BROWNSTONE INSTITUTE

THE RIGHT TO HEALTH SOVEREIGNTY

POLICY REPORT

IHRP INTERNATIONAL HEALTH REFORM PROJECT

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FIGURES

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INTERNATIONAL HEALTH REFORM PROJECT PANEL

David Bell
Co-Chair

Ramesh Thakur
Co-Chair

Roger Bate
Garrett Wallace Brown
Héctor Carvallo
Thi Thuy Van Dinh
Harriet Green
Reginald Oduor
Wellington Oyibo
Elisabeth Paul

The Right to Health Sovereignty, Policy and Technical reports, are complementary and reflect the consensus of the IHRP panel. Specific assertions do not necessarily reflect the opinion of individual panel members.

Lead writer: RT. Co-writers: DB, GWB, RO, EP, TTVD, RB.

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Acronyms and Abbreviations

AFGHS	America First Global Health Strategy (2025)
BMJ	*British Medical Journal*
BRICS	Brazil, Russia, India, China, South Africa (group of nations)
CDC	US Centers for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
COP	Conference of the Parties
DG	Director-General
DRC	Democratic Republic of Congo
EIOS	Epidemic Intelligence from Open Sources
EU	European Union
FDA	US Food and Drug Administration
FENSA	Framework of Engagement with Non-State Actors
FCTC	Framework Convention on Tobacco Control
G7	Group of Seven Nations
G20	Group of Twenty Nations
GAVI	GAVI, the Vaccine Alliance
GPW	General Programme of Work
HIC	High-Income Country
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IAEA	International Atomic Energy Agency
ICC	International Criminal Court
ICJ	International Court of Justice
IHO	International Health Organization
IHR / IHRs	International Health Regulations
IHRP	International Health Reform Project
ILO	International Labour Organization
IMF	International Monetary Fund

IPCC	Intergovernmental Panel on Climate Change
LMICs	low- and middle-income countries
NGO / NGOs	Non-Governmental Organization(s)
NPT	Nuclear Non-Proliferation Treaty
ODA	fficial development assistance
P5	Permanent (five) members of the United Nations Security Council
PABS	Pathogen Access and Benefit Sharing System
PAHO	Pan American Health Organization
PHEIC	Public Health Emergency of International Concern
PHSM	Public Health and Social Measures
PPPR	Pandemic Prevention, Preparedness and Response
R2P	Responsibility to Protect
REPPARE	Re-evaluation of the Pandemic Preparedness and Response Agenda (University of Leeds)
SARS	Severe Acute Respiratory Syndrome
SEARO	South-East Asia Regional Office
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
US	United States
WEF	World Economic Forum
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

FOREWORD

International cooperation on health is a widely accepted global good. Capacity building and development assistance reduce historic health inequalities and, as a result, strengthen economies. Management of cross-border infectious disease threats is best done through joint surveillance, data sharing, and response. Collaboration on norms and standards provides efficiencies and facilitates trade in health products. However, the interaction between disease, the environment, and human populations is complex, and threats are heterogenous in their effects and gravity. Collaboration must therefore take such variability into account, with decision-making ultimately based around those affected.

Experience has demonstrated that international health cooperation can, when poorly governed, undermine trust, distort priorities, and produce significant unintended harm. Recent trends of centralized decision-making, emergency exceptionalism, and donor-driven agendas, exemplified during the Covid-19 response, displaced proportionality, local context, and established public-health ethics. These failures revealed structural weaknesses rather than temporary lapses.

At the same time, cooperation in public health also requires an understanding of the sovereignty and equality of individuals, and of the states that represent them – an understanding that underpins the United Nations itself. Thus, any institution tasked with managing health cooperation must be based on this understanding and be fully subject to the states it is intended to serve.

It should surprise no one that, after nearly 80 years of existence in a greatly changed world, the World Health Organization (WHO) is perceived by many to have drifted from its original model. Fundamental shifts in its

funding base, and now the exit of its largest state funder, present both an opportunity and an urgency to reassess the optimal way in which states should work together to serve the health needs of their populations, applying the fundamental principles on which public health should be based to a greatly changed and evolving world.

WHO and the state of international health cooperation

The WHO constitution, signed in 1946 by 51 states then comprising the United Nations, had little input from most current African and Asian states. Its governing body, the World Health Assembly, gradually expanded as states broke from colonialism or foreign mandates to achieve sovereignty. Defining health in its constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," the WHO took on a broad mandate including support for these less-resourced states, coordinating cross-border outbreak management, disease elimination, and the setting of international normative standards. It was hoped that the improvements in health and longevity that economic development had brought to wealthier countries could be accelerated in the lower income countries, reducing the inequalities resulting from colonialism and neglect.

The WHO's 150 country offices have formed a framework to strengthen local capacity and health systems. The organization is well known for successes such as smallpox eradication and early focus on the major drivers of well-being and longevity such as improved sanitation, nutrition, and access to basic healthcare. Major programmes in tuberculosis, malaria, vaccination, and child health have set standards for disease management and reduced overall disease burdens. A global decline in infectious disease mortality, continuing today, is testament to the success of multilateral cooperation in improving the basic drivers of longevity, reducing poverty, and improving healthcare access.

However, a drift over recent decades towards a focus on centralized, commodity-driven responses to relatively low-burden disease outbreaks, rather than the major drivers of health resilience and the high-burden endemic diseases that paralyze many countries, raises questions as to the influence of both state and non-state actors in directing WHO priorities

through specified funding. A parallel rise of public-private partnerships and private philanthropy has further driven these changes. Such homogenous commodity-based responses to highly heterogeneous disease risks are an inevitable outcome of the shift in how WHO policy is financed and therefore influenced. This must be reversed if international health cooperation is to fulfill its promise.

The International Health Reform Project (IHRP) report

The IHRP brings together independent professionals with experience in the WHO, UN, academia, and global health from a diverse range of countries. The policy report presented here, and the companion technical report, address the crisis in the management of international public health, reviewing the ethical principles upon which public health and the collaboration of states must be based and the key attributes of an international health organization (IHO) fit for such a purpose. The WHO is then assessed against this standard. The report is intended to provide a template that countries can use as a basis for discussions on deep reform, or the creation of a new organization which may replace the WHO in its entirety, or complement the WHO by taking on functions that are poorly compatible with an organization focussed on what should be the WHO's core mandate. Deep reform is necessary to return international public health to an ethical and effective footing.

Control needs to reside in states, with a decentralized structure that reflects their diversity and interests, whilst maintaining the advantages of global collaboration. An emphasis on building resilience of peoples to disease, and of states to promote and sustain the well-being of their populations, should form the basis of endemic disease control and mitigation of cross-border health threats. Human rights and medical ethics must be the fundamental building blocks of any such approach. Whether the radical reform needed to achieve this can be achieved through the WHO, or can only be achieved through a replacement organisation, is a question that only countries can debate and decide.

The report which we now present has been agreed by the ten IHRP panel members. As co-chairs we are indebted to our fellow panellists for the exceptional depth of knowledge, experience, and judgment they

brought to the preparation of this report over a long and gruelling year of meetings and conversations. They brought many different personal views to the table, and the report on which we have agreed does not necessarily reflect in all respects the preferred views of any one of them. This is particularly true of the optimum levels of autonomy and the terms of the engagement among the different levels of local, national, and international health actors; of the list and hierarchy of principles of international public health; and of the key question of the choice between reforming the WHO or establishing a new international health organisation (IHO). But we are agreed that the existing set of arrangements and practices is not the best that we can or should hope for.

David Bell & *Ramesh Thakur*
Co-Chairs

This Policy Report sets out the governance, ethical, and institutional failures revealed by recent global health practice and proposes principles for reform or replacement of the World Health Organization. It is complemented by a Technical Report providing detailed evidence and analysis.

The report proceeds in three stages:

(1) diagnosis of failures in current global health governance;
(2) articulation of ethical and constitutional principles; and
(3) institutional options consistent with these principles.

EXECUTIVE SUMMARY

Overview and purpose

The Right to Health Sovereignty argues for a new international health framework grounded in human rights and dignity, national sovereignty, and medical ethics. It contends that the current system – dominated by the World Health Organization (WHO) – has drifted from its founding mission of scientific neutrality and technical assistance. The Panel calls for a renewal of international public health cooperation, requiring either deep reform of the WHO or the creation of a new international health organisation (IHO) that reflects post-1945 human-rights norms and the ethical foundations of healthcare.

The report situates health not merely as a development or humanitarian issue but as an essential attribute of sovereign responsibility: the right and duty of every state to protect the health and welfare of its citizens while engaging cooperatively, but voluntarily, with others. Sovereignty in this report is not presented as a guarantee of good policy, but as a necessary condition for accountability, proportionality, and ethical consent. The IHO envisioned here would serve as a transparent, decentralized network of states – reflecting diversity of need, facilitating cooperation but never controlling them.

The Panel concludes that current arrangements for international health cooperation are failing to deliver proportionate, ethical, and accountable outcomes. Over-reliance on earmarked funding has distorted priorities; emergency preparedness has crowded out wider system capacity building and high-burden disease management; authority has become centralized without accountability; and public-health ethics are being compromised.

These are structural problems. Incremental technical reform alone is insufficient.

The policy challenge

The central question is: How can international health cooperation strengthen rather than dilute individual agency, and avoid eroding state sovereignty and responsibility? That is: How can we structure an international health organisation to help states meet their sovereign responsibility to support and protect the health of their people?

The answer lies in subsidiarity – ensuring that decisions are made at the lowest level capable of acting effectively, whilst facilitating global cooperation on joint priorities.

Under this principle:

- National governments coordinate health policy and finance, working through their network of facilities and practitioners.
- Regional bodies act as intermediaries between national and global priorities and manage cross-border cooperation. Regional governance is a sweet spot in that it can capture the benefits of economies of scale and collective action, while allowing for better policy contextualization via smaller, more focused, representational processes and need-based recognition.
- Global institutions play supportive and advisory roles, limited to technical assistance, capacity building, data sharing, and normative guidance. The aim is to support the medium-to-long-term goal of creating localized, self-reliant, and sustainable health systems.

This reverses the drift towards centralization and the creation of aid dependency cycles, reanchoring global health in the 1948 vision of sovereign equality under the UN Charter, whilst also recognizing the expansion of the international community since the WHO's inauguration.

The ethical foundation of public health

An international health organisation must rest on universal basic human rights, and the resultant principles that underpin all legitimate medicine and international cooperation. These principles derive from classical and modern bioethics, notably the Hippocratic Oath and Geneva Declarations

and the Universal Declaration of Human Rights. The report identifies four primary moral principles:

- Beneficence – the duty to act for the good of the patient and community.
- Non-maleficence – "First, do no harm;" the obligation to avoid preventable injury or suffering.
- Confidentiality – respect for privacy as the foundation of trust in medical relationships.
- Informed consent – recognition of individual autonomy and voluntary decision-making.

These principles represent the negative rights of the person – freedoms from coercion, manipulation, or experimentation – that must be protected in all public-health systems.

From these arise the consequent principles of international health: sovereignty, accountability, transparency, and the subordination of global administration to individual and state agency.

Rebuilding international health cooperation

The Panel outlines the roles and limits of a reformed WHO or a successor IHO consistent with these principles:

IHO role and functions

- Policy dialogue: Facilitate open consultation and coordination among countries.
- Normative guidance and harmonization: Develop and maintain international health standards, including the International Health Regulations, without coercive enforcement.
- Knowledge and data sharing: Serve as a repository of trusted information, free from commercial or private influence.
- Capacity building: Support national strategies and primary health systems, emphasizing technical assistance, training and health

system strengthening.

- Focus on root determinants: Prioritize the main drivers of improved health and resilience – sanitation, nutrition, education, economic well-being, and chronic-disease prevention – over bureaucratic emergency management.
- Disease prioritization: Concentrate resources on high-burden and preventable illnesses – both infectious and non-communicable – based on local need.
- Balanced emergency response: Outbreak response should be integrated within overall health-system resilience, not treated as a separate global command function.
- Monitoring and evaluation: Maintain transparent, centralized, and standardized data systems to track progress.
- National and regional response: Operational response to remain primarily at community, country, and regional levels.
- Sustainability: Promote time-bound interventions that build capacity and eventually render IHO assistance unnecessary, reducing dependency and encouraging national self-reliance.

The WHO's drift

This report, in conjunction with the Technical Report, chronicles the WHO's transformation from a technical agency into a politicized bureaucracy directed increasingly by non-state and vested interests.

- Early decades delivered triumphs like smallpox eradication.
- Later decades produced mission creep, dependence on earmarked funding (over 80 percent of its budget), and alignment with corporate and ideological agendas.
- The Covid-19 response – marked by contradictory messaging, censorship, and neglect of established pandemic science – revealed how far the WHO has strayed from its founding principles.

The pandemic accords of 2024-25 (the Pandemic Agreement and revised International Health Regulations) risk institutionalizing this drift by centralizing authority and legitimizing censorship under the pretext of

combating "misinformation," consolidating priorities of invested funders whilst misrepresenting relative health risks and expected returns on further investment to member states. The Pandemic Agreement is also a raw deal for many low- and middle-income countries, which make up most of the world's population. It entrenches unfair practices while burdening lower resource states with unrealistic demands and expenditure, for example with respect to One Health.

Sovereignty and the new global context

Since 1945, global interdependence has deepened, but so too has resistance to technocratic governance detached from democratic legitimacy. Across democracies, a populist or people-centred reassertion of sovereignty should be seen as a challenge to supranational overreach. The report considers this to be an opportunity to engage in healthy dialogue to address present shortcomings and undue mission creep. Cooperation remains essential. However, cooperation that is voluntary, accountable, and anchored in the sovereign equality of states, so that they are better able to self-fulfill their responsibility for the health and development needs of their peoples.

The US withdrawal from the WHO illustrates further demands consistent with this vision: international coordination that is scientific, transparent, and accountable, not politicized or donor-driven.

Principles for IHO structure and governance

To embody these values, the governance and structure of the proposed IHO would differ from that of the WHO.

Structure

» Decentralized organisation: Regional offices hold operational responsibility, consistent with existing regional WHO or sub-regional groupings [e.g., the Pan-American Health Organization (PAHO), the South-East Asia Regional Office (SEARO), West, Central, and East African].

- Smaller, modular staffing: Focus resources at regional and national levels rather than an inflated Geneva-style headquarters.
- Direct country representation: Smaller voting blocs to balance influence among large and small states.
- Streamlined secretariat: Leadership limited to coordination, knowledge management, and facilitation.

Constitution

- Embed fundamental human rights based on individual sovereignty and consequent medical and public health ethics discussed in this report into the constitution as inviolable guiding principles for policy and implementation.
- Codify equality of states, the organisation's independence from non-state actors, and improved checks and balances to prevent capture.
- Explicit and more robust conflict-of-interest clauses and financial transparency requirements.

Funding

- Prefer assessed national contributions to preserve independence.
- If voluntary or private funds are accepted, they must remain unspecified and within capped, transparent limits.
- Budget formulas should allocate resources to reflect needs of high-burden, low-income regions with emphasis on time-bound capacity-building programmes structured to achieve self-reliance.

Staffing

- Enforce term limits, rotation, and periodic external service to avoid institutional ossification.
- Prioritize technical competence and field experience over political patronage.
- Create clear conflict-of-interest disclosure and cooling-off requirements for staff moving to or from private industry.

Transition from WHO to IHO

The report acknowledges the obstacles to reforming or replacing the WHO:

- Centralized structures and ossified bureaucracy will resist power redistribution.
- A dense ecosystem of public-private partnerships and non-state actors (e.g., World Bank, Wellcome Trust, Gates Foundation) has vested interests in the existing model.
- Leadership culture steeped in close private-sector collaboration has normalized opacity and fear-based communication.

The Panel notes the League of Nations precedent: major institutional reform can be achieved under the banner of "replacement." A new organisation can retain valuable assets – such as national and regional office networks – while resetting governance and purpose.

Regional structures could be rationalized (e.g., dividing Africa into more coherent West, East, Central, and Southern blocs; decoupling Central Asia from Europe).

A reformed funding formula could direct higher proportions towards populous, high-burden regions.

Recommendations

A. Underlying principles

1. Base all international health activity on four cardinal ethical principles:
» Beneficence
» Non-maleficence
» Confidentiality
» Informed consent
2. Recognize these four cardinal principles as fundamental rights that protect individuals from coercion and serve as the ethical substrate for international cooperation.
3. Affirm the UN Charter principle of sovereign equality of states and the post-WWII human rights framework as the constitutional

foundation of any IHO.
4. Present a set of principles for international public health cooperation based on this foundation.

B. Role of an IHO

1. Facilitate dialogue and technical cooperation among states while preserving national ownership and autonomy.
2. Provide normative guidance and promote harmonized health standards, including international health regulations, without coercive enforcement.
3. Act as a transparent repository for verified data and scientific evidence.
4. Support states in health system strengthening and developing and implementing national health strategies.
5. Focus on root determinants of health – sanitation, nutrition, education, and chronic disease prevention – over prioritizing emergency micromanagement.
6. Prioritize interventions against high-burden diseases with the greatest impact on life expectancy and poverty reduction.
7. Integrate proportionate levels of pandemic preparedness within the overall context of health-system resilience.
8. Maintain centralized monitoring and evaluation but devolve operational response to regional and national levels.
9. Build sustainable national capacity and plan for the eventual redundancy of IHO interventions as health outcomes improve.

C. Governance and structure

1. Establish a decentralized, regionally focused structure aligned with existing economic and health blocs.
2. Ensure equitable staffing representation through smaller blocs.
3. Maintain a staff and budget proportionate to mandate, with concentration at regional and country levels.
4. Codify equality of states and checks against conflict of interest in a constitution.

5. Incorporate term limits and rotation policies for staff and leadership.

D. Funding

1. Prioritize assessed national contributions to maintain independence.
2. Limit voluntary and private funding to transparent, capped proportions that remain unspecified.
3. Allocate funding using formulas that favour high-burden, low-income regions.
4. Require full public disclosure of all donors as a partial check against the major contributors influencing priorities unduly.

E. Transition and reform

1. Pursue reform through an external, state-led process rather than internal WHO mechanisms.
2. Retain useful components of the WHO's current architecture (e.g., country offices) but reconstitute governance and finance.
3. Decentralize regional offices for genuine subsidiarity while maximizing the benefits of economies of scale (e.g., divide Africa and Europe into smaller sub-regions).
4. Use transitional arrangements that include conflict-of-interest rules, equality of states, and super-majority amendment requirements.
5. Ensure that leadership, staffing, and decision-making are independent of non-state (e.g. private sector or philanthropic foundation) direction.

F. Long-term vision

1. Build an IHO that acts primarily as a forum and facilitator, not a governing authority.
2. Emphasize capacity-building over control, self-reliance, and sovereignty over supranationalism.
3. Design time-limited programmes that strengthen local systems

rather than perpetuate dependency.

4. Measure success not by expansion of the IHO but by its progressive redundancy as national capacities mature.

Conclusion

The Right to Health Sovereignty concludes that the restoration of trust in international health governance depends on rediscovering the moral foundations of medicine and public health, and the sovereign responsibilities of the nation state. The WHO's model – centralized, donor-captured, and ideologically driven – may not be able to meet that challenge.

The future of global health lies in an ethical, sovereign, decentralized architecture designed to serve people through their states, not to govern them. An International Health Organization built on sovereignty, subsidiarity, and ethics would integrate universal moral principles (beneficence, non-maleficence, confidentiality, informed consent) and consequently a set of public health principles derived from these including an architecture of accountability and decentralization. It would preserve the benefits of cooperation while upholding the freedoms of individuals and nations.

I. THE POLICY CHALLENGE

How can we structure an international health organisation (IHO) to help states meet their sovereign responsibility to provide public health for their people? An IHO that is accessible, affordable, world class, and independent of undue donor influence? Framing the question like this raises another aspect that is all too often neglected in the discourse on public health: the topic is not solely, perhaps not even primarily, about health outcomes. Rather, the main focus is on the policy challenge. And this means that policy trade-offs and calculations of costs and benefits of necessary policy choices are central to the discussion, not peripheral nor avoidable.

The answer to the challenge, furthermore, is to redesign an IHO using the organizing principle of subsidiarity where health decisions reflect the desires and intent of those closest to where they will have their effect. Subsidiarity is a concept about the level of governance (local, provincial, national, regional, global) and the sharing of powers among levels to determine the point at which action should be taken to adopt and implement public policy. In an intergovernmental organisation, it empowers the individual members and not the organisation to make decisions on issues that affect them. The principle is most closely associated with the European Union (EU). Article 5.3 of the Treaty on European Union (1992),[1] commonly known as the Maastricht Treaty, is an attempt to safeguard in law the rights of member states to make decisions and take actions on matters affecting them, and for the EU to intervene only when the objectives cannot be achieved by individual states and are better

1 https://www.europarl.europa.eu/factsheets/en/sheet/7/the-principle-of-subsidiarity

achieved at the EU level owing to scale and effects. The condition is not met therefore simply on the argument that the objectives can be achieved better or more efficiently at the EU level; it must also be the case that it cannot be achieved at the local level. The principle is further conditioned by the related principle of proportionality, described in the 1997 Protocol on the application of the twin principles,[2] which stipulates that action by the EU shall not go beyond what is necessary to achieve the objectives of the treaty.

Thus, the principle of subsidiarity guarantees the independence for the lower authority in relation to a higher body and serves to regulate the exercise of powers of the latter body. A global authority like the World Health Organization (WHO) should have to be functionally subsidiary to that of regional authorities; a regional health organisation should be subsidiary to that of national authorities; a national government should perform only those tasks that cannot be effectively performed at local levels; and public authorities at the local level in turn should recognize the primary role of individual sovereignty and informed consent that underpins medical and public health decision-making. The principle would thus reverse the centralizing trend of recent decades outlined in the companion Technical Report and return the balance between sovereign states and international organisations closer to the original vision of 1948 when the WHO was established.

The foundational principle of the United Nations is state sovereignty of its member states. The WHO is one of the specialized agencies that are integral components of the UN system. It works worldwide advocating for universal healthcare, monitoring public health risks, preparing for emergencies by identifying, mitigating, and managing risks, and coordinating responses to health emergencies.[3] It sets international health standards and guidelines and provides technical assistance to countries. To deliver on this broad mandate, it employs over 9,000 staff dispersed across 150

2 https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:11997D/PRO/07:EN:HTML

3 https://www.who.int/about/what-we-do

countries and regions in addition to the headquarters in Geneva.[4]

The organizing principle of individual-centric liberal democracy is constitutional arrangements that prioritize citizens as rights bearers with agency for making decisions concerning their own welfare. By contrast, the organizing principle of collectivist political systems is the welfare and safety of the political community as a whole and the subordination of individual preferences to community welfare.

The practice of Western medicine has been predicated on the norm that, in assessing benefits against the risk of harms of treatment options, the primary responsibility is the welfare of each individual person or patient. Community welfare is secondary to individual interest. An individual's primary role in determining the nature of this care, through informed consent, is the basis of post-World War Two medical ethics. But public health is inherently collective in orientation and emphasis. It seeks to promote the health of the community as a whole, but errs ethically when it subordinates the rights of the patient in the clinic to make an informed choice regarding their own management. While decisions are made by public health officials, experts, professional colleges, and regulators intended to be operating at arm's length from governments in Western democracies but nonetheless as the authorized agents of the society concerned, in socialist systems the distance between health officials, experts, professional colleges, and regulators is often greatly reduced and they all act as the direct agents of the state.

I.1 The rise of interstate global collaboration

The international order is based on a system of sovereign states as a means of organizing the world to discharge the states' responsibility to their people of protecting their lives and livelihoods and promoting their well-being and freedoms. However, states' ability to exercise national sovereignty has been increasingly circumscribed in the decades since 1945. The steady erosion of the principle of sovereignty is partly rooted

4 https://www.reuters.com/business/healthcare-pharmaceuticals/who-proposing-cut-jobs-slash-budget-by-fifth-memo-shows-2025-03-29/

in the reality of global interdependence: no country is an island sufficient unto itself. In a globalizing seamless world, political frontiers became less salient both for sovereign states, whose responsibilities within borders can be held to international normative benchmarks and external scrutiny, and for international organisations, whose rights and duties can intrude inside national borders.

The primary purpose of the United Nations is the maintenance of international peace and security. However, the concept of security has itself broadened from defusing and defeating national security threats to risk assessment and management and being prepared – normatively, organisationally, and operationally – to cope with strategic complexity and uncertainty. That being the case, the overwhelming challenge is to structure the institutions of international governance in order to make them more robust – so that they can withstand both exogenous and endogenous shocks; resilient – so that they can bounce back when they do buckle in the face of some shocks; flexible and adaptable – so that they can deal with the changing nature and source of threats, including 'black swans;'[5] yet subservient to member states who are the principals. International organisations act as the agents of member states.

All states face mutual vulnerabilities owing to the reality that the world is interdependent in areas as diverse as financial markets, infectious diseases, climate change, terrorism, nuclear peace and safety, product safety, food supply, water availability, fish stocks, ecosystem resources, and so on. In addition to their potential for provoking interstate military conflicts, these are all drivers of human insecurity due to the threat they pose to individual lives and welfare. In recognition of this empirical reality, the international system rests on a network of treaties, regimes, intergovernmental organisations, and shared practices that embody common expectations, reciprocity, and equivalence of benefits.

Multilateralism refers to collective, cooperative action by states – at times in concert with non-state actors – to deal with common problems and challenges when these are best managed collaboratively at the international

5 https://www.amazon.com.au/Black-Swan-Impact-Highly-Improbable/dp/081297381X

level. Areas such as maintaining international peace and security, economic development and international trade, human rights, functional and technical cooperation, harmonization of regulatory requirements and markets, and the protection of the environment and sustainability of resources require joint action to promote collaboration, reduce costs, and bring order and regularity to international relations. Even the most powerful states cannot achieve security nor maintain prosperity and health as effectively when acting unilaterally or in isolation.

The world has changed enormously since the creation of the United Nations. There are four times as many state actors, a significant rise in the number of non-state actors, and a tremendous diversity in the types of state and non-state actors compared to 1945. There has been a matching proliferation in the number, nature, and types of threats to national security and world peace alike. Consequently, the growing number and types of actors in world affairs must grapple with an increasing number, range, and complexity of issues in a networked, deeply intertwined, but also more fragmented world. The sense of community that might once have bound together the member states of the United Nations has been attenuated over the decades.

I.2 The WHO in the crossfire

The WHO was once the world's trusted guardian of global public health with a simple, clear, and noble mission. The early decades demonstrated what a focused WHO can achieve; for example, broad improvements in childhood nutrition and the celebrated eradication of smallpox. But in recent decades, bureaucratic inertia, politicized science, and mission creep have corroded that purpose and eroded public trust. That dysfunction produced questionable policy recommendations during Covid-19 by the WHO and/or failure to call out poorly evidenced policy interventions by many states, such as: economy-crushing lockdowns; arbitrary two-metre physical distancing; cloth masks on toddlers; mandatory vaccines for healthy children, adolescents, and youth; prolonged school closures; and the suppression of low-cost therapeutics in favour of inadequately-tested drugs that critics allege were still in their experimental stage because the usual full cycle of trials and tests had been shortened to grant them

emergency-use authorization. Expressions of concern were frequently mischaracterized as misinformation and disinformation, and their reach suppressed under the guise of an 'infodemic,' further eroding trust.

Moreover, the pandemic demonstrated inadequacies in the existing WHO-centric architecture of international health governance. Yet, it was also a sharp reminder of the limits of unilateralism in an age of shared threats and fragility but unequal resilience. As such, it highlighted a need for international cooperation to identify, quantify, and address risks early, while building international resilience to reduce their frequency and severity.

Thus, the coronavirus crisis simultaneously reaffirmed the crucial role of a properly functioning IHO in addressing global health emergencies, while also revealing critical flaws in the WHO's operations. The WHO's focus was narrow and inadequate,[6] exaggerating the gravity of the threat and the effectiveness of the responses being proposed against it, in China and elsewhere, with little regard for context or impact of responses on other health burdens. It lost trust by deferring needlessly to the initial claims of the lack of human-to-human transmission; and its messaging was confused and sometimes contradictory, for example with respect to face masks,[7] and workplace and school closures, failing to recognize and explain early evidence of low risk in school and working age populations. The pathology of politicizing specialized agencies is most acutely reflected in the balance between assessed financial contributions that contribute towards strengthening institutional integrity (about 17 percent in the case of the WHO), and voluntary contributions that attempt to shape its work priorities to donors' agendas (about 80 percent).

The pandemic and the WHO's response demonstrate the need to maintain a broad conception of public health, the importance of North–South partnerships in addressing human security vulnerabilities, the critical role of the UN system in coordinating and leading global efforts, as well as the many flaws that result in a suboptimal performance and hence the

6 https://www.who.int/publications/i/item/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-(covid-19)

7 https://www.bbc.com/news/health-52945210

need for continual reforms. There is no substitute at present for the WHO's worldwide efforts to promote universal healthcare, monitor public health risks, coordinate preparation for emerging epidemiological emergencies, coordinate responses, set international health standards and guidelines, and provide multilateral technical assistance to developing countries.

The WHO was originally intended primarily to transfer capacity to struggling states emerging from colonialism and address their higher burdens of disease but lower administrative and financial capabilities. This remit prioritized fundamentals like sanitation, good nutrition, and competent health services that had brought long life to people of wealthier countries.[8] Its focus now is more on stocking shelves with manufactured commodities. There is some contradiction between the WHO's budget, staffing, and remit expanding while the infectious disease burden has declined.[9]

While major gaps in underlying health equality remain, and were exacerbated by Covid policies,[10] the world is a very different place from when the WHO was formed. Rather than acknowledging and refining towards progress, the post-Covid world has been framed as simply an "inter-pandemic period," where the WHO and its partners should be given ever more responsibility and resources in prioritizing preparedness for the next hypothetical outbreak (like Disease X).[11] Excessively dependent on "specified" funding from national and private interests heavily invested in profitable biotech fixes rather than the underlying drivers of good health,[12] this agenda looks more and more like other public-private partnerships that channel taxpayer money to pet projects and the priorities of private industry.

Pandemics happen, but a proven natural one of major impact on life expectancy has not happened since pre-antibiotic era Spanish flu

8 https://onlinelibrary.wiley.com/doi/10.1111/ehr.13019

9 https://ourworldindata.org/burden-of-disease

10https://www.oxfam.org/en/press-releases/mega-rich-recoup-covid-losses-record-time-yet-billions-will-live-poverty-least

11 https://www.who.int/activities/prioritizing-diseases-for-research-and-development-in-emergency-contexts

12 https://open.who.int/2022-23/contributors/contributor

over a hundred years ago. Better nutrition, sewers, potable water, living conditions, antibiotics, and modern medicines help to protect far more effectively than was possible in previous centuries when periodic pandemics ravaged populations (see Figure V.2 below). Yet, current WHO policy is predicated on messaging of a continuous "existential threat" where people need to be ever more fearful of the next outbreak. Covid happened, but it also overwhelmingly affected the elderly in Europe and the Americas.[13] Moreover, there is increasing evidence, as the US government now notes, that the Covid pandemic likely resulted from a laboratory mistake by the very pandemic industry that is promoting the WHO's new approach.[14]

Collaborating on health internationally remains popular, as it should be in a heavily interdependent world. It also makes sense to prepare for severe rare events of low likelihood but high impact. Most of us buy insurance. But we don't exaggerate flood risk in order to expand the flood insurance industry, as anything we spend is money taken from our other needs.

Public health is no different. If we were designing a new WHO now, a rational approach would not allow funding and direction to be based primarily on the interests and advice of those who profit from illness. Rather, decisions would be based on accurate estimates of localized risks of high-burden, preventable, and remediable diseases. The WHO was once independent of private interests and mostly core-funded, and was thus able to set rational priorities. That WHO is gone.

Over the past eight decades the world too has changed. It makes less sense now to base thousands of health staff in one of the world's most expensive (and healthiest!) cities, and it makes no sense in a technologically advancing world to keep centralizing control there. The WHO was structured in a time when most mail still went by steamship. Might a network of regional bodies tied to their local context be more responsive and effective than a distant, disconnected, and centralized bureaucracy of thousands?

In his inaugural address[15] and follow-up teleconference address to

13 https://data.who.int/dashboards/covid19/cases

14 https://www.whitehouse.gov/lab-leak-true-origins-of-covid-19/

15 https://www.whitehouse.gov/remarks/2025/01/the-inaugural-address/

the World Economic Forum in Davos on 20 and 23 January 2025,[16] US President Donald Trump promised "to give the people back their faith, their wealth, their democracy, and, indeed, their freedom."

The Trump administration's disruptive multifront assault on apparently settled narratives of multilateral cooperation provides a unique opportunity to rethink global health governance. The WHO, at nearly 80 years old, comes from a bygone era, and is increasingly estranged from its world. We can do better. Fundamental change in the way we manage international health cooperation will be painful, but ultimately healthy.

What can be done to restore trust and return the WHO to its core mission? Or, if this is not practicable, to create a successor IHO? Possible answers include refocusing the mission on protecting against health threats that kill the largest number of people, not those that kill in an intense but short outbreak; concentrate on the historic determinants of health and drivers of infectious disease reduction and longevity – including nutrition, sanitation, improved living conditions and accessibility of basic healthcare – thus building resilience against both long- and short-term threats; strengthen global and domestic systems to predict, track, and respond to new threats and outbreaks; improve access to data, laboratory, and epidemiological capacity, and policy dialogue between states; apply gold-standard science to every recommendation; and return to the original mission of supporting national and regional health departments on the front lines of healthcare.

I.3 The foundations of health sovereignty

As noted above, modern health care is premised on the concept of the right of each individual to choose (bodily autonomy or individual sovereignty). The right to health sovereignty has its foundations in the following international declarations and conventions:

16 https://useu.usmission.gov/remarks-by-president-trump-at-the-world-economic-forum/

1. The United Nations Charter (1945)[17]
2. The Universal Declaration of Human Rights (1948)[18]
3. The WHO Constitution (1948)[19]
4. The International Covenant on Economic, Social and Cultural Rights (1966)[20]
5. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)[21]
6. The Convention on the Rights of the Child (1989)[22]

The relevant extracts from the texts of these authoritative documents are discussed in the *Technical Report* and published as Appendix II at the end of this document. The most important of course is the United Nations Charter itself. Article 2 affirms the sovereign equality of all member states and adds: "Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state." There can be little doubt that in 1945, the drafters and signatories would have understood health to be a matter that is "essentially within the domestic jurisdiction" of a state. The Charter then goes on to specify roles for the General Assembly and the Economic and Social Council in the promotion of international health cooperation, solutions to health problems in order to create "conditions of stability and well-being which are necessary for peaceful and friendly relations among nations" (Article 55), and to initiate studies on international health conditions so that informed recommendations may be made.

Article 25.1 of the Universal Declaration of Human Rights affirms that

17 https://www.un.org/en/about-us/un-charter/full-text

18 https://www.un.org/en/about-us/universal-declaration-of-human-rights

19 https://cdn.who.int/media/docs/default-source/documents/publications/basic-documents-constitution-of-who179f0d3d-a613-4760-8801-811dfce250af.pdf

20https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

21 https://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

22 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family." The second principle in the very first paragraph of the WHO constitution declares that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" is reaffirmed in Article 12.1 of the International Covenant on Economic, Social and Cultural Rights.

The Convention on the Elimination of All Forms of Discrimination against Women contains several clauses specifically on ending discriminatory policies and practices in relation to women. The most important health provision is stated in Article 12.1: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."

The Convention on the Rights of the Child contains several provisions for the promotion of children's health. The key clause is Article 24.1: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

It seems clear therefore that there exists a right to health in international law as part of universal human rights, and that the primary responsibility for protecting and promoting the right to health is vested in sovereign states, with a secondary responsibility in international organisations to support states in this. More recent discussions in global health policy, particularly in Africa, reflect this understanding, with agreements such as the Paris Declaration on Aid Effectiveness (2005),[23] the Lusaka Agenda

23 https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html

(2023),[24] and the Accra Reset (2025)[25] stressing the need for increased national ownership, contextualized health programming, and "health sovereignty" through improving self-reliance, local system capacities, and sustainability of health delivery.

That said, the right to health is but one element of national sovereignty that citizens believe have been undermined by the growth of the institutions of global governance. There is some unease that this has been done in the name of efficiency gains, thereby compounding the problem by transferring rule-making and policy-setting authority from national governments to professional experts who shift back and forth between national and international offices. Whether the erosion of principles embedded in national and global governance institutions occurred more through accident and neglect or by intent, the disquiet it is starting to give rise to requires open and urgent discussion. This is the subject of the next chapter.

24 https://futureofghis.org/final-outputs/lusaka-agenda/

25 https://online.africa.com/accra-reset/

II. SOVEREIGNTY AS AN ORGANIZING PRINCIPLE OF WORLD ORDER

The military conquest of one country by another through the use of force determined the geopolitical map of the world from the mists of antiquity until the 20th century. The First and Second World Wars enshrined the notion of national self-determination that completely delegitimized the change of borders by means of military force. The post-1945 liberal international order was embedded in and underpinned by a vast latticework of institutions centred on the United Nations. The newly independent nations of Asia and Africa that emerged from the yoke of European colonialism became the most passionate champions of national sovereignty and territorial integrity, using the weight of their numbers throughout the UN system to offset their lack of military power, financial muscle, and geopolitical heft. Yet, history had no more ended than had the empirical reality of the unequal distribution of resources, wealth, and power among nations, setting the scene for the continuing contestation between powerful and weak countries for control and influence of foreign actors inside sovereign jurisdictions. In addition to this historical continuity, however, there was a new development: the growth of intergovernmental actors intruding with increased visibility into domestic affairs of sovereign states in the name of the international community. One of the most recent domains in which this has occurred is health, the subject of this report.

II.1 Sovereignty: meaning, origins, evolution

The Peace of Westphalia (1648) is the foundation of the modern state system built around the concept of territorial sovereignty. The meaning, rights, and duties of states in international law are set out in the 1933

Montevideo Convention.[26] A state must have '(a) a permanent population; (b) a defined territory; (c) government; and (d) capacity to enter into relations with other states' (Article 1). Internally, sovereignty refers to the exclusive competence of the state to make authoritative decisions of government with regard to all people and resources within its territory. Externally, it means the legal identity of the state in international law, an equality of status with all other states, and the claim to be the sole official agent acting in international relations in the name and on behalf of the nation.

However, just as constitutional arrangements and distribution of powers between different branches and levels of government qualify the absolutism of domestic sovereignty, so international constitutional arrangements through agreements entered into voluntarily – such as the United Nations Charter, the statutes of the World Court and the International Criminal Court (ICC), the World Trade Organization (WTO), and the network of European Union (EU) level treaties – qualify external sovereignty.

The approach taken to domestic sovereignty has varied over time and been shaped by domestic political theory. In absolutist states, the sovereign entity enjoyed absolute power in which the lack of international checks was matched by a lack of internal checks. The 20th century successors were totalitarian states devoted to a secular ideology or religious radicalism. In liberal states, sovereign state power was initially seen as limited by conditions of an imagined social contract and later a real constitution.

The traditional view holds that state sovereignty is based on power. An alternative conception holds that popular sovereignty must derive from the active choice of the governed. Over time, alongside greater sensitivity to the inherent dignity, worth, and rights of individuals, sovereignty as the philosophical underpinning of the European state system was redefined in terms of a social contract between citizens and rulers. With the expansion of democracy in the 20th century, state sovereignty was challenged by popular sovereignty, first conceived of as the consent of the governed, and then their active choice. Internal power relations experienced an inversion. Rights-bearing citizens did not owe duties to sovereigns. Rather, states

26 https://treaties.un.org/doc/Publication/UNTS/LON/Volume%20165/v165.pdf

were responsible for and accountable to their citizens.

In 2001, the International Commission on Intervention and State Sovereignty concluded that it is necessary and useful to reconceptualize sovereignty as responsibility.[27] (One member of the IHRP panel, Ramesh Thakur, was a Commissioner and a principal author of the report.) The principle of the Responsibility to Protect (R2P), unanimously endorsed by the UN World Summit in New York in 2005 in paragraphs 138 and 139 of the Outcome Document incorporated in General Assembly Resolution A/RES/60/1 (24 October 2005),[28] adapted this change to the international level, shaping both relations between citizens and states domestically, and between states and the international community represented by and acting through the United Nations globally. Individuals are rights bearers and states have the primary responsibility to protect all peoples on their territory, but the United Nations has a fallback responsibility when states are manifestly failing to do so.

Sovereignty does not imply that all states act competently or justly. Weak institutions, corruption, and limited capacity remain real constraints. The significance of sovereignty lies not in guaranteeing good outcomes, but in locating responsibility, accountability, and policy learning at the level where benefits and harms occur. It is an imperfect, but necessary, way of distributing decision-making.

II.2 Contrasting approaches to sovereignty

The Westphalian system oversaw the imperial expansion of the European great power rivalries and the resulting global rise of European colonialism. The export and universalization of the principle of sovereignty, and its expression as nationalism by colonial subjects, paved the way for the emergence of powerful independence, self-determination, and national liberation movements culminating in the worldwide decolonization process.

27 https://www.globalr2p.org/resources/the-responsibility-to-protect-report-of-the-international-commission-on-intervention-and-state-sovereignty-2001/

28 https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_60_1.pdf

Having emerged from colonial conquest and rule, the newly independent countries proved to be fiercely jealous about protecting their sovereignty against external exploitation and foreign interference. In effect they domesticated what had been a European export. The UN became the principal international forum for collaborative action in the shared pursuit of the three goals of state-building, nation-building, and economic development. At one level, the developing countries' attachment to sovereignty is deeply emotional, reflecting the history of Europe's encounter with Arabs, Africans, and Asians. At another level, the commitment to sovereignty was also functional. As the foundational organizing principle of the postcolonial international order, sovereignty has helped to provide order, stability, and predictability in conditions of international anarchy.

As an ex-colony that itself won independence on the back of a revolutionary war, the United States has always been a stout defender of national sovereignty against international encroachments. Unlike the weak and poor developing countries that had little to back their defence of sovereignty beyond the strength of numbers, the United States has been the world's preeminent geopolitical heavyweight since the inception of the United Nations in 1945. The former Soviet Union was equally firm in the defence of its sovereignty as the second superpower during the bipolar Cold War. For international law to be accepted as legitimate, its application must be impartial, with no country above nor any below the law. But enforcement depends on the military might and economic muscle of the powerful and the rich, ensuring selectivity in the implementation of international law that erodes its legitimacy. Both Cold War bloc leaders illustrated, although not to an equivalent degree, Thucydides' ancient wisdom that justice does not apply to relations among unequals. Instead, strong powers do what they can and weak states suffer as they must. Hungary in 1956, Czechoslovakia in 1968, and the many instances of US sanctions, interventions, and regime changes are key markers of the relevance of Thucydides' insight to post-1945 international history.

Compliance is proving as problematic against the nodes of a polycentric order as it was against the bloc leaders in the bipolar order. China has emerged as the most formidable US rival and global champion of sovereignty. India is also a powerful advocate as it too emerges as a consequential power. Under this polycentric order key pacts are vitiated by

the abstentions of mission-critical countries like China, the USA, India, and Russia. For example, China, India, Russia, the US, and many other countries do not support the ICC and thus render its jurisdiction very limited. President Donald Trump has withdrawn the US from the UN Human Rights Council, UNESCO, climate pacts, and the UN's Sevilla Commitment pact (July 2025) that redirects additional tax revenues to the UN's Sustainable Development Goals, and now from the WHO.[29]

Moreover, international treaties on areas of scientific inquiry raise another vexed question, as exemplified by climate pacts, the WHO's tobacco treaty (FCTC), and the pandemic accords. Treaties establish the norms and legal obligations of States Parties. They are based on the state of scientific knowledge at the time. But science is never static. Rather, it is constantly evolving, as it is a process of questioning and testing existing knowledge. This poses two challenges. The first is that treaty negotiations are usually protracted and lengthy processes. It is possible that some of the scientific tenets informing a treaty might already be under critical challenge when the treaty is adopted. A more likely eventuality is that over time, the shared understandings, evidence base, and accepted theories in the scientific foundations of a particular treaty have undergone substantial revisions and thus overtaken the treaty obligations that are static.

This appears to be happening with the constantly evolving climate change agenda. The World Climate Declaration issued in 2022 had been signed by over 2,000 experts from 60 countries by September 2025, including Nobel Laureates.[30] It boldly declared "there is no climate emergency." The conclusions of computer models are driven by what is put into the models, with the declaration noting that warming results from natural as well as anthropogenic factors. In any case, warming has been "far slower than predicted" and global warming has not increased natural disasters. The declaration called for climate science to be less political and climate policy to be more scientific. On 29 July 2025 the US Department of Energy issued a deeply consequential report that rejects the core tenets of climate alarmism, notes that US policies will "have

29 https://news.un.org/en/story/2025/07/1165276

30 https://clintel.org/world-climate-declaration/

undetectably small direct impacts on the global climate," and insists that the dominant energy systems deserve to be celebrated for their role in "the rise of human flourishing over the past two centuries."[31] Accordingly, the US is set to revoke many restrictive climate regulations in the push for continued global energy dominance. A pivotal private donor of climate-related action, Bill Gates Jr., has also backtracked in late 2025, claiming alarmism that previously underpinned a dominant narrative supporting climate treaties has been demonstrated to be untrue.[32]

This report does not take a position on the relative merits of the advocates and opponents of climate change science. The pertinent point here is different. Science evolves, is contested, and advances through constant testing against the evidence and the robustness and explanatory power of alternative, competing hypotheses. Consequently, treaties on matters of scientific enquiry can be trapped in a time freeze to become unmovable paradigms. Compliance with international obligations becomes problematic when the scientists of member states dispute the understandings of the international body, whose pronouncements can never have the status of scientific infallibility. In public health this can have direct consequences, promoting the use of outdated management strategies, and suppressing debate on and delaying the introduction of more effective approaches.

II.3 Multilateral curtailments of state sovereignty

Domestically, power sharing between the executive, legislature, and judiciary, at federal and provincial levels, is regulated by constitutional arrangements and practices. Internationally, states are constrained by globally legitimated institutions and practices. Internal forms and precepts of governance must conform to international norms and standards of state conduct. There were increasing attempts to generate formal mechanisms

31 https://www.energy.gov/sites/default/files/2025-07/DOE_Critical_Review_of_Impacts_of_GHG_Emissions_on_the_US_Climate_July_2025.pdf

32 https://www.gatesnotes.com/home/home-page-topic/reader/three-tough-truths-about-climate

for protecting human rights, from the UN Human Rights Council to the European Court of Human Rights which can give binding orders to sovereign states. As well, aid and trade can be tied to what is considered to be acceptable internal behaviour of states on human rights, gender equality, and climate sustainability goals. Initially, Western governments were the subjects and developing countries the objects of international human rights regimes that were written in the liberal occidental script. By now, however, many Western populations too feel that they are being subjected to technocratic, anti-democratic global governance which has weaponized the language of human rights to prioritize other communities over the desire of citizens to promote their own communities and national interests. This perception has given rise to populist movements in many liberal democracies, which offer a new challenge to expanded global governance and globalization.

A second set of challenges comes from the apparent inability of some states to maintain the internal order that is central to sovereignty. Westphalian sovereignty was predicated on the effective control of territory. International law recognizes states and governments on the basis of who exercises effective political control over discrete territories. However, state fragility, failure, and breakup may mean the end of viable central public authority and control. The legalist model of international politics – premised on the primacy of sovereign autonomy and equality, non-interference, and the irrelevance of domestic forms of government – is demonstrably out of touch with reality in several respects. Not all states are equally viable. Weak capacity and institutional fragility afflict many states. State incapacity is an underlying source of a wide range of pressing problems. Many threats to national and international security today are rooted, not in conquering states in the Westphalian paradigm, but in failing states from the pre-Westphalian world.

Another set of challenges comes from the rise and recognition of new actors playing significant roles and wielding considerable power, including transnational corporations, regional and global international organisations and agencies, and powerful and mega-wealthy individuals. In contrast to the many weak states, in the unipolar decade after the end of the Cold War the US was able to exercise virtually unchecked global power. Commerce is boundary-less and the lucrative businesses of the illicit trade in drugs

and human smuggling grew exponentially as examples of the dark side of globalization.[33] Transnational criminals use weak or failed states as bases and safe havens as well as sources to fund their operations. Mega-wealthy individuals can distort economies and social programmes in ways that reflect their interests above those of the populations concerned.

The functions and roles of proliferating numbers of international organisations have expanded, but only at the cost of curtailing the previously unlimited independence of states to act as they saw fit. A good example is the right to go to war against an enemy state, which previously was an accepted attribute of sovereignty. Curtailments of sovereignty have also extended to types of armaments. The 1968 Nuclear Non-proliferation Treaty (NPT) outlaws the acquisition of the bomb beyond the five nuclear-weapon states of the time: China, France, Russia, UK, and the USA. This means that the empirical reality of four additional states possessing nuclear weapons (India, Israel, North Korea, and Pakistan) cannot be reconciled with the legal definition of a nuclear-weapon state, creating a crisis of credibility and legitimacy for the NPT itself. Security Council Resolution 1373 (28 September 2001) imposed significant requirements on member states within their domestic jurisdictions to end any form of support for terrorism and established the Counter-Terrorism Committee to monitor implementation and increase state capacity to combat terrorism. The International Convention for the Suppression of Acts of Nuclear Terrorism (2005) requires States Parties to make it a crime punishable with stiff penalties to possess or demand a radioactive device or material with the aim of causing death or serious injury or substantial damage to property.

The rise and spread of human rights norms and conventions and the extension and diffusion of international humanitarian law were among the major achievements of the last century. The United Nations was at the centre of that effort by constructing a treaty structure in which the principles were embedded and led to the establishment of many national human rights institutions alongside intergovernmental machinery. The ICC was established by the Rome Statute in 1998. Yet by now, even in the institutions of international criminal justice, the liberal conceit of

33 https://digitallibrary.un.org/record/719485?v=pdf

professional international elites and technocrats is leading them into appropriating powers of sovereign states to make carefully calibrated policy trade-offs. The result is the refusal by a number of consequential countries to abide by their international commands and even threats against any country that implements some of their legally binding obligations with respect to people under ICC indictment. For in the 'real world' outside the normative framework of human rights lawyers, this is a profoundly political decision, a matter of high politics requiring foreign policy calculations by sovereign states. No self-respecting independent state can outsource the moral, legal, and strategic calculus to a foreign international body. Their recalcitrance is helped by the fact that neither the world's most powerful countries nor those representing the majority of the world's peoples are party to the ICC statute.

Sudan's President Omar Hassan Bashir, indicted by the ICC in 2009, never did stand trial at The Hague. The challenge to the ICC's authority has only intensified since then. Russia's President Vladimir Putin continues to be welcomed in several countries, both parties and non-parties to the ICC.[34] On 6 February 2025 the US administration imposed sanctions on the ICC for unlawfully targeting Americans and Israelis since neither country is a member, neither accepts its jurisdiction over nationals, "and both nations are thriving democracies with militaries that strictly adhere to the laws of war."[35] The blowback effects of criminal convictions of state leaders that remain unenforced damage the credibility, authority, and legitimacy of the courts themselves. The ICC has thus produced one of the clearest challenges to overreach by the institutions of global governance and a defiant reassertion of sovereign decision-making instead.

II.4 Global governance without world government

Multilateral solutions without passports are necessary in what, in a speech to African-American civil society leaders on 7 October 2003,

34 https://www.bbc.com/news/articles/cly2exvx944o

35 https://www.whitehouse.gov/presidential-actions/2025/02/imposing-sanctions-on-the-international-criminal-court/

the late UN Secretary-General Kofi Annan called "an age of problems without passports."[36] Global governance is not synonymous with world government. Instead, global governance refers to the workings of the international system of authoritative rules, norms, institutions, and practices for managing world affairs. Consequently, global governance never has nor ever can fully escape the tension between the need and demands for the internationalization of rules, on the one hand, and the powerful push to retain national control on the other. To date reconciliation between the two competing pressures on instruments of global governance has proven elusive.

The United Nations lies at the centre of the Westphalian system of global governance and multilateral order. It was created and functions essentially as a state-centric system: an organisation of, by, and for member states. They are the sole decision-makers, rule enforcers, and also the only subjects and primary objects of international decisions. Article 2.7 of the UN Charter explicitly proscribes the United Nations from intervening "in matters which are essentially within the domestic jurisdiction of any state." Under the impetus of globalization, however, the machinery of global governance slowly rebalanced the Charter division of authority and jurisdiction between states and international organisations to tilt it towards the latter. This happened not through any formal denunciation of the Article 2.7 stipulation, but by stretching the boundaries of state sovereignty to accommodate emerging new issues like weapons of mass destruction, environmental threats, international terrorism, and renewed emphasis on infectious disease outbreaks that were global in origins, reach, and impacts and whose resolution benefits from multinational collaboration.

Consequently, even while still firmly anchored in a system of states, international forums and sites became primary vehicles for setting global agendas, framing global issues, and adopting international standards. To accomplish these tasks, they often prescribed requirements for international permission structures, monitoring, reporting, and compliance. There was a parallel proliferation in the number and types of actors playing some role

36 https://press.un.org/en/2003/sgsm8922.doc.htm

in the implementation, delivery, and monitoring of these globally-driven norms and efforts. Over the decades since 1945 when the United Nations was established and the liberal international order came into being, the initially thin but gradually thickening overlay of global governance was spread on the dense web of interstate interactions. Geopolitical changes, gaps in and failures of global governance, and a newly conscious assertion of identity politics have begun to reinfuse statism into the liberal internationalist web of global governance.

II.5 Compliance pull and health policy rigidity

In regulating state conduct, both laws and norms serve enabling (licence) and restraining (leash) functions. In general, legal norms are more effective in regulating state behaviour. But in specific instances, a particular law may be breached while a political norm shapes a decision through a calculation of reputational costs. On mass atrocity crimes, for example, the 1948 Genocide Convention imposes legal obligations on states to act. By contrast, the 2005 Responsibility to Protect (R2P) is a global political norm that creates a moral responsibility but no legal duty on outside states to prevent and halt atrocities. However, even R2P has to be interpreted and applied in the broader context of binding obligations on states under national, international, humanitarian, and human rights laws. For great powers, R2P makes it more costly, on the one hand, to resort to self-interested unilateral interventions, including so-called "humanitarian interventions." On the other hand, it also makes it more costly to resist UN-authorized calls to collective action to save strangers under threat of imminent mass atrocities.

The nuclear ban treaty (The Treaty on the Prohibition of Nuclear Weapons, 2017) is legally binding, but only for signatories. However, by changing the prevailing normative structure, the ban treaty shifts the balance of costs and benefits of possession, deterrence doctrines, and deployment practices, and could create a deepening crisis of legitimacy for nuclear weapons-possessing states. It removes the NPT-rooted fig leaf of international legitimacy that the five formal nuclear weapons states have used to cloak their nuclear weapons, while insisting that the pursuit of nuclear weapons by anyone else is both illegal (a violation

of the international law of treaties) and illegitimate (a violation of the global norm).

In a matching vein, the ongoing pandemic accords' legal effect will lie in strengthening the Pandemic Prevention and Preparedness Agreement and One Health as global norms. In combination with the amended International Health Regulations (IHR) that came into force in September 2025 for most states unless they had opted out in July,[37] and which must and will be read in parallel with the Pandemic Agreement, the political reality is that member states will be enmeshed into the international pandemic management framework led by international technocrats. Like many international agreements across all sectors, they lack the legitimacy of democratically elected political leaders, are often not accountable in practice, and have been given this enhanced directive role without meaningful parliamentary scrutiny and public debate by citizens.

Of course, WHO recommendations are not legally binding obligations on Pandemic Agreement signatories. This treaty explicitly states that nothing in it gives the WHO or the Director-General (DG) "any authority to direct, order, alter, or otherwise prescribe" any policy; "or to mandate or…impose any requirements" that States Parties "take specific actions" like travel bans, vaccination mandates, or lockdowns (Article 22.2). Nevertheless, the treaty's preamble recognizes that the WHO "is the directing and coordinating authority on international health work, including on pandemic prevention, preparedness and response." Nothing in the Covid experience, to be reviewed in Chapter 5, inspires confidence about the willingness and capacity of political leaders to resist WHO recommendations in this global institutional milieu. This is why the pandemic accords are the latest way stations on the journey to an international administrative state that consolidates what Garrett W. Brown, David Bell, Jean von Agris, and Blagovesta Tacheva call the globe-spanning new pandemic industry.[38]

In sum, the genuflection to national sovereignty is formal and abstract. The encroachments on sovereignty are real and concrete. The normative

37 https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_ACONF14-en.pdf

38 https://essl.leeds.ac.uk/directories0/dir-record/research-projects/1260/re-evaluating-the-pandemic-preparedness-and-response-agenda-reppare

structure created by the amended IHR and Pandemic Agreement will be nearly impossible to resist for most States Parties. They could also exercise a powerful compliance pull on non-States Parties. Thus, national bureaucrats, non-governmental experts, and international officials will be able to draw on the authority of the pandemic accords to reinforce their technocratic legitimacy.

Good policy development and decision-making processes ensure better long-term outcomes and act as checks against suboptimal outcomes, abuse of power, and wastage of public funds. The existing frameworks, processes, and institutional safeguards under which liberal democracies operated until 2020 had ensured expanding freedoms, growing prosperity, an enviable lifestyle, quality of life, and educational and health outcomes without precedent in human history. Abandoning them in favour of a tightly centralized small group of decision-makers liberated from limited external scrutiny, contestability, and accountability produced both a dysfunctional process and suboptimal outcomes: very modest gains for much long-lasting pain. The growing influence of non-state actors on these institutions only exacerbates this lack of accountability and legitimacy. Interventions rooted in panic, driven by political machinations, and using all the levers of state power to terrify citizens and muzzle critics in the end needlessly killed massive numbers of the most vulnerable, while putting the vast low-risk majority under house arrest. The benefits were modest,[39] but the harms were increasingly obvious and are likely to be long lasting.[40] The pandemic accords will exacerbate the dysfunctionality by adding internationally centralized coordination to centralized national decision-making.

39 https://rss.org.uk/RSS/media/File-library/Events/Discussion%20meetings/covid-final-preprint.pdf

40 https://www.tandfonline.com/doi/full/10.1080/09581596.2024.2349894

II.6 World Court Advisory Opinion on climate change liability: relevance for pandemics

An example of the direction the pandemic accords could take regarding state sovereignty once scientific inquiry is replaced by legal authority is seen in the International Court of Justice (ICJ) ruling on the legal obligations and liability of states on climate change.[41] On 29 March 2023, the UN General Assembly requested an Advisory Opinion on this from the ICJ. On 23 July, the court published its Advisory Opinion.[42] Relying primarily on IPCC reports and on states' commitments to both environmental and human rights treaties, the court concluded that states have legally binding duties to prevent significant environmental harm and to cooperate internationally to uphold fundamental human rights in the face of escalating climate risks. Failure to do so leaves a country exposed to claims for restitution from those who have been harmed.

Either coincidentally or intentionally, in many countries the Covid response mimicked the playbook that had been established in relation to climate change policies. The policies were said to be based on scientific consensus and the public was asked to follow the science and trust the experts. The threat from the climate and pandemic emergency, if not addressed urgently, could prove to be existential. The catastrophism was based on models, and any variance from empirical data was ignored. The claim of scientific authority and existential crisis escalated the policy responses into moral crusades and people were asked to bear sacrifices for the good of the collective humanity and the planet. To that end, state power expanded under both agendas to interfere with people's freedom of choice in their personal lives including health choices and to restrict consumer choice with diktats to implement the Net Zero agenda and classification of goods and services into essential and non-essential. The same moralism and risks were used to launch personal attacks on critics and to ridicule and censor dissenting opinions, even from experts in the field, by

41 https://www.icj-cij.org/sites/default/files/case-related/187/187-20250723-pre-01-00-en.pdf

42 https://www.icj-cij.org/sites/default/files/case-related/187/187-20250723-adv-01-00-en.pdf

claiming a monopoly on truth and the best policies to manage the crises. The costs of the policies, risks of collateral harms, and the resulting need for policy trade-offs were downplayed and dismissed. These included the disproportionate burden placed on the poorer people and countries. And resources devoted to flagship green causes and to pandemic preparedness alike would save more lives if redirected to basic health, nutrition, and economic development.

Against this backdrop, the world court's climate liability opinion intersects with the issue of health sovereignty on four points. First, falling trust in the competence, integrity, and truthfulness of public institutions and media following the Covid experience has had a flow-on effect in a new willingness to question other policy domains, including climate change and net zero. In turn this has triggered a growth in support for radical ethnonationalism that is being tapped by increasingly popular centre-right parties.

Second, to ensure that such an outcome aligns with official policy preferences, governments engage in narrative management whereby a false impression is deliberately fostered of scientific consensus, the policy option is said to be based in that settled science, and efforts are mounted to censor dissenting opinions as misinformation. On 15 May 2025, Elisa Morgera, UN Special Rapporteur on the Promotion and Protection of Human Rights in the Context of Climate Change, submitted a report (A/HRC/59/42) that warned of the need to "defossilize" information systems and called for criminal penalties on those peddling misinformation and disinformation (pp. 18–19).[43]

Third, the ICJ justified its conclusion on the reasoning that the "adverse effects of climate change" "may significantly impair the enjoyment of certain human rights," including "the right to health" (paragraph 379). The "obligation to prevent significant harm to the climate system and other parts of the environment…*applies to all States, including those that are not parties to one or more of the climate change treaties*" (paragraph 409, emphasis added). This sets an obvious precedent for the same argument to be repeated in a future pandemic contingency, even for states that

43 https://docs.un.org/en/A/HRC/59/42

may have opted out of the pandemic accords. Moreover, the scope for this could be virtually unlimited if judges hold the view that treaties are "living instruments."

Fourth, the opinion is not binding but will shape climate governance around the world in myriad ways in the years to come in academia, courts, bureaucracies, and civil society.[44] This is the same argument as that made above on the compliance pull of the pandemic accords.

II.7 The US exit is a wake-up call

On 21 January 2025, President Trump signed an executive order to withdraw the US from the WHO.[45] Since that order the US has also stopped funding to GAVI, the global vaccine alliance as well as reduced funding for the Global Fund. Other countries have followed suit, reducing funding for global development and key global health initiatives. The US withdrawal from the IHR was announced jointly by the US Secretary of Health and Human Services and the US Secretary of State on 18 July 2025.[46] According to this announcement "The first reason is national sovereignty."[47] The announcement goes on to state, though inaccurately, that nations that "accept the new regulations are signing over their power in health emergencies," or even when confronting nebulous "potential public health risks," to "an unelected international organisation that could order lockdowns, travel restrictions, or any other measures it sees fit."

The pandemic accords' vision, according to the US health secretary, is of "a technocratic control system that uses 'health risks' and 'pandemic preparedness' as a Trojan Horse to curtail basic democratic freedoms" by creating "global systems of health IDs, vaccine passports, and a centralized

44 https://blogs.law.columbia.edu/climatechange/2025/07/24/the-icjs-advisory-opinion-on-climate-change-an-introduction/

45 https://www.bbc.com/news/articles/c391j738rm3o

46 https://www.hhs.gov/press-room/state-department-hhs-rejects-amendments-to-international-health-regulations.html

47 https://www.youtube.com/watch?v=u5ID0s-oLyA&ab_channel=U.S.DepartmentofHealthandHumanServices

medical database." The United States is not prepared to subject itself to "a future where every person, every movement, every transaction, every human body is under surveillance at all times."

The accuracy of this statement is contestable, since the WHO constitution does not grant it this power and the final draft of the Pandemic Agreement specifically says that the WHO does not have this authority. That aside, it would be churlish to discount the concerns and perceptions of eroded national sovereignty underpinning US action, in view of the ICJ decision on climate above. Studies in globalization have also demonstrated that an erosion of sovereignty has occurred across most sectors, while anti-globalization views are clearly guiding new policies. Moreover, the current US administration is not alone in their perception and there is a significant literature in global health policy, particularly from the perspective of low- and middle-income countries (LMICs), articulating concerns about global health policy as a vehicle for "neocolonialism" and "Western centrism." All of which reflect a concern for an eroded national sovereignty.

A more salient point, regardless of WHO's lack of legal authority, is that it does hold a significant amount of epistemic authority combined with normative, convening, and agenda-setting power. The WHO is often relied upon by states, particularly LMICs, for information, guidance, and assistance. As a result, policies such as the accords can act as a form of soft power, which manifests both internationally and domestically. When this form of agenda-setting soft power is combined with the hard financial power of the World Bank, the International Monetary Fund (IMF), GAVI, and other global health initiatives, it becomes a structural form of power. Although processes of global health governance can have extremely positive effects on health outcomes, which should not be dismissed, there are also well known concerns within the development aid for health literature about how these forms of power can undermine the creation of nationally owned programmes, generating aid dependencies, producing vertical and misaligned policies, imposing uncontextualized "travelling models," and demanding funding conditionalities that can run counter to local needs.

In this light, the pandemic accords have been viewed by several LMICs and high-income countries (HICs) as a technocratic control system that

uses potentially inflated claims of "existential threat" to lock in existing forms of asymmetric power, which risks the promotion of vested interests while curtailing local control.

If genuine, the actions of the US and its America First Global Health Strategy (AFGHS)[48] provide potential opportunities to reevaluate and reform global health governance to reduce foreign aid dependencies and drive meaningful change towards better and more sustainable global health outcomes, an emphasis reflected more broadly by African states in the Accra Reset of 2025.[49] The key to promoting positive change is to design assistance that strengthens local capacities to self-administer and self-finance their health systems in the medium and long term. An important goal articulated in the AFGHS is to reverse structures that undermine local control, self-reliance, sustainability, and overall population and system health. Taking the Health and Human Services Secretary's words at face value, the process for rethinking global health must start to "strengthen national and local autonomy to hold global organisations in check and to restore a real balance of power." Again, if genuine, and not merely window dressing to obscure US business as usual, then AFGHS could be a catalyst for change.

On the same day, 18 July 2025, Italy provided a clear articulation of the above concerns regarding national sovereignty over policy within a health emergency in a letter from the Minister of Health to the WHO DG, Tedros Adhanom Ghebreyesus.[50] Italy's deputy minister for foreign affairs and international cooperation, explained:[51]

48 https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf

49 https://presidency.gov.gh/statement-african-health-sovereignty-in-a-reimagined-global-health-governance-architecture-a-co%E2%80%91creation-summit-under-the-leadership-of-his-excellency-john-dramani-mahama-president-of-the/

50 https://en.ilsole24ore.com/art/italy-rejects-oms-health-regulation-amendments-as-usa-AHD6a2nB

51 https://www.agenzianova.com/en/news/litalia-rifiuta-gli-emendamenti-al-regolamento-sanitario-internazionale-delloms/

> *It's absurd and dangerous to think that Italy should cede parts of its healthcare sovereignty to an organization like the WHO, which, during Covid, has shown clear limitations. This is not cooperation: it's bureaucratic centralism in a health-care context, with the risk of drastic measures being imposed without any democratic debate…I firmly believe that each nation's right to decide how to address a health emergency must be defended. This isn't narrow-minded sovereignism: it's a responsibility to its citizens.*

On any understanding, creating a permanent dependency on financial and technical assistance from external actors undermines self-reliance and is a de facto threat to health sovereignty. Since 1948, huge leaps have occurred in healthcare technology and the economic growth that underpins improved health outcomes. This should, rationally, reduce the burden of disease and the lack of capacity that WHO was intended to address. Instead, the growth in mandates, authority, resources, and personnel to match an expansion of the WHO's scope of work has catered to the corporate interest of the WHO as an international bureaucracy and to the career interests of a continually expanding corps of international civil servants, technocrats, philanthropic foundations, health-related think tanks, and the profit-maximizing pharmaceutical and biotech industries. To understand this shift better, in Chapters 4 and 5 we will review the history of the WHO. Before that, however, in the next chapter we trace the political ramifications of a resurgent anti-globalization movement.

III. THE WHO UNDER RESURGENT ANTI-GLOBALISM

The recent drift away from an international rules-based order towards reinvigorated forms of power politics suggests that the old liberal order is crumbling. At the grassroots level, traditionally left-wing anti-globalization agendas in HICs and LMICs have found increasing resonance among more conservative audiences in the form of anti-globalist movements. Anti-globalization movements have historically protested corporate-driven economic globalization, advocating for social justice, fair labour, and greater subsidiarity in decision-making against powerful multinational corporations and international institutions like the World Trade Organization (WTO), IMF, and the World Bank. In what became a powerful symbol of defiance in the West, the 1999 G7 protests in Seattle called for greater "local control" and a respite from what they saw as a "Washington consensus" to promote a global elite and their corporate interests. Many similar movements against corrupt, "puppet," and "bought" governments arose in non-Western contexts, again demanding greater community control and greater responsibility for their citizens.

More recently, many of these themes have resurfaced within partisan claims against so-called "globalism." where demands to "take back control" include a dismantling of global institutions that are seen as proxies for a global corporate elite and increasingly influential non-state corporate clubs such as the World Economic Forum (WEF).[52] Although each movement is distinctive and they have diverse ideological histories,

52 https://www.weforum.org/

what unites them is a belief that globalization has failed to live up to its promise in a post-Cold War world and the perception that the international order has merely been captured for the benefit of some interests over others.

At the level of the nation state, an equally harsh assessment of the United Nations as the pinnacle of the liberal order was delivered by President Trump on 23 September 2025. He depicted the UN as long on strongly worded letters and resolutions but short on action, constituting a failure to live up to its potential with little measurable impact. A common theme "connecting the dots" of the manifold challenges to the liberal international order is the reassertion of national sovereignty and hard borders against perceived overreach by intergovernmental organisations that have grown bigger and taken on additional tasks as they reach ever deeper into the internal affairs of states. The dissatisfaction with the WHO mission drift must be understood in this broader context, for it structures the realistic alternatives for WHO supporters and critics alike.

As is often described within the globalization literature, state agency has been increasingly circumscribed by institutions of global governance. Areas that previously were the preserve solely of sovereign states, like immigration, border control, trade, human rights, health, energy policy, even self-defence against armed attack and international terrorism, must now conform to international standards enforced by supranational tribunals. National intellectual, bureaucratic, and political elites are perceived to collude with international technocratic elites to establish and defend their vision that elevates the collective good over the values, interests, and policy preferences of nation states that created and consented to the institutions in the first place.

The architecture of global governance is made up of formal international organisations with the United Nations system at the core, regional organisations, and informal G-groups of which the most prominent is the G20 but which also include the old G7 and the newer BRICS groupings of industrialized and emerging market economies. UN membership has almost quadrupled since its establishment. The rising and revisionist powers wish to redesign the international governance institutions to inject their own interests, governing philosophies, and preferences. Without continual structural and procedural reforms, the legitimacy and performance deficits

accumulate, producing an intensifying crisis of confidence in the world's system of UN-centric organized multilateralism.

III.1 Global governance by the lanyard class

The concept of equality of state legitimacy – that all states are endowed with equal rights to legal respect, sovereign prerogatives, political independence, and inviolable territorial integrity – is not universally accepted. A further problem with the state-centric nature of international organisations is that many challenges and problems are transnational and involve non-state actors, including but by no means limited to terrorist groups. With respect to influencing policy and awareness in the area of human rights, major NGOs and civil society actors such as Amnesty International, Human Rights Watch, the International Committee of the Red Cross, Greenpeace, and Transparency International have proven worthy competitors as well as complements to the UN's human rights mechanisms.

The phrase "the lanyard class" refers to the professional cadre of managerial elites who run the national public sector and international secretariats. Nationally, their entrenched institutional hostility is a serious barrier to governments transitioning from being in office to being in power, for they can sabotage government efforts to implement policy based on voter mandates at multiple points of resistance. Members of this elite class of technocrats network seamlessly across sovereign borders and work together to advance their vision of the international interest. For example, the International Maritime Organization,[53] a UN-specialized agency based in London as the global standard-setting authority for the safety and security of international commercial shipping, has been considering a new tax on carbon emissions. Under a "net aero framework" for shipping, it had negotiated a deal for a graduated scale of charges per tonne of CO_2 emissions above specified limits that would amount to an annual global emissions tax of $10-12 billion to be paid directly to the UN. At a vote in London on 17 October, the US and Saudi Arabia succeeded in scuttling the talks that would have seen shipping become

53 https://www.imo.org/en/

the first industry to adopt internationally mandated targets to reduce CO_2 emissions.[54] The decision was deferred for a year.

III.2 Rebooting the ethic of global health cooperation

The WHO too has been caught in the crossfire of those who support strengthening the institutions of global governance and others who are determined to create a new order that reconnects global governance to power politics and the nation state as the foundational entity, reducing international institutions to optional add-ons. Amidst the broader turmoil roiling the post-1945 international liberal order, the recent US notice of withdrawal from the WHO presents a unique opportunity to rethink the type of international health institution the world needs, how that should operate, where, for what purpose, and for how long.

In 1987, the Brundtland Commission Report affirmed: "The Earth is one but the world is not."[55] In 2004, the report of the high-level panel on UN reform held that collective security is necessary because contemporary threats cannot be contained within national boundaries, they are interconnected, and they have to be addressed simultaneously at all levels.[56] The pandemic and the resulting economic and social crises give a human face to the reality that the evolution of institutions of international governance lags behind the rapid emergence of global threats. Thus, the pandemic underscores the need and provides an opportunity to reboot the ethic of global cooperation.

The WHO is a specialized UN agency. The UN system is a trusted agent for the necessary tasks of surveillance, detection, and guidance on response measures because of its perceived universality and the resulting legitimacy; its expertise accumulated over decades of experience; its scientific objectivity alongside its political neutrality; its presence in the

54 https://www.bbc.com/news/articles/c3vnl0yxg53o

55 https://sustainabledevelopment.un.org/content/documents/5987our-common-future.pdf

56 https://www.un.org/peacebuilding/sites/www.un.org.peacebuilding/files/documents/hlp_more_secure_world.pdf

field in so many countries around the world that gives it a truly global footprint; and its unmatched convening authority and mobilizing capacity across all levels and sectors of global governance.

The UN Charter was a triumph of hope and idealism over the experience of two world wars. The flame of idealism flickered in the chill winds of the Cold War, but refuses to die out. In the midst of the swirling tides of change, the UN must strive for a balance between the desirable and the possible. It is still the symbol of our dreams for a better world, where weakness can be compensated by justice and fairness and the law of the jungle replaced by the rule of law.

As international organisations, both the UN and the WHO (or a replacement IHO) have to strike a balance between realism and idealism. The UN is the repository of international idealism. Yet, at the same time, its various entities, departments, and specialized agencies, including the WHO, reflect the flaws of structure, personnel, and performance of any bureaucracy, including the extra challenges built into an international bureaucracy.

Beyond the specific features of an international organisation, however, the UN and all its entities, including the WHO, represent the idea that unbridled nationalism and the raw interplay of power must be mediated and moderated in an international framework. The UN system is the centre for harmonizing national interests and forging the international interest. Of course, the UN is an international bureaucracy with many failings and flaws; and a forum often used and abused by governments for finger pointing, not problem solving. There is a proclivity in UN circles to seek fresh legislation as the solution to problems of implementation. All too often the UN has demonstrated a failure to tackle urgent collective action problems due to institutionalized incapacity or unwillingness. These are the three facets – an international bureaucracy, a politicians' talk-shop, and a spineless-cum-toothless cop on the beat – that oftentimes have drawn the most serious criticism.

Yet the world body remains the focus of international expectations and the locus of collective action. The reason for this is that much more than the attributes of bureaucratic rigidity, institutional timidity, and intergovernmental trench warfare, the UN is the one body that houses the divided fragments of humanity. It is an idea, a symbol of an imagined

and constructed community of strangers. It exists to bring about a world where fear is changed to hope, want gives way to dignity, and apprehensions are turned into aspirations.

This explains why an IHO remains essential in some form. It is for the sovereign states of the world to determine whether better returns are more realistically expected from efforts to reform the existing WHO or invest in a successor international health organisation that retains the best elements of the WHO, sheds its many pathologies, and is more fit for purpose for the next 50 years free of nostalgia for a world that no longer exists. We will return to this central question in the final chapter of the report.

IV. THE WHO's INCREASING FOCUS ON EMERGENCIES

The WHO is first and foremost an international bureaucracy rather than the repository of cutting-edge medical science knowledge or a collection of the world's foremost medical practitioners and researchers. It would be a very rare bureaucracy indeed that over the span of nearly 80 years had not developed a stable equilibrium of interests that prioritize the corporate interest of the organisation and the self-interest of its technocrats in gaining additional powers, resources, and personnel. This will typically be justified in the language of adapting the founding mission to changing circumstances and needs. In addition, the bureaucracy will also have acquired and instilled in its institutional memory techniques to deflect criticisms and reform efforts designed to trim back its size and resources. In short, it is in the nature of bureaucracies to deepen, broaden, and perpetuate the very need that brought about their creation in the first place, rather than to complete their mission successfully and be downsized out of existence.

That said, new health priorities will arise. The emergence of new, deadly, and highly contagious diseases has always occurred and will continue. They spread across borders, with greater vulnerability among poor countries and poor people owing to lower nutrition, poorer living conditions, and sparse preventative and therapeutic care. The back-and-forth movement of people in large numbers as business travellers, tourists, traders, soldiers, migrants, internally displaced, and refugees – with modes of transport more rapid than the incubation periods – ensures that symptoms develop only after borders have been crossed. But such travel also promotes wider population immunity – making the devastating epidemics of immunologically naïve

populations of former times less likely.

The very first function of the WHO is described in its constitution as "to act as the directing and coordinating authority on international health work" (Article 2.a).[57] From the first International Sanitary Conference in Paris in 1851 until the early 20th century, states engaged in protracted negotiations culminating in the adoption of the ratification of the First Sanitary Convention, on cholera, in Venice in 1892 and the International Sanitary Regulations in 1903, later renamed as International Health Regulations (IHR). Yet, most states largely ignored the IHRs until the 1980s. The end of the Cold War witnessed an efflorescence of multilateral health cooperation from the 1990s onwards. That is, global health governance was weak from the birth of the regulations around the turn of the century through to the 1980s. But with the elimination of smallpox and its dramatic demonstration of how a normative consensus and solid knowledge can underpin effective international health governance, and in the new post-Cold War spirit of multilateral collaboration, faith was renewed in the possibility of successfully attacking other global health challenges in the years ahead.

However, the WHO is expected to perform this function within the context of its broader public health role, as a source of knowledge and guidance to member states that prioritizes overall disease burden, not just a narrow response to a specific threat. WHO priorities of child nutrition, safe birthing, and control of major preventable killers such as malaria, HIV/AIDS, and tuberculosis all suffer with diversion of resources and healthcare and economic disruption, with major long-term consequences to health and mortality. Tuberculosis alone kills up to 1.3 million people annually today, a figure to be borne in mind when considering the examples of outbreak mortality discussed below.

57 https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

IV.1 The eradication of smallpox

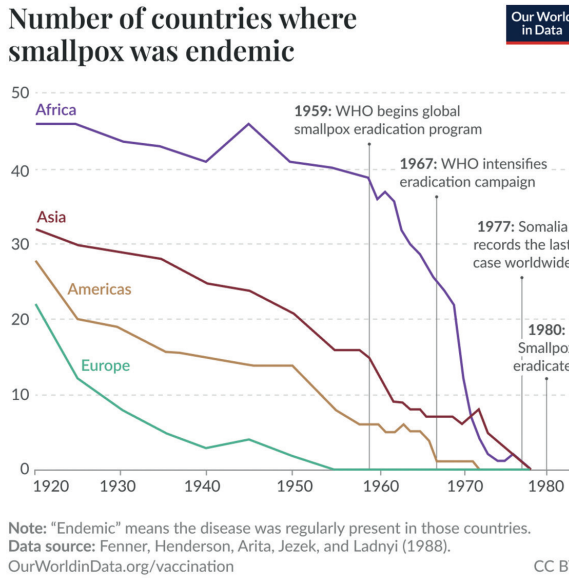


Figure IV. SEQ Figure_IV. * ARABIC 1 – The eradication of smallpox.

Source: https://ourworldindata.org/data-insights/smallpox-declined-gradually-until-the-who-coordinated-the-global-effort-to-eradicate-it

Smallpox, a disease that was endemic across all continents and a major cause of human mortality in previous centuries, is the only human disease to have been successfully eradicated: a major success story for global health. The smallpox vaccine, originally developed by the English country doctor Edward Jenner in 1796 was, as it happens, the first vaccine to be developed. The disease was eradicated from Europe in the mid-1950s. Yet, it was still endemic across Africa and Asia in the mid-20th century, infecting tens of millions of people every year (Figure IV.1) with a case

fatality rate of up to 30 percent.[58]

When the WHO began the eradication campaign in 1959, scepticism was widespread since no human disease had previously been eradicated and so only minimal funding was provided to the effort. What sustained scientists' optimism was that smallpox affects only humans and thus has no animal reservoir, it presents clear symptoms, requires close contact to maintain transmission, and an effective and low-cost vaccine was already available. The WHO intensified the campaign in 1967 with a focused strategy of "ring vaccination" to contain outbreaks by vaccinating people around each case and embedding the fieldwork within local health programmes. A surveillance system was set up to detect and investigate cases and contain outbreaks. Three principles were critically important: all countries would need to participate, with some form of regional and global coordination; programmes would need to be flexible and adapted to the specifics of each country; and ongoing research, in the field and the laboratory, would be needed to evaluate progress and solve problems as they arose.

By the early 1970s, smallpox was on the retreat. By 1975, the number of countries where the disease could still be found had fallen from 30 to three – India, Bangladesh, and Ethiopia. The last case in the world was recorded in Somalia in 1977 and three years later, in the WHO's finest hour, it was officially declared eradicated from the world. The total cost of the 11-year effort had been around $300 million, one-third of which came from international sources and two-thirds from the affected countries themselves.

Thus, in a triumph of science and international cooperation under the auspices of the WHO but reliant predominantly on resources and action of member states, the number of cases fell to zero within a decade. Smallpox still serves as a positive and inspiring example of a successful campaign to eradicate a major killer disease when its epidemiology is supportive, the norm of eradication is accepted, the requisite political will is mustered, and the necessary financial and organisational resources are mobilized.

58 CDC: https://www.cdc.gov/smallpox/about/index.html

IV.2 Epidemics in the new millennium

SARS

The first severe and easily transmissible disease of the new millennium was SARS, the innocuous sounding acronym for what is a "severe acute respiratory syndrome." The WHO coordinated the international response and worked closely with health authorities in affected countries to provide epidemiological, clinical, and logistical support as required.

SARS is believed to have originated in Guangdong Province in southern China around November 2002, crossed over to Hong Kong in February 2003, and then spread to Vietnam, Singapore, Mongolia, the Philippines, New Zealand, Canada, and Germany. Public health officials first recognized SARS in February 2003. By the end of July 2003, more than 8,000 possible SARS cases and almost 800 deaths had been reported. Economies were disrupted, schools, hospitals, and in some cases even borders were closed, and the daily lives of millions of people were affected. Throughout Asia and the Pacific, international travel and hotel occupancies fell sharply. Unusually for an international crisis, to UN personnel required to undertake international travel on official UN duties to and from the Asia-Pacific region, its impact on travel protocols was highly visible. This would have helped shape their understandings and internal discussions of the crisis and policy interventions to manage it.

WHO headquarters in Geneva issued a "global alert" on 12 March 2003, warning of the outbreak of unexplained cases of atypical pneumonia. This was followed a few days later by disseminating clinical information on the disease to health authorities, airlines, and travellers, with a travel advisory against people exhibiting symptoms. The cause of the disease was found by the US Centers for Disease Control and Prevention (CDC), in a sample from Singapore, to be a new virus, the SARS coronavirus or SARS-CoV, which had not previously been detected in humans and animals.

While the total number of countries affected was 26, over 95 percent of the outbreaks were in the western Pacific. Accordingly, the WHO's Western Pacific Regional Office in Manila, the Philippines, took lead responsibility for dealing with the pandemic by supporting member states to contain and control the outbreak, supporting the health care infrastructure in affected countries, helping vulnerable countries prepare for and avoid introduction

to their shores, and collecting and providing up-to-date information to health officials in the region and globally.[59] In addition to WHO staff in the area, professionals in the field of epidemiology, infection control, laboratory diagnosis, and public information were contacted. Infection control equipment was dispatched to affected and vulnerable countries. A regional laboratory network was established under WHO auspices to carry out testing for countries with limited laboratory facilities. Local public health officials worked with WHO specialists to put in place enhanced surveillance and early detection systems and procedures, and close liaison was established and maintained with the media in order to raise public consciousness.

For a new communicable disease, the daily toll of SARS fell quite fast, and on 5 July 2003, Taiwan was the last area to be delisted from the SARS sheet. In other words, an integral part of the UN system, the WHO, was the lead actor in filling knowledge gaps through data collection and collation rather than original research, and through acting as a clearing house for information; promulgating worldwide the norms of safe international travel to guard against the disease; and informing and helping governments to institute preventative and curative measures (filling policy gaps) to contain and eliminate the threat. However, the low mortality reflects the limited transmissibility, relative ease of containment, and perhaps rapid reduction in virus virulence. There was a failure to draw longer-term lessons regarding the disproportionate cost to economies that have wider health implications.

Avian flu

Similar comments hold true of the outbreak of avian flu,[60] a contagious disease of animals caused by viruses that are normally restricted to birds and sometimes also pigs. Its chief causative agent was identified as the H5N1 virus. Highly pathogenic, it is one of a number of influenza viruses to periodically cross the species barrier from birds and animals to humans.

59 https://iris.who.int/bitstream/handle/10665/207501/9290612134_eng.pdf

60 https://iris.who.int/bitstream/handle/10665/69749/WHO_HSE_EPR_DCE_2008.3_eng.pdf

The most common means of cross-species infection is direct contact of people with infected poultry or with surfaces and objects contaminated by the faeces of infected poultry.

Just as SARS was declining in the Asia-Pacific, the region was hit by avian flu in mid-2003, with a response involving the culling of an estimated 250 million birds (mainly chickens) across several Southeast Asian countries. It subsequently spread to South Asia, the Middle East, Europe, and Africa. The WHO led the main international campaign against the threat of avian flu.[61] Its recommended integrated strategy included actions to strengthen national preparedness and improve early warning systems. These might have delayed international spread, and accelerated vaccine development. Data show that 774 people died from SARS[62] and just 455 people had died of avian flu over 15 years to 2019.[63]

The WHO's exclusion of Taiwan from the WHO's activities during multiple epidemic responses stemmed not from a technical assessment of public-health risk, but from its position within the UN system and the UN's adherence to a "One China" policy. Taiwan's non-recognition as a UN member state is a political determination made by a large majority of UN member governments, all of which also sit in the World Health Assembly. Even if the UN General Assembly were inclined to revisit this position, the effort would still face a veto in the Security Council.

Global health security depends on the rapid, transparent, and inclusive exchange of epidemiological data, clinical experience, and response capacity. Any significant geographic gap in collaboration creates potential blind spots in surveillance, delays in information sharing, and weakens collective preparedness – reducing the ability to manage transboundary health threats. The consequences of this structural weakness were evident during the Covid-19 pandemic in 2020, when political constraints impeded information sharing with Taiwan.

61 https://iris.who.int/bitstream/handle/10665/69749/WHO_HSE_EPR_DCE_2008.3_eng.pdf

62 https://ourworldindata.org/historical-pandemics

63 https://d.docs.live.net/Volumes/RThakur%20hard%20drive/RCT/Boards/AWH/Report/Policy%20Report/2E/link%20dead

IV.3 Swine flu and the Tamiflu scandal

The H1N1 influenza virus infects cells in the linings of the nose, throat, and lungs. In the winter of 2009–10, a new H1N1 virus, commonly called the swine flu because it was a combination of influenza viruses that infect pigs, birds, and humans, began causing illness in humans. The WHO declared the highly contagious strain a pandemic on 25 April 2009 – the first declared influenza pandemic since the 1968 Hong Kong flu – and declared it had ended on 10 August 2010, by which time the WHO estimates that 123,000 to 203,000 people had died from it (considerably fewer than the annual mortality from seasonal influenza).[64] However, unlike the 90 percent of seasonal flu deaths that occur among seniors aged 65 and above, 80 percent of swine flu deaths were in people aged 64 and lower, thereby greatly magnifying the quality-adjusted life years (QALY) lost. Since then the H1N1 flu has become one of the strains that cause seasonal flu.

In response to the WHO's declaration of the Swine flu pandemic, a joint investigation by the *BMJ (British Medical Journal)* and the Bureau of Investigative Journalism, published on 4 June 2010, raised "troubling questions" about how the WHO manages conflicts of interest among the scientists who advise its pandemic planning and the transparency of the science underlying its advice to governments.[65] Key scientists advising the WHO on planning for an influenza pandemic had done paid work for pharmaceutical firms that stood to gain from their guidance. How appropriate was it for the WHO to take advice from experts who had declarable financial and research ties with pharmaceutical companies producing antivirals and influenza vaccines? In addition, the BBC reported on the same day, membership of the emergency committee which advised the WHO's director-general on declaring an influenza pandemic had been kept secret, and as such their possible conflicts of interest with drug companies were not known.[66]

64 https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf?ua=1

65 https://www.bmj.com/content/340/bmj.c2912

66 https://www.bbc.com/news/10235558

Between 1999 and 2009, oseltamivir, an antiviral drug marketed by Roche under the brand name Tamiflu, was approved for seasonal flu by the US CDC, Food and Drug Administration (FDA), the European Medicines Agency, Japan, India, and others for prophylactic and therapeutic use to treat influenza. Several randomized controlled trials, systematic reviews, and meta-analyses, many funded by Roche, indicated a favourable efficacy and safety profile for the drug. In May 2009, the WHO prequalified a generic version of oseltamivir and it was widely purchased and stockpiled by various governments.

After the pandemic proved to be far less virulent and severe than predicted, the whole Tamiflu saga was considered to have been a "costly mistake."[67] With the 2009 swine flu, instead of the feared 1.3 percent fatality rate, the actual rate was 0.02 percent,[68] comparable to US 2007–09 seasonal flu mortality.[69] In the UK, against the "reasonable worst-case scenario" of 65,000 deaths, there were only 457.[70] The government spent £1.2 billion on flu remedies that were not needed. A National Audit Office review in May 2013 concluded that the Tamiflu drug bill had proven to be a "shocking waste of taxpayers' money."[71] The WHO came under severe criticism for having served the interests of "Big Pharma" in selling unnecessary vaccines.[72] A Cochrane Review in 2012[73] and related articles raised doubts about the regulatory decision of approving Tamiflu and questioned the risk-benefit ratio of the drug.[74] WHO recommendations

67 https://pmc.ncbi.nlm.nih.gov/articles/PMC4375804/

68 https://www.reuters.com/article/us-flu-h1n1-pandemic-idUSBRE90O0T720130125

69 https://www.webmd.com/cold-and-flu/news/20100907/h1n1-swine-flu-no-worse-than-seasonal-flu

70 https://www.ft.com/content/1e390ac6-7e2c-11ea-8fdb-7ec06edeef84

71 https://www.bbc.com/news/health-22608671

72 https://web.archive.org/web/20100114013335/http:/www.news.com.au/world/swine-flu/story-e6frfkyi-1225818388508

73 https://pubmed.ncbi.nlm.nih.gov/22258996/

74 https://www.bmj.com/content/344/bmj.d7898

for stockpiling the drug were also criticized. An updated Cochrane Review published in April 2014 concluded that hundreds of millions of dollars may have been wasted on the drug for flu that works no better than paracetamol.[75]

John Snow reported for *Channel 4 News* (UK) in 2010 that "in one of the greatest medical scandals of the century," the health chief of the Council of Europe "has accused major pharmaceutical firms of organizing a campaign of panic and unduly influencing" WHO decisions in relation to the H1N1 flu.[76] However, at a press conference on 14 January 2010, Keiji Fukuda, the WHO's chief flu scientist, rejected criticisms that the swine flu pandemic was "fake," its threat to human health was hyped, and WHO policies were unduly influenced by vaccine manufacturers who benefited from the pandemic virus.[77] Some other observational studies did support the net benefits of Tamiflu.[78]

Nevertheless, on 9 February 2011, Report A7-0035/2011 of the European Parliament noted a resolution, adopted on 25 January 2011 by a 58-2 vote by its Committee on the Environment, Public Health and Food Safety.[79] In it, the European Parliament:

- Urged the WHO to revise the definition of a pandemic to take into consideration not only its geographical spread but also its virulence and severity
- Pointed out that purchasing procedures led to concerns regarding compliance with rules on public procurement and transparency, resulting in lawsuits alleging corruption and conspiracy between officials and pharmaceutical companies

75 https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008965.pub4/full

76 https://www.youtube.com/watch?v=q9qeLcq3y8w&ab_channel=Minerva

77 https://www.science.org/content/article/facing-inquiry-who-strikes-back-fake-pandemic-swine-flu-criticism

78 https://theconversation.com/controversies-in-medicine-the-rise-and-fall-of-the-challenge-to-tamiflu-38287

79 https://www.europarl.europa.eu/doceo/document/A-7-2011-0035_EN.html

- Reaffirmed that "liability for the quality, safety and efficacy of medicinal products…rests with the manufacturer"
- Demanded transparency on meeting the three conditions of vaccine efficacy, a positive benefit-risk balance, and targeting of risk groups for vaccination strategies
- Underscored the need for studies independent of the pharmaceutical companies on vaccines and antiviral medications
- Affirmed the need for scientific experts to be free of "financial or other interests in the pharmaceutical industry that could affect their impartiality"
- Reminded the European Medicines Agency of the regulatory requirement to make access available to all the documents relating to clinical trials, research protocols, and undesirable effects of the medicinal products evaluated by its experts, including the vaccines and anti-viral drugs.

Every one of these comments was to prove prescient with regard to how the WHO mismanaged the Covid-19 pandemic just over a decade later. In February 2012, Transparency International Germany joined the chorus of calls supporting the Cochrane Collaboration requests for open access on Roche's clinical trial results on Tamiflu[80] – something that many sceptics have been demanding of Pfizer regarding their Covid-19 vaccines as well.

IV.4 Ebola

The WHO was also subjected to considerable criticism for its handling of Ebola. There have been several outbreaks of this exceptionally lethal disease with a mortality rate ranging from 25 to 90 percent.[81] There was a particularly virulent outbreak from December 2013 to June 2016 in West African countries, with some travel-related cases in Italy, Spain, the UK, and the US. The outbreak caused the death of just over 11,000 people. The

80 https://www.transparency.org/en/press/20120202-tamiflu

81 https://pmc.ncbi.nlm.nih.gov/articles/PMC11660724/

WHO management of the crisis was criticized for tardiness of response, unwillingness to challenge official reports from governments, and a lack of adequate coordination. The response to the 2018-20 outbreak in the Democratic Republic of the Congo (DRC), in which 2,299 deaths from 3,481 cases were recorded, cost over $1 billion[82] – an enormous opportunity cost in a country recording over 60,000 (preventable) childhood malaria deaths per year.

Between them, a number of studies and reviews of the WHO performance on swine flu and West African Ebola outbreak identified several structural, financial, and operational factors that contributed to the mishandling of the crises: the lack of flexibility (an "emergency culture"),[83] bureaucratic inefficiency, inadequate human and financial resources due to the disproportionate level of specified and thematic contributions, weak technical capacity, and unhelpful competition between regional offices and the WHO headquarters.

IV.5 Monkeypox

The most recent example of pandemic panic from the WHO concerns monkeypox. On 23 July 2022, WHO Director-General (DG) Tedros Adhanom Ghebreyesus unilaterally declared monkeypox a Public Health Emergency of International Concern (PHEIC).[84] Until that date it had affected few people, overwhelmingly within a specific demographic group (sexually-active male homosexuals) in a handful of countries and killed just five people.[85] The DG declared this against the advice of the emergency committee. This was lifted in May 2023 after a

82 https://gh.bmj.com/content/8/10/e012660

83 https://pmc.ncbi.nlm.nih.gov/articles/PMC7122988/

84 https://www.who.int/europe/news/item/23-07-2022-who-director-general-declares-the-ongoing-monkeypox-outbreak-a-public-health-event-of-international-concern

85 https://www.who.int/director-general/speeches/detail/who-director-general-s-statement-on-the-press-conference-following-IHR-emergency-committee-regarding-the-multi--country-outbreak-of-monkeypox--23-july-2022

worldwide total of 140 deaths.[86]

A number of further outbreaks of monkeypox, by then renamed Mpox, arose in African states from 2024, particularly the DRC and were in this case also prevalent in young, often malnourished children, due to close contact with infected relatives. The WHO again declared a PHEIC in August 2024,[87] though numbers have remained low with laboratory-confirmed Mpox deaths rising to just 410 from January 2022 to September 2025.[88] The DRC had seen 68 of those confirmed deaths, compared to up to 70,000 malaria deaths per year in the same country. Regardless, Mpox has received great prominence from WHO, with a vaccination programme once again being promoted and implemented. An analysis for the DRC suggests that procurement costs alone would range between $682.5 million (that is, roughly twice the yearly public health expenditure) and $1.7 billion in order to save between 301 and 378 lives, though current trends suggest mortality is not likely to be that high.[89]

IV.6 Putting outbreak response in context

The new emphasis on relatively small outbreaks demonstrated above suggests a fundamental problem for an organisation tasked with improving equality and overall well-being[90] – such outbreaks make up a tiny fraction of total infectious disease burden, and even less of diseases overall. While the WHO claims the threat of expansion to a major pandemic justifies the emphasis, such an outbreak from natural origin has not occurred since the Spanish flu in the pre-antibiotic era, and modelling to produce significant

86 https://www.bbc.com/news/health-65564033

87 https://www.who.int/news/item/14-08-2024-who-director-general-declares-mpox-outbreak-a-public-health-emergency-of-international-concern

88 https://worldhealthorg.shinyapps.io/mpx_global/

89 https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00047-6/fulltext

90 https://essl.leeds.ac.uk/downloads/download/228/rational-policy-over-panic

annualized tolls must rely on historic outbreaks such as medieval plagues.[91]

For the pharmaceutical industry and the global health workforce, the WHO's emphasis on surveillance and vaccine-based responses to threats is a windfall, as the pandemic accords propose this goes forward irrespective of actual outbreak events. In the context of rising burdens of traditional emphases of WHO such as malaria, and falling funding for key drivers of overall health such as nutritional supplements, questions must be asked on whether the influences on WHO policy have shifted from its original mission. The centralized outbreak response approach of the WHO has not functioned well, with lack of timeliness and questions of proportionality. This suggests that a response mechanism far closer to the seat of an outbreak may be more efficient and effective.

91 https://essl.leeds.ac.uk/downloads/download/254/when-models-and-reality-clash-a-review-of-predictions-of-epidemic-and-pandemic-mortality

V. WHO OVERREACH

The previous chapter traced the origins of the WHO, the eradication of smallpox as the apogee of its accomplishments, and its mixed record in tackling the SARS, avian flu, swine flu, and Mpox epidemics. This chapter examines a shift in the organisation's approach to global health management that accompanied mission creep and mandate expansion. The social purpose of an international organisation infuses the collective action ecosystem of global governance with moralism. In the case of the WHO, the obvious question that arises is: Whose public health and medical moralism does the organisation embody? The question intersects with another. Technocratic health elites at both the national and international level believe they know what is best for everyone's health and they have the expertise, mandate, and moral duty to impose their choices on the general population through nudging behaviour,[92] coercive mandates, suppression of alternative voices, and new legal instruments to codify the changed role and mission of the WHO in line with this. This came to a head during 2020–24 with the Covid-19 pandemic when the organisation seemed to drift far from its scientific moorings and in contradiction of its own pre-pandemic recommendations, but the problem predates this. A steady expansion of the WHO's remit into culturally and locally sensitive areas of health policy is also arguably evident in the more recent WHO guidance on abortion care and alcohol.

In addition to the risk of overreach, a related risk is that there is a lot of money to be made from dressing private profit in the cloak of public virtue. This increases the scope for public subsidies to be given

92 https://www.goodreads.com/book/show/3450744-nudge

in the name of the greater good. The first step is for the health industry to recruit and co-opt those who are responsible for embedding moral frameworks into the health organisation's mission and programmes of action as advocates for its interests. Public health foundations, NGOs and activists speaking the language of universal ethical principles, and economic and bureaucratic actors who stand to benefit materially from more regulations, can team up to form a powerful coalition to advocate for their adoption and enforcement. Public health watchdogs need to be ever vigilant to ensure that the institutional mandate of an organisation, whose bureaucratic identity deepens the longer it is in existence, continues to serve the collective public interest against capture by commercial and organisational self-interests. In other words, moral rhetoric is no reason not to follow the money.

V.1 The FCTC and the moral framing of tobacco control

As the first treaty enacted by the WHO beyond the regularly evolving International Health Regulations, the WHO Framework Convention on Tobacco Control (FCTC) stands as a cautionary example of the risks of restricting complex public health problems to legal dogma and anchoring its oversight in vested interests.[93] It has major implications for the current path toward centralization and legal obligations underlying the WHO's growing pandemic agenda, and the need to anchor public health policy within local context.

The WHO's efforts to lead an international campaign to drastically reduce smoking reflects good intentions in pursuit of a laudable goal, falling victim to the law of unintended and perverse consequences. Tobacco use is acknowledged to be a major driver of non-communicable diseases like cancers and heart diseases, causing widespread death and disability.[94] Tobacco kills more than seven million people each year and lifelong

93 https://www.who.int/europe/teams/tobacco/who-framework-convention-on-tobacco-control-(who-fctc)

94 https://news.un.org/en/story/2025/02/1160481

smokers lose ten years of their life on average.[95] Tobacco cultivation depletes vital land and water resources and diverts them from sustainable food production. Tobacco-related illnesses are responsible for "catastrophic" health expenditures, particularly for the poor peoples of the world. Trillions of discarded cigarette butts pollute ecosystems. The industry's aggressive lobbying and marketing efforts undermine public health goals and efforts to combat the scourge of smoking.

Article 19 of the WHO constitution vests the World Health Assembly, the organisation's policy setting and budget approving organ, with the "authority to adopt conventions or agreements with respect to any matter within the competence of the Organization" by a two-thirds majority.[96] The new legal instrument comes into force for each member on ratification by it in accordance with its constitutional processes. The FCTC was adopted by the Health Assembly on 21 May 2003, the first treaty to be adopted under Article 19. It came into force on 27 February 2005. It has 183 States Parties. It is hosted by the WHO in its headquarters but is not a unit under WHO control.[97] Free of any direct WHO legal authority over it, the FCTC has its own governing body in the Conference of the Parties (COP).

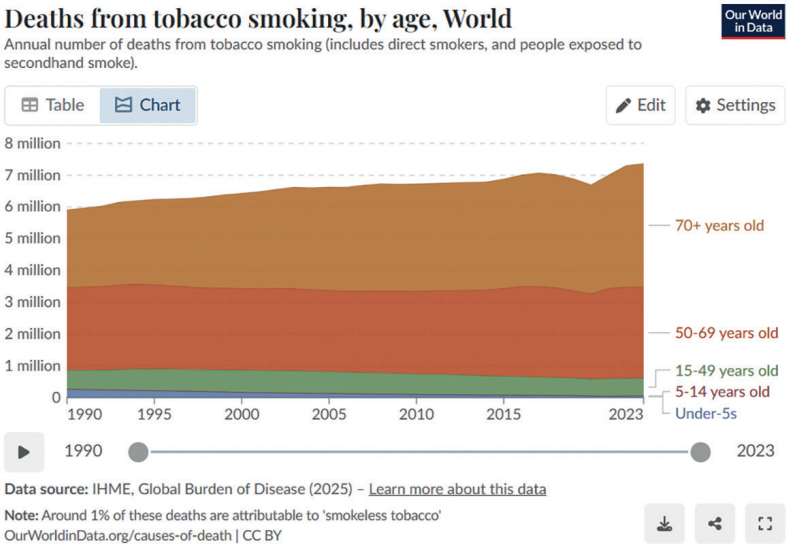
The goals of the treaty are to reduce and end the consumption of tobacco, addiction to nicotine, and exposure to tobacco smoke. To help achieve these goals, the treaty's provisions include measures to govern the production, sale, distribution, advertisement, and taxation of tobacco. The FCTC tackles both demand and supply and sets out a framework for tobacco control measures to be implemented at the national, regional, and international levels. These include price and tax measures to reduce demand; sales, advertising, and packaging restrictions; and public health messaging on the dangers of tobacco. Dr Adriana Blanco Marquizo, head of the FCTC secretariat, said in February 2025 in remarks to mark its 20th anniversary, the treaty "equips Parties with a comprehensive set of

95 https://www.who.int/europe/news-room/fact-sheets/item/effects-of-tobacco-on-health

96 https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

97 https://pmc.ncbi.nlm.nih.gov/articles/PMC6589464/

measures to protect populations from the industry's ever-evolving tactics – designed to profit at the cost of people's lives and the health of our planet."[98] FCTC standards are set out as minimum requirements and states are encouraged to adopt more stringent regulations wherever possible.



Marking the 20th anniversary of the FCTC entry into force, on 20 February 2025 WHO Director-General (DG) Tedros Adhanom Ghebreyesus described tobacco as "a plague on humanity – the leading cause of preventable death and disease globally."[99] He claimed that the FCTC's "comprehensive package of evidence-based tobacco control measures underpinned by international law" – pictorial health warnings on cigarette packages, smoke free laws, increased taxes – "have saved millions of lives." Expert evaluation teams that studied the treaty's impact in its first decade of operation found that it had accelerated the development and implementation of tobacco control legislation, serving as the catalyst for

98 https://fctc.who.int/newsroom/news/item/25-02-2025-first-ever-who-treaty-marks-20-years-of-saving-millions-of-lives-worldwide

99 https://fctc.who.int/newsroom/news/item/25-02-2025-first-ever-who-treaty-marks-20-years-of-saving-millions-of-lives-worldwide

new policies and strategies in some countries and strengthening existing weak laws in others.[100] Health measures under the stimulus of the FCTC, such as smoke-free laws, health warnings, and youth access laws, were claimed to have achieved measurable progress on tobacco consumption. The FCTC was described as "a powerful legal instrument" and evidence showed that "FCTC-compliant measures are effective." By one estimate, nearly 22 million future premature smoking-attributable deaths had been averted between 2007 and 2014.[101]

Not everyone is convinced. To be sure, tobacco use had fallen globally by a third from 29.3 percent in 2005 to 20.9 percent in 2022, albeit with a recent slowing in the rate of decline.[102] However, how much of this can be explained by the impact of the FCTC? Figure V.1 from *Our World in Data* shows no real discernible impact of the FCTC in 2005 on age-segregated deaths from smoking between 1990 and 2021. The total number of deaths went up from 5.75 million in 1990 to 6.51 million in 2005 (+760,000) and 7.25 million in 2021 (+740,000). The only age group in which the deaths increased, from 583,627 in 1990 to 678,809 in 2005, before falling to 536,486 in 2021, were those aged 15-49. There was a steady fall in deaths in the under-15s over the entire period and a steady rise in deaths among those aged 50 and over, with no evidence that the FCTC marked an inflection point in 2005 for either age group. Moreover, against a fall in smokers from 34.3 to 21.7 percent between 2000 and 2022, global tobacco yield has maintained an upward trajectory since 1961 while tobacco production and land used for tobacco cultivation increased from 1961 to peak levels in 1997 before beginning a decline.

There is a fundamental ambiguity at the heart of the FCTC. Is it a production, consumption, addiction, and harm-reduction treaty, or a prohibition treaty? Some scholarly works suggest that political activists appropriate the language of "public health," cloaking health regulation

100 https://tobaccocontrol.bmj.com/content/28/Suppl_2/s129 ; https://pmc.ncbi.nlm.nih.gov/articles/PMC6589489/

101 https://tobaccocontrol.bmj.com/content/27/1/50

102 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)00336-8/abstract

as consumer protection, to promote the interests of bureaucracies and bureaucrats, industries, and their own careers.[103] Does funding from health-centric philanthropic foundations to promote more stringent regulations therefore constitute a declarable conflict of interest similar to industry funding? Independent efforts to evaluate FCTC effectiveness and implementation show state compliance with the framework is low.[104] Steven Hoffman and Zain Rizvi of McMaster University in Canada found that one-third of country responses had been misreported in the WHO database, one-quarter of submitted reports were missing, some had been misinterpreted by WHO staff, and some were clear errors, for example "yes" being recorded as "no."[105]

As with many public policies driven by good intentions, tobacco regulations are also subject to the law of unintended and perverse consequences. Experts have described Australia's tobacco regulations, for example, as the world's "worst example of bad policy."[106] Steeply rising taxes on cigarettes that amount to more than half the total sale price have driven sales into the black market controlled by organized crime. The projected tax take of AUD7 billion in 2025 is down from $16.3 billion in 2020.[107] The Australian Association of Convenience Stores blames government policies for the $2 billion collapse in sales,[108] with the tobacco market handed over to criminals. Tax revenues have halved

103 https://bristoluniversitypressdigital.com/view/journals/jpfpc/aop/article-10.1332-25156918Y2025D000000022/article-10.1332-25156918Y2025D000000022.xml

104 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61402-0/fulltext

105 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61402-0/fulltext

106 https://www.theaustralian.com.au/nation/bad-policy-how-skyhigh-tobacco-taxes-sparked-a-5bn-black-market-inferno/news-story/490cec6f481f04f90015f0978129ac26

107 https://www.spectator.com.au/2025/09/time-to-stub-out-the-tobacco-tax/

108 https://www.theaustralian.com.au/nation/killing-the-corner-store-2bn-lost-to-black-market-tobacco-after-ludicrous-government-reforms/news-story/96ab7f9c85420068921acde391d35001

as tax rates have doubled and a health issue has been corrupted into a crime issue with shops firebombed as gangs fight for control of territory. As economists Dmitri Burshtein and Peter Swan put it in the *Spectator Australia* magazine (6 September 2025): "Government thought it was squeezing smokers; in truth, it squeezed the legal market out of existence. The result was a windfall for organized crime, which now pockets the margin, while Treasury bleeds and the deficit balloons."[109]

Designed around tobacco control, the FCTC has also struggled to adapt to innovations involving low-risk nicotine-containing alternatives such as vapes. Its institutions, guidance, and politics are path-dependent on a "quit or die" paradigm rather than comparative-risk regulation. The COP decisions incentivizing blanket restrictions (taxation parity with cigarettes, flavour bans, retail prohibitions, advertising blackouts) ignore large differences in harm between combustibles and non-combustibles. With its advisory and negotiating processes excluding independent harm-reduction scientists and manufacturers who hold safety and usage data, a moral-political coalition has replaced public health science under the treaty process, treating all nicotine as if it were tobacco smoke. The treaty architecture tends to apply the precautionary principle asymmetrically – demanding proof of zero risk for alternatives rather than prioritizing reduction of the accepted harms of combustible tobacco use. Scientific review and surveillance are weakly integrated into COP deliberations. The legal framework of the treaty, formed at a time when few alternatives existed, are now driving a dogmatic rather than science-based public health agenda and arguably impeding a reduction in use.

The FCTC illustrates the risks of turning a public health issue into a treaty. A response driven by evidence and science becomes a response driven by a rigid legal framework. While management would normally evolve with changing evidence, the fixed aims of the treaty and the bureaucracy that grows to support it become an end unto themselves, over time reducing impact and potentially doing harm. The same issues appear likely to arise from the Pandemic Agreement adopted by the World Health Assembly (WHA) in 2025 but with ongoing negotiation,

109 https://www.spectator.com.au/2025/09/time-to-stub-out-the-tobacco-tax/

and is seen with other policies. Decision-making is removed from local priorities and context, and ultimately can pass to judicial mechanisms with no public health background.

V.2 Covid-19

In September 2019, just six months before the formal declaration of the Covid-19 pandemic, the WHO published a report titled *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza*.[110] Non-pharmaceutical interventions (NPIs – hand hygiene, face masks, ventilation, school closures, isolation, quarantine, travel advisory and restrictions, entry screening, border closures, etc.) –were intended to help in delaying transmission during an outbreak of a respiratory virus by flattening the infection curve, thereby buying time to distribute vaccines (or, as in the case of Covid-19, to develop, make, and distribute vaccines) and reduce the surge hospital bed capacity to mitigate the impact of the pandemic. [The NPIs have since been relabelled *public health and social measures* (PHSMs) in the WHO's 2023 *Managing Epidemics Handbook: Key facts about major deadly diseases*.[111] To avoid confusion, this report maintains the usage of the 2019 *Handbook* while discussing that document.] The 2019 report compiled, reviewed, and evaluated a list of NPIs "that have the potential to contribute to pandemic mitigation," identified existing and performed new systematic reviews for each NPI, assessed the available evidence on the effectiveness of each NPI, and drafted the guideline document with policy recommendations in accordance with the reviews and evidence.

The WHO's 2019 report recommended different suites of NPIs for mild, moderate, severe, and extraordinary outbreaks. Contact tracing, quarantine of exposed individuals, entry and exit screening, and border closures were "not recommended in any circumstances." Some important caveats were acknowledged. In most cases, the evidence base on the effectiveness of NPIs was limited, of very low quality, or even non-existent.

110 https://iris.who.int/bitstream/handle/10665/329438/9789241516839-eng.pdf

111 https://www.who.int/publications/i/item/9789240083196

Personal protective measures like hand hygiene and face masks had, "at best," a small effect on transmission, and the use of masks was deemed an "extreme measure." Travel-related measures were likely to prove ineffectual owing to lack of technical capacity to detect pre-symptomatic and afebrile infections and "are likely to have prohibitive economic consequences."

During Covid, in the absence of high-quality and reliable evidence for the effectiveness of NPIs like face masks and school closures, hope was turned into strategy and the health, mental health, educational, and social costs were largely ignored. The importance of the qualification on the potential downsides and costs of the measures was forgotten, causing lasting damage to the credibility of national and WHO public health experts. The reason for that was the campaign of fear mounted to emphasize severity and lethality of Covid-19, starting with WHO DG Tedros on 11 March when he declared the outbreak to be a pandemic. At a media briefing, he spoke of "the alarming levels" of infection spread, severity, and "levels of inaction" despite the organisation having "called every day for countries to take urgent and aggressive action."[112]

Emphasizing that this wasn't just a public health crisis but "a crisis that will touch every sector" and hence the need for "a whole-of-government, whole-of-society approach," Tedros urged every country to "find, isolate, test and treat every case and trace every contact." He also warned that "All countries must strike a fine balance between protecting health, minimizing economic and social disruption, and respecting human rights." That said, the WHO set the tone for worldwide panic and governments and the media amplified it. In the process the importance of policy trade-offs, balance of benefits over costs for each policy intervention, minimizing disruptions, and respecting human rights, were largely sidelined.

A recent academic comparison of pre-Covid and post-Covid WHO pandemic guidance gives some insight into what lessons the WHO has learned from Covid-19.[113] The comparison of nine WHO documents

112 https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

113 https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1664330/full

revealed several key changes in WHO post-Covid recommendations as well as a normalization of Covid-era PHSMs, including population-wide interventions such as quarantine, travel measures, and universal masking. The study further revealed that many of these changes were included without systematic evidence assessment. When evidence was cited, the study found that it focused on narrowly defined short-term outcomes, with "limited consideration of broader societal impacts." Like the 2019 outbreak guidelines, the post-Covid recommendations gave little recognition of the adverse effