Generation Equality Forum, CIFF is promoting self-care as a critical way to empower women and girls, and is working to ensure that self-care is integrated into the new feminist global blueprint.

Complementing healthcare systems with new self-care devices, drugs, and the use of digital health can help transform how individuals, especially women and girls, engage with health systems and enable them to take greater control of their health. They can also be a critical way to respond to the Covid-19 pandemic and to advance towards a more gender equitable world.

"Enabling women to control their own health decision-making and care supports their bodily autonomy and realisation of their reproductive rights. These are essential elements of gender equality.

15 million
Anticipated number of unintended pregnancies in low- and middle-income countries due to Covid crisis.

Below: In Their Hands digital platform provides access to critical information and services.
Philanthropy can greatly help the implementation of Universal Health Coverage, but it needs to pay attention to some key issues.

With 400 million people the world over lacking essential health services and many others in low- and middle-income countries pushed to extreme poverty by the high cost of healthcare, Universal Health Coverage (UHC) is seen as the way to access health services for all, while ensuring that high standards of service delivery are upheld. Moreover, the UN’s UHC Political Declaration recognises UHC as fundamental to achieving the 2030 SDG Agenda. Governments are therefore called upon to significantly increase their health investments to deliver it.

Philanthropy can potentially play a key role here, but to do so effectively it should embody the key principles of the UHC promise – quality, equity and accountability.

The UHC agenda is centered on varied approaches including integration, coordination, efficiency and collaboration. Philanthropic funding approaches can be remodelled to ensure alignment with these approaches and to propagate publicly funded UHC reforms. Effective philanthropy must be community-driven so that it addresses the most important UHC challenges, with priority setting done by the people who will benefit from the services. The White Ribbon Alliance-led What Women Want (WWW) campaign revealed the importance of this. Reaching close to 1.2 million women and girls across 114 countries, the WWW campaign sought to understand what quality, a key principle of UHC, means for them. Respect and dignity were the first priority - being called by name, absence of discrimination and judgment when seeking care. Water and sanitation, especially clean toilets, clean linen, etc., were also ranked high. These responses show people’s desire to reclaim power from those who make decisions on their behalf and from those who design and implement health policies and programmes without consulting them.

Advocacy by civil society has been an essential component of the progress in global health over the past 20 years. By championing the informed, independent voices of people who are most affected by weak healthcare systems, grassroots CSOs are essential amplifiers in UHC implementation. They raise awareness about gaps and inequities, propose solutions to address them and lead accountability mechanisms for UHC tracking and delivery. However, in the ongoing UHC
reforms, they are often left out. Data to support implementation in countries, such as the Kenya UHC pilot, is based on research generated by UHC experts and not on the views of CSOs or community groups. Philanthropy must provide support for their endeavours. This means prioritising funding for national- and grassroots-level advocacy for accountability, something which is overlooked by both governments and funders, but which can improve use of UHC resources and sustainability. Furthermore, multi-stakeholder and cross-sectoral partnerships should never leave out local advocacy efforts and people’s voices if sustainable impact is desired.

Philanthropy should help nations in planning and implementing strategic health financing models that can better support UHC delivery from primary healthcare to more complex curative, palliative and rehabilitative care. This will ensure that reforming national UHC architecture addresses the current widespread inequities. Philanthropies should prioritise the impact of their work on the most marginalised populations.

Another critical element they need to confront is the gaping governance and leadership deficits in UHC delivery, addressing in particular corruption in the health sector. It’s no use continuing to fill a leaking bucket. Well-funded evidence generation and analysis is required to inform better interventions and responsive funding policies. Factors which produce corruption are varied in different healthcare settings and country contexts, hence the need for more deliberate funding for social accountability. At the end of the day, investing in the voice and agency of citizens will directly guarantee desired social impact and will build a strong accountability mechanism to ensure UHC is delivered as promised.

Effective philanthropy must be community-driven so that it addresses the most important UHC challenges, with priority setting done by the people who will benefit from the services.
Philanthropy has a long and distinguished history in supporting developments in health and healthcare, including providing access to vital services for the poor and vulnerable, from the establishment of the world’s first incorporated charity by Captain Thomas Coram in 18th-century London to care for abandoned infants, to the Rockefeller Foundation in the United States.

Philanthropy has also played a major role in funding scientific research in the world’s universities and research institutes, which has produced many of the medicines and technologies that have contributed to huge advances in medicine in the last 100 years.

This has resulted in unprecedented improvements in human and animal health, and is a trend that continues today as philanthropic money from groups such as the Wellcome Trust and Gates Foundation funds research into Covid-19 treatments and vaccines.

**Equitable distribution of healthcare benefits**

But in addition to funding services and research that increase the supply of effective health services, philanthropy can and should play a major role in ensuring that the benefits of advances in medicine are distributed equitably around the world, and in particular that they reach the poor and vulnerable.

Philanthropy can and should play a major role in ensuring that the benefits of advances in medicine are distributed equitably around the world, and in particular that they reach the poor and vulnerable.
I was proud to oversee the adoption of the SDGs when I was secretary-general of the United Nations, and remain convinced today that only through publicly-funded universal health coverage can we build the necessary resilience of health systems and healthy populations to withstand future pandemics.

**Free at point of delivery**

As part of moves towards Universal Health Coverage (UHC), countries should remove health service user fees and ensure that everyone can access services free at the point of delivery. Philanthropists who fund health services in the developing world can amplify this message to heads of state and policymakers when discussing their funding priorities.

Removing financial barriers to health services is particularly important in the midst of a pandemic, especially for disadvantaged groups such as women, children and the elderly.

Furthermore, a large proportion of additional resources should be spent on primary healthcare services, including on vital public health services, which must be better integrated within overall UHC reforms. For far too long, public health has been the poor relation of hospital services – this imbalance needs to be rectified as a priority.

Within this framework, there are some excellent examples of foundations and philanthropists using their resources to improve access to services for vulnerable populations; for example the public health programme of Open Society Foundations who ‘support communities that receive substandard care or face barriers to services because of who they are’.

But whilst philanthropic health financing is extremely valuable, the essential step to achieving UHC is when countries switch to a publicly-financed health system based on collective solidarity. Philanthropists and the sector can complement the state but they cannot replace it. As we have seen throughout 2020 as the world grapples with this pandemic, democratic accountability and transparency are essential to retain public trust and confidence in the health system.

**...and pay your taxes!**

Philanthropists can play their part to strengthen the system by deploying their considerable resources to specific areas of research and development when public finances are stretched, but more importantly they can commit to paying their fair and full share of taxes in their home countries and not exploit loopholes or offshore schemes.

The Patriotic Millionaires group offer a salutary example for other wealthy global citizens to follow, with their affirmation that ‘taxes are the best and only appropriate way to ensure adequate investment in the things our societies need’.

The coronavirus pandemic has taught us all that we are only as strong as the weakest link in our human chain. But as we face the future, I am confident that the innovation, dynamism and public-spiritedness of modern philanthropy can help ensure that we can all emerge strengthened to build back better.

1 tinyurl.com/UBS-billionaires-report

*Above: Ban Ki-moon visits an HIV clinic in San Francisco.*
Mental health

Human rights are at the heart of it

We don’t just need to invest in more and better treatments for mental health disorders, we need an approach that’s grounded in treating people with dignity.

The 2018 G7 Charlevoix Summit Communiqué set out the commitment of the world’s most developed economies to ‘bring greater attention to mental health’ in their mission to contribute to sustainable global growth. Soon after, the British Government and the World Health Organization (WHO) hosted the first Global Ministerial Mental Health Summit in London, which in its own words, served as a ‘call to action’ in the quest to ‘achieving equality for mental health’.

More recently, UN secretary-general António Guterres reminded governments that, following the coronavirus pandemic, ‘grief, anxiety and depression will continue to affect people and communities’ for a long time to come and that failure to engage with this question will undoubtedly cause longer-term social, political and economic damage.

Despite high-level commitments, however, and notwithstanding the collective era of global trauma in which we find ourselves, the WHO points out that mental health continues to be neglected: few states invest more than 2 per cent of their national health budgets in mental health service provision, and less than 1 per cent of development assistance in the field of health goes to mental health.

Even prior to the pandemic, the investment case appeared strong, with the WHO estimating the global cost of the ‘mental health gap’ at $1-8.5 trillion in lost economic productivity each year, a figure predicted to double by 2030 without concerted action. Yet, a note of caution must be struck, particularly in the Global South.

The risks of the public health narrative

An approach grounded overwhelmingly in the narrative of (global) public health runs the risk of disempowering, even further stigmatising, the very people who
should be the beneficiaries of investment. There is a perceptible bias on the part of some donors to stress a biomedical model of mental health which emphasises the need to provide ‘care’, ‘treatment’ and ‘access’ to drug therapies for people regarded as ‘mentally disordered’ and focuses attention around conventional psychiatric interventions including those based on coercion.

This approach will not catalyse the type of action which is needed to dismantle the structural forms of discrimination, social marginalisation and attitudinal biases which so profoundly affect the lives of people. In short, we do not only need to pump funding into mental health, and by extension into psychiatric hospitals all over developing countries. What we need are investments which are explicitly grounded in human rights – mostly notably the Convention on the Rights of Persons with Disabilities (CRPD).

Towards an inclusive, rights-based notion
This may sound like a technical, almost rhetorical, shift, but the consequences are profound.

A human rights-based approach would first and foremost stress the direct involvement of the people being served. All too often, the debate is dominated by mental health advocates – psychiatrists, family members, social workers: those who speak on behalf of beneficiaries, not those who receive public services. By involving persons with psychosocial disabilities from the beginning, donors simultaneously tackle discriminatory notions concerning mental health, improve the targeting of their investments and achieve a wider benefit by enhancing public engagement in the development agenda.

Learning the lessons from the HIV epidemic
Scepticism about a shift in emphasis from health to human rights is to be expected. But some crucial lessons can also be drawn from the response to another epidemic. In March this year, UNAIDS was one of the first UN entities to release a report entitled Rights in the time of COVID-19. The authors urged stakeholders to pursue ‘a community-centred and informed response, one that embraces solidarity and kindness’. But this is not just about operating at the level of good intentions. As they explain: ‘Forty years of responding to the HIV epidemic has generated significant experience and lessons learned on the importance of a human rights-based approach to ensuring effective and proportionate responses to epidemics.’ Indeed, it is this very approach which has begun to make inroads around the world, where a pure health response has steadily given way to a more inclusive notion that emphasises livelihoods, citizenship, empowerment, and education, while directly tackling stigma, isolation and discrimination.

A similar logic can – and should – be applied when coordinating philanthropic efforts to improve the mental well-being of our societies. Instead of the dominant focus on expanding health provision alone, greater emphasis should be placed on achieving the inclusion of persons with psychosocial disabilities within our societies. This will require donors to look far beyond the health paradigm, and should raise questions about other investments that can be made, such as developing personal assistance schemes, improving housing and strengthening civic engagement.

A human rights-based approach to disability inclusion is undoubtedly a far more complex undertaking than simply increasing mental health budgets. Yet, the signs are there that it will be a far wiser investment in the long term.

The Validity Foundation is a human rights organisation which deploys legal strategies to promote, protect and defend the human rights of persons with disabilities worldwide.

An approach grounded overwhelmingly in the narrative of (global) public health runs the risk of disempowering, even further stigmatising, the very people who should be the beneficiaries of investment.
Eating disorders are a serious mental health issue which has been exacerbated by confinement during the pandemic. Alliance talks to Dutch business leader and philanthropist Gerard van Breen who has helped set up a Netherlands-based foundation to work on the issue.

Alliance: What led you to become interested in tackling eating disorders?

Gerard van Breen: After my retirement, I was looking to do something completely different and give something back. Through a friend, I became aware of plans to advance the field of eating disorders in The Netherlands. Having a daughter who suffered from Anorexia Nervosa, I saw the need to give more attention to the illness and other eating disorders. In the UK 1.25 million people suffer from an eating disorder and in The Netherlands more than 200,000. People do not recognise that eating disorders are a mental illness with the highest mortality rate of all mental illnesses in the western world.

What does the name of the new foundation Stichting Kiem mean? And why did you feel that a philanthropic vehicle was needed to address eating disorders?

Kiem refers to the initial growth phase of a seed and eating disorders often prevent the metaphorical seed from blooming. We want to support sufferers and their families to cure or find ways to cope with the eating disorder. But it should also become the reference for up-to-date knowledge in the field. To achieve these goals, having supporters that are committed to the cause and share this vision is important.

People do not recognise that eating disorders are a mental illness with the highest mortality rate of all mental illnesses in the western world.

Which philanthropists are involved in the initiative? How much are they each contributing?

A Dutch family foundation provided the means to establish the organisation and to run it for the initial three-year period. Recently we have received support from a second family. Many people see close up the effects and the struggles that often accompany a loved one suffering from an eating disorder. Stichting Kiem intends to attract funds from multiple sources and we are of course open to discuss support for our work with interested partners.

What will be the main focus of your activities?

Stichting Kiem has three main goals: first, providing insights into the prevalence, incidence and mortality of the disease; drawing the attention of politicians and policymakers to this serious illness; providing early-recognition tools and training for key stakeholders; second, providing online and on-the-ground support for families.
Fashion models, cosmetics models, influencers, sports icons and the like definitely play a role in the perception of what is considered aspirational and desirable.

that are dealing with a relative with an eating disorder and providing a digital platform for finding the best possible treatment, the so-called Helpfinder and, third, promoting the exchange and implementation of best practice in treatment, first within The Netherlands and later on, also internationally. In the medium term, we may fund research into the field of eating disorders for a more fundamental understanding of underlying patterns to help prevention.

Has Covid created more public understanding given the increase in eating disorders being reported? If anything, Covid has created more stress in families that are dealing with an eating disorder. Being at home and having more meals together is likely to cause more stress for sufferers and their families. Also, for the day-care patients Covid can cause loneliness and affect motivation. And if hospitalisation is needed, it extends the waiting times for admission, which were already far too long.

Your initiative is notable for philanthropic cooperation and dialogue between The Netherlands and the UK. How is this working and what role is UK charity Beat playing in the effort? We are inspired by the groundbreaking work that Beat has done in the area of addressing eating disorders in the UK and through a cooperation agreement we plan to build on the work they have done and bring some of the insights and recommendations to The Netherlands. We have regular consultation and exchange of ideas with them to mutually progress in the field and accelerate our efforts. We are hoping this type of partnership, a form of joint learning which is highly informative as well as inspiring, might prove to be a model that could be used in other countries.

You have a background in health and beauty retailing. Do you think that the cosmetic industry should create more realistic images of young women, and does philanthropy have a role in pressing for changes? I believe the pressure on young people nowadays is enormous. In our predominantly individualistic society people are held (or hold themselves) responsible for their own well-being. The use of social media and the ‘selfie-culture’ have magnified this tendency. Role models like fashion models, cosmetics models, influencers, sports icons and the like definitely play a role in the perception of what is considered aspirational and desirable. In the industry we see the first signs of change (Unilever with Dove advertising, minimum body mass index requirements for fashion models) but I believe it is too little and too late. I think that we should aim to raise our kids in such a way that we make them resilient to these influences in order to develop healthy and balanced response mechanisms. However, overall our ambition at the moment is first and foremost focused on prevention and early detection of eating disorders and secondly, on those interventions which are the most rigorous and effective.

Tom Barrett
Betting on a pandemic – cast in its worst light, that’s what a pandemic bond does. In its best light, a pandemic bond is an earnest effort to fill the gap between what countries promise to pay in aid during a crisis and what they actually pay.

Early in the Covid-19 pandemic, the mounting death toll prompted a Guardian headline to declare, ‘World Bank’s $500m pandemic scheme accused of “waiting for people to die”’. Similarly, as the number of deaths from Ebola increased in the Democratic Republic of Congo (DRC) in 2019, there was outrage in prominent journals. ‘The World Bank has the money to fight Ebola but won’t use it’ wrote eminent science writer, Laurie Garrett in Foreign Policy.

So what are we to make of the financial innovation called the pandemic bond? Hailed by former World Bank president Jim Kim as an instrument that ‘would rapidly respond to future outbreaks by delivering money to countries in crisis’, critics judge the bond harshly, raising many points we agree with. For example, in the DRC case, the official death toll increased to more than 2,400 but money from the bond was not released, because the epidemic did not meet predetermined benchmarks for payout. From non-bond sources, the World Bank has released more than $410 million for Ebola in the DRC. As the Bank pledged billions in emergency financing assistance for Covid-19 in early March 2020, the pandemic bond it created only paid out $196 million in late April and May 2020.

But what these critiques have not sufficiently considered is that the bond’s failure to launch is legal, and the World Bank is not alone in advocating such solutions. Rather, they are likely the future of humanitarian health aid and disaster relief.

**Pandemic Emergency Financing Facility**

The Pandemic Emergency Financing Facility (PEF) pandemic bond was facilitated by the World Bank to pre-pool money for rapid response ahead of a disease outbreak. It is a response to a dilemma: when health crises occur, many countries promise financial support but do not pay. The call for cash-on-demand intensified during the 2014-16 west African Ebola pandemic, and the World Bank issued the world’s first pandemic bond in July 2017, raising $425 million from private investors. The financial terms of the pandemic bond are complex, but, in short, large private investors rather than nation states put money in upfront for three years. If a qualifying pandemic occurs during that time, some of the money is disbursed for pandemic response. Otherwise, the investors get their money back plus interest of 10 per cent or more.

**Contractual constraints**

Everyone concerned with public health agrees that pre-committed pandemic funds are a good idea but three crucial components of the bond need to be more widely understood. First, Garrett’s claim that ‘the World Bank has the money to fight Ebola but won’t use it’ ignores the bond’s disbursement criteria. The PEF bond is a financial relationship governed by a legally
binding agreement between the World Bank and its investors. Regardless of the severity of an epidemic, the release of pandemic bond funds is contractual and rules-based. If the predetermined disbursement criteria (which include confirmed deaths, cross-border spread, and disease growth rate) have not been met, the Bank has no authority to release investors’ money. These criteria result from the fact that the bond contract was not written for pandemic responders or the sick. Rather, its design was driven by financial industry priorities to constrain the uncertainties that arise for investors when they put up millions of dollars that they could lose. These priorities are largely alien to global public health practitioners fighting to keep people alive.

**Legal black boxes**
Second, from late 2014 to early 2017, the individuals designing the bond debated and made choices about the terms of the contract between the World Bank and investors. The contract stipulates that a third party – formally called a calculation agent – adjudicates whether disbursement criteria are met. By design, such agents are meant to take the decision to deploy funds away from the World Bank and investors. Their involvement is understandable but problematic: the calculation agent is a private data modelling firm that maintains proprietary rights over its adjudicating models. Therefore, aid triggers are black-boxed outside of public oversight.

Third, we are amid a transformation of humanitarian aid funding. The pandemic bond is not an anomaly. Financial innovation in humanitarian aid is increasing. The next version of the PEF is in development at the World Bank. Other pre-financed models, such as the African Risk Capacity (ARC) mutual sovereign drought insurance pool, use similar parametric modelling mechanisms to trigger release of funds.

The Famine Action Mechanism (FAM) is a new multilateral organisation partnership with Amazon, Microsoft, Google, and the insurance sector. In theory, it will use artificial intelligence to identify impending food crises and trigger the release of the Bank’s $1.5 billion in earmarked funds to avert famine through early response. If the PEF and ARC raise concerns about triggering aid through black-boxed technical schemes, concerns will inevitably multiply as profit-driven private technology giants become stakeholders in humanitarian outcomes.

**Public health response?**
Indignation from the public health sector is unlikely to quash new forms of aid, but health partisans can engage with and interrogate the language and priorities of finance. They can require that the bonds’ triggers be publicly negotiated and open access. They can push for disbursement criteria that place the needs of the sick before the demands of investors. They can fight for consultation with communities where pandemics occur. But public health influence on these financial instruments will require getting involved in the politics of global health and humanitarian aid, activities which for too long have been considered dirty upstream hustles rather than profound first-order health prevention.

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**Amount raised from private investors after World Bank issued world’s first pandemic bond in July 2017**

$425m