global POLICY

WHO's 'Investment Round' - will mimicking global health partnerships' replenishment model pay off?

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Abstract

In November 2024, the World Health Organization (WHO) will hold its first "investment round" with the goal of raising USD 7.1 billion. The agency hopes to secure more predictable funding, flexible grants, and widen its donor base after decades of struggling to attract funding. The WHO's "investment round" mimics the fundraising approach of global health partnerships like Gavi and the Global Fund, which raise voluntary donor contributions in multiyear funding cycles known as replenishments. However, it is unclear whether this model will work for the WHO. This article argues that the WHO competes on unfair grounds with the partnerships that are also currently seeking replenishment within an increasingly tight funding environment. Compared with the WHO, the partnerships can more easily demonstrate a "return on investment" and draw on years of experience fundraising this way, backed by support from powerful global advocacy coalitions and the Gates Foundation. A replenishment-style model also pushes the WHO towards a problematic private sector "investment" logic. The article argues that the WHO should be fully funded for the unquantifiable services it delivers to as a normative agency and coordinator of global health efforts – rather than for doubtful estimates of its impact in terms of lives saved.

Policy Recommendations

- The WHO should use its investment case as an advocacy tool cautiously, as it might alter its priorities and weaken its legitimacy as a public and normative agency.
- All countries should increase their membership dues to WHO's budget, as agreed in 2022. In addition, middle-income countries should increase their voluntary contributions, while major donors should uphold the high levels of theirs, but change their grants to make them more flexible, longer, and more predictable.
- The WHO should establish clear indicators to evaluate the impact of its 'investment round', showing transparently whether the funding secured is more flexible, predictable, and resilient than before.

Introduction

The World Health Organization's (WHO) first "investment round" will conclude at the G20 summit in Brazil 18-19 November 2024 with the goal of raising USD 7.1 billion. The investment round mimics the "replenishment" model made popular by global health partnerships like Gavi, the Vaccine Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). But is adopting a replenishment model a good strategy for the WHO?

In this article, we explain the origins of the replenishment model in global health, why the WHO has adopted this model, what it hopes to achieve, and why this might prove difficult. In a "replenishment traffic jam" that will see a dozen major development funds aim to raise over $100 billion from donors over the next two years (Keller, Landers, and Martinez 2024), the WHO enters the competition on unfair grounds. It will be pitted against competitors who can more easily demonstrate a "return on investment" and can draw on over a decade of experience fundraising in this way, backed by support from powerful advocacy coalitions and private philanthropic foundations, notably the Gates Foundation. We argue that adopting a private sector "investment" logic is problematic for a public agency like the WHO, which draws its legitimacy from its normative work and its democratic governance structure. Instead, we suggest, Member States should contribute membership dues (assessed contributions) and voluntary contributions to fund the WHO for the important, unquantifiable service it delivers to the world as a normative agency and coordinator of global health efforts – rather than for doubtful estimates of its impact in terms of lives saved.

What is replenishment?

The replenishment model that has become popular in global health can be traced to the World Bank's International Development Association (IDA), which was the first international organization to adopt such an approach to fundraising in the 1960s. The IDA convenes donors every three years to review its policies and negotiate a budget based on their pledges. Currently, its "ask" for its 24th replenishment period is for USD 100 billion (World Bank 2024).

In global health, the replenishment model was first introduced by public-private partnerships, often referred to as thematic global health initiatives, partnerships, or funds. The Global Fund first asked its donors to "replenish" its budget in 2005, three years after it was established, and has worked in three-year replenishment cycles ever since. Gavi introduced a similar model in 2011 with five-year strategic periods. Both the Global Fund and Gavi rely entirely on voluntary contributions from donors, such that replenishment periods ensure the financial predictability needed to implement their programs. It proved to be a successful fundraising model, facilitating both partnerships' tremendous financial growth over the past two decades, which has outpaced that of the WHO (Figure 1). Replenishment also became a blueprint for the new global health partnerships established during the past decade, notably the Coalition for Epidemic Preparedness Innovation (CEPI), the Global Financing Facility (GFF) and the Pandemic Fund.

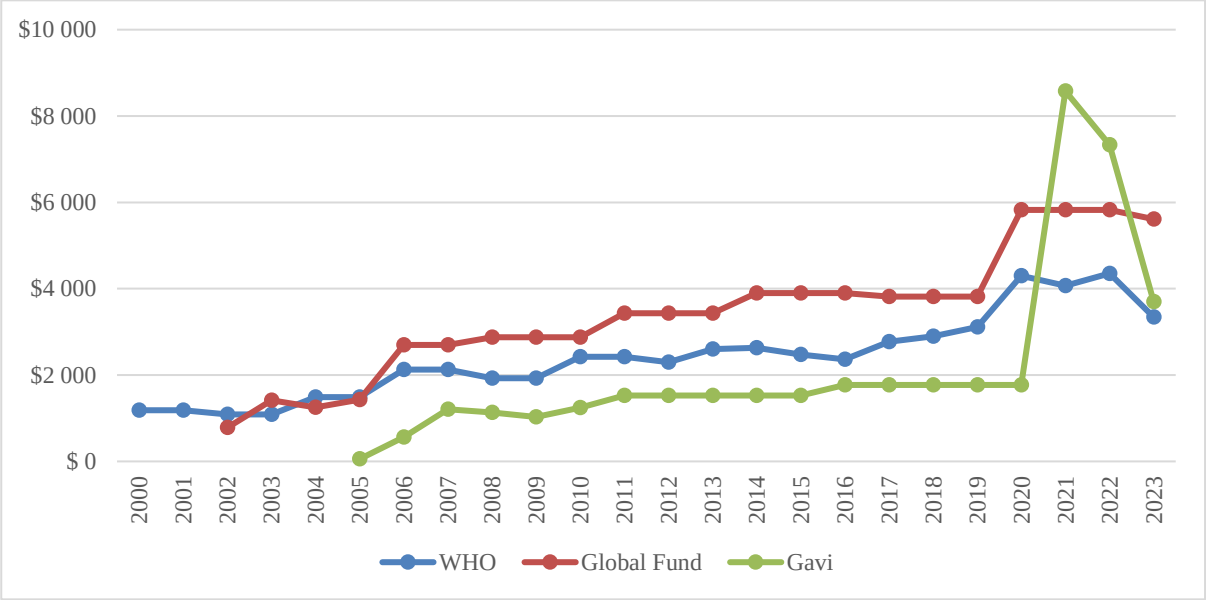

Figure 1: Evolution of WHO's, Global Fund's and Gavi's revenue (2000-2023). Source: The authors, compiled from the financial audited statements from the WHO, Gavi and the Global Fund.[1]

Over time, global health partnerships have perfected the replenishment blueprint. It begins with the development of a strategy and investment case demonstrating how funding will help achieve measurable outcomes and 'value for money'. This is followed by an extensive, often year-long, advocacy campaign that includes visits to key donor countries; intensive media campaigns emphasizing impact metrics; and participation at high-level political events from Davos and Geneva to New York. For example, as part of its current replenishment campaign, Gavi sent a delegation of 14 staff to the UN General Assembly, participating in over 50 events (Nishtar 2024). For the past decade, Gavi has also hired a lobbying firm in Washington DC to ensure continued financial and bipartisan support in the US – a practice also adopted by other partnerships such as CEPI, FIND, Unitaid and Medicine for Malaria Venture (de Bengy Puyvallée 2024). Replenishment cycles culminate in grandiose pledging events bringing together heads of states or high-level political representatives who unveil their financial contributions during a highly ritualized show set-up to create visibility for donors' generosity. At the GFF replenishment event we attended in 2018, the moderator invited donors to the podium to announce their pledge with an invitation to "Show me the money," to huge applause from the audience (Storeng 2018).

These are the dynamics the WHO is mimicking with its "investment round" – from the strategy, investment case, advocacy campaign and final pledging event. It has even hired Gavi's replenishment director as its new Director of Resource Mobilization (Thornton 2024).

[1] The figure is based on annual revenues compiled from the audited financial statements from WHO, Gavi and the Global Fund. For the WHO, this includes the revenues to fund its base budget, special programs, emergency operations and global polio eradication program. The WHO's investment round only seek to raise funds for its base budget – the other components being fundraised an on *ad hoc* basis, depending on external events and emergency needs. Gavi and the Global Fund, on the other hand, work through strategic periods (replenishment cycles). It therefore made more sense to calculate and display their average annual revenue for each period, rather than to highlight annual variations.

Why an "investment round"?

Why has the WHO opted for an "investment round"? The short answer is to deal with its persistent funding challenges.

The WHO is an intergovernmental organization whose budget should, in theory, be funded by Member States' membership dues (Lee 2009). These 'assessed contributions' are calculated based on countries' capacity to pay and provide the most flexible and predictable form of funding to the WHO. However, the value of these membership dues has stagnated over time, leading to a steady decline of their share in WHO's total budget (Eckl 2024). By 2023, the majority (85%) of the total budget came from voluntary contributions from a small group of donors including wealthy country governments, the Gates Foundation and Gavi, the Vaccine Alliance (WHO 2024a). Despite their rapid economic growth since the 1990s, rising powers such as China, India, and Brazil have been reluctant to provide voluntary contributions, which remain marginal (Eckl 2024). Indeed, lower middle-income countries provide more voluntary funding than upper middle-income countries (Iwunna, Kennedy and Harmer (2023)

Such "extrabudgetary" voluntary funding tends to be unpredictable, short-term, and earmarked for specific programs, forcing WHO program managers to fundraise to finance their own salaries and programs through thousands of grants (Iwunna, Kennedy and Harmer 2023; Hanrieder 2015). Earmarking reinforces donors' influence over priority-setting (Sridhar and Woods 2013; Graham 2014). This constrains the WHO's ability to allocate funding strategically in line with member-state endorsed programs of work and leaves important areas of work underfunded (Chorev 2012).

In light of the WHO's financing challenges, Member States agreed at the World Health Assembly in 2022 to a two-track plan to strengthen the WHO's financing model.

First, Member States agreed in a landmark decision in 2022 to gradually increase their membership dues from 16% (2020-2021) to 50% (2030-2031) of the approved program budget (WHO 2022). This effort, if implemented, would dramatically strengthen the WHO's autonomy by ensuring a more sustainable funding model.

The second part of the plan is to mobilize more resources through voluntary donations while also changing how these funds are provided and their "quality". The aim is to make voluntary contributions 1) more predictable, by raising resources upfront for a four-year period (2025-2028); 2) flexible, by increasing the share of fully flexible and thematic contributions (instead of earmarked to specified projects); and 3) resilient, by expanding the donor base, including by attracting contributions from member states who could, but haven't so far, made such contributions, as well as greater philanthropic investment (WHO 2024b).

The WHO has much to gain from streamlining its patchwork of grants, centralizing fundraising, and strengthening its autonomy in funding allocation – but is a replenishment model the best way to achieve this?

Is a private-sector investment logic right for a public organization?

Global health partnerships' replenishment model is firmly rooted in the wider business logic that permeates to the core of the idea of public-private partnership. Ahead of each replenishment period, the Global Fund and Gavi develop a strategy including a vision, clear goals and priorities that guide the organization's work for the next cycle (3-5 years). The strategy sets concrete objectives for the secretariat monitored through key

performance indicators (KPIs), which are key sources for the organizations' results-based legitimacy (Bruen et al. 2014).

This is followed by the presentation of an "investment case" to showcase the potential benefits of funding the organization. Investment cases apply a market logic to health by seeking to quantify the impact of dollars invested. For instance, Gavi promises that with a budget of USD 11.9 billion over the next four years, it will save 8-9 million lives, vaccinate 500 million children, and generate 100 billion in economic benefits (Gavi 2024). Similarly, in 2022 the Global Fund promised to save 20 million lives over three years with its requested USD 18 billion (Global Fund 2022). In this investment logic, a key measure is "return on investment," or the value for money the organizations provide to donors. Gavi claims that for each dollar invested, it generates 54 dollars (1:54), while the Global Fund claims a return on investment of 1:31.

The WHO's current investment case in support of its most recent four-year strategy (its 14th General Program of Work) mimics this logic closely. The investment case claims that the WHO will save at least 40 million lives and provide a return on investment of 1:35 – even higher than that promised by the Global Fund (WHO 2024c).[2]

Gavi and the Global Fund can estimate the cost of purchasing and distributing a vaccine or a drug – and forecast the benefits of its intervention based on clinical or epidemiological studies. By contrast, quantifying WHO's impact in econometric terms is difficult due to the nature of WHO's work, which focuses on technical, normative and coordination functions, and therefore has a more diffuse and indirect impact.

To overcome this challenge, WHO's investment case adopts an extremely wide definition of its impact, incorporating the impact of *any* policy for which the WHO issued guidance, "regardless of the payer or role of different agencies and national governments in implementation" (WHO 2024d). In other words, WHO takes credit for the lives saved with the financial support provided by and programs implemented by others. Indeed, the WHO draws explicitly on the investment cases of the Global Fund and Gavi and takes credit for a share of their impact. When the WHO claims to save 5 million lives due to its work on HIV/AIDS, tuberculosis, and malaria, the agency is appropriating a portion of the Global Fund's estimated future impact.

Similarly, the WHO draws from the impact of vaccination programs implemented by Gavi and national governments to claim 4.5 million lives saved through vaccination. This enables the WHO to claim it will save 40 million lives in four years with just USD 7.1 billion, even though Gavi saved 'only' 17 million lives between 2000 and 2020 with USD 21 billion. The multiple and partially overlapping investment cases presented by different global health initiatives begs the question as to how many times the same life can be saved.

This issue of multiple attribution in lives-saved metrics is not new. A decade ago, McCoy and colleagues (2013) analysed how the Global Fund calculates its impact and found that the partnership takes credit for every program related to its three focused diseases – including those paid for by national governments. WHO's latest

[2] This investment case is not the first of its kind for the WHO, with a first edition published in 2018 (WHO 2018) and a second in 2022 (WHO 2022b). These documents seem to have had unclear impact on WHO's fundraising effort – as the organization's base budget has not substantially increased since their publications.

investment case similarly underlines that the Global Fund's estimates are based on a counterfactual of zero coverage – if any intervention focusing on HIV/AIDS, TB and Malaria would cease to exist should its programs be discontinued.

The use of 'lives-saved' metrics for fundraising purposes also leads to unhealthy competition between organizations each vying to demonstrate the most impact, which creates a perverse incentive to inflate the numbers (Usher 2018, Storeng and Béhague, 2017). The "lives-saved" metric tends to inflate the performance of vertical-based, disease-focused interventions, and underplays the critical role of national governments and broader health systems interventions (McCoy et al 2013), while "playing the numbers game" by adopting such metrics in political advocacy detracts attention from the need for structural change to address health inequalities (Storeng and Béhague 2014). While the strategic adoption of "evidence-based advocacy" invoking claims of return on investment has clearly helped some health issues achieve political priority (Storeng and Béhague 2014), the extent to which donors really "buy" these estimates when choosing whether to replenish organizations remains an empirical question.

Finally, there is a risk that the pressure on the WHO to demonstrate a positive return on investment and tangible results expressed in terms of "lives saved" will distract the organization from its core work by pushing it to work on quantifiable interventions. We already see signs of this in the WHO's fundraising communication for the 'investment round', which emphasizes the WHO's operational capacities and interventions, like how many patients it treats, or how many solar panels it set up on health facilities. However, critics argue that this is not the type of work the WHO is mandated to perform or for which the WHO has a comparative advantage (Wenham and Davies 2023). It is certainly unlikely to outcompete global health partnerships on these grounds.

Whereas global health partnerships' corporate governance model and result-based legitimacy may justify a private-sector approach to "investing" in these organizations, the argument is much more problematic for a public organization like the WHO, which draws legitimacy from its normative work and inclusive, democratic governance model incorporating 194 member states. Shouldn't the WHO be funded for the important, unquantifiable service it delivers to the world – rather than for doubtful estimates of its impact in terms of lives saved? Isn't playing the investment card setting the organization up for a competition on unfair grounds against organizations that can more easily demonstrate "cost-effectiveness"?

Will the WHO have enough advocacy muscle?

During their past replenishments, global health partnerships such as the GFF, CEPI, Gavi and the Global Fund have devised sophisticated fundraising campaigns that have been amplified through external PR companies and a well-orchestrated civil society advocacy campaign. As public-private partnerships, the GFF, Gavi and the Global Fund work with – and fund – hundreds of NGOs to implement their projects, and civil society constituencies are represented on their boards. Many of these NGOs advocate for the partnerships' replenishment through media contributions, public events, and meetings with elected officials, often with support from private foundations, notably the Gates Foundation (Storeng and de Bengy Puyvallée 2018). The Global Fund even has a Friends of the Global Fund and the Global Fund Advocates Network, which are NGOs

set up to advocate on behalf of the Global Fund.

Both organizations also recruit celebrities to endorse and promote their missions, such as U2's singer Bono, who has been a champion for the Global Fund since 2006. They also seek the patronage of a donor country willing to host their final pledging event and use its diplomatic clout to ensure a successful replenishment. For instance, French President Emmanuel Macron is described has having played an important role as host in securing the Global Fund's successful replenishment in 2019. The Global Fund recounts that President Macron "electrified the conference with a stirring appeal", which prompted "donors [to] answer that urgent call to step up the fight – many making last-minute increases on top of their original pledges." (Global Fund 2019)

The WHO, by contrast, does not possess comparable support networks. Instead, the WHO relies on an in-house resource mobilization department comprising 87 staff across all levels of the organization, which an external review described as "lean relative to comparator agencies" (WHO 2023). The WHO has recruited "goodwill ambassadors" who are celebrities enlisted to "raise awareness about critical health issues," but their role in mobilizing resources is unclear (WHO 2024e). The WHO has also sought the patronage of countries, with France, Germany, and Norway announced as co-hosting its final 'investment round' event at the G20 in Brazil, recently adding Brazil, Mauritania, South Africa, and Saudi Arabia (WHO 2024b). Having multiple co-hosts might provide diplomatic backing across the world and help expand WHO's donor base, but it might also reduce the incentive of hosts to demonstrate generosity when the political prestige associated with doing so is more diluted.

What should the WHO expect for its investment round?

WHO's investment round takes place in an extremely challenging context. Mr Trump's remarkable comeback in the recent US election is not good news to the WHO. In May 2020, President Trump ordered the US to withdraw from the organization, accusing it of lacking transparency and siding with China – a decision later reversed by the Biden administration (Gostin et al. 2020). Moreover, donors cut their aid budgets massively in 2024 and have announced further cuts for 2025, while shifting their priorities away from global health and towards issues like humanitarian aid, refugees, and climate change (Keller, Landers, and Martinez 2024). Because WHO's voluntary contributions from Member States are largely funded by aid budgets, this poses a further challenge to the success of its investment round.

With the WHO, the Pandemic Fund, Gavi, the Global Fund and the IDA fundraising within the same year-long period, the WHO is a competitor in what has been called a "fundraising pileup" (Keller, Landers, and Martinez 2024). But the WHO is competing on an uneven playing field. It lacks its competitors' long-standing experience of orchestrating replenishment campaigns and struggles to communicate an equally compelling investment case.

The WHO's goals of gaining more predictability, flexibility and resilience in its funding are necessary, but there are reasons to doubt whether a replenishment model will achieve these goals. The challenges global health partnerships have experienced in previous replenishments provide some cautionary lessons.

Predictability. Experience has shown that pledges do not always translate into contributions. Gavi and the Global Fund have, for the most part, successfully turned

pledges into contributions negotiated through payment schedules spread over their strategic periods. Yet discrepancies occur. In their last completed strategic period (2020-2022), contributions to the Global Fund fell one billion short of the 17.5 billion pledged (5.7% deviation) (Global Fund 2024), while Gavi received 8.8 billion out of the 9.2 billion pledge (4.4% deviation) for the 2016-2020 period (Gavi 2024b). Agreed-upon contributions may also be disbursed later than agreed or renegotiated. Both organizations seek to hold donors accountable through transparent communication about pledges and contributions – a naming and shaming tactic that the WHO may benefit from implementing to ensure pledges are transformed into actual disbursements.

Flexibility. The WHO wants voluntary contributions that are as flexible as possible in terms of themes, geographic focus, or grant duration. This is a major difference from past partnership replenishment events, which are oriented around partnerships' much more narrowly defined mandates. The sheer complexity of donors' voluntary contributions to the WHO makes it difficult to track progress – at least initially – until all the grants are negotiated and signed. In effect, this means that unlike the global health partnerships that can celebrate a successful replenishment, the WHO will have to develop metrics and indicators to show over time – once the grants are signed – if voluntary contributions have indeed become more flexible. Current pledges from philanthropic foundations cast doubt that it will be the case. The Wellcome Trust, for instance, announced a USD 50 million contribution "for a range of projects under its 2025-28 programme of work," earmarking USD 25 million for climate and health (Wellcome Trust 2024), while the Gates Foundation "pledged an initial USD 42 million to support WHO's work in infectious diseases, vaccine delivery, maternal and child health and digital health" (WHO 2024f).

Resilience. A key aim of the investment round is to broaden the WHO's donor base. Currently, high-income countries and private donors based in high-income countries provide 90% of WHO's voluntary contributions (Iwunna, Kennedy and Harmer 2023), and WHO's ten largest donors provided 65% of its total budget (WHO 2024a). Here again, the experience from global health partnerships calls for caution, where their five largest donors still account for 70-90% of their funding despite efforts to expand the donor base (de Bengy Puyvallée, 2024). Similarly, efforts to attract private funding from corporate and philanthropic actors are likely to have limited effects. Overall, the share of private sector funding – excluding the philanthropic funding from the Gates Foundation – accounts for less than 3% of partnerships' budget, even though the private sector shares decision-making and exerts considerable influence within these organizations (Rushton and Williams 2011; de Bengy Puyvallée 2024). The establishment of the WHO Foundation in May 2020 has struggled to boost private giving but raises important questions in terms of governance – notably how the Foundation's due diligence and transparency practices have drifted away from WHO's governance norms, with little political oversight (Ralston et al. 2024).

Conclusion

The WHO has faced an unsustainable funding situation for at least three decades, with detrimental effects on the organization's performance and independence. WHO's adoption of a replenishment model is an attempt to address this issue, but time will tell whether this has been a successful strategy. At the time of writing, a few days ahead its

final pledging event in Brazil, donors have pledged only 1.1 billion towards the WHO's USD 7.1 billion target (WHO 2024b). By comparison, Gavi had already raised USD 2.7 billion towards its USD 9 billion target even though its final replenishment will not take place until 2025 (Gavi 2024c).

If the investment round does not deliver, the WHO may yet have to redirect its advocacy efforts towards convincing its Member States and partners to fund it simply to do the job that it is constitutionally mandated to do, that is work for the "attainment by all peoples of the highest possible level of health" by being the "directing and coordinating authority on international health work" (WHO 1946).

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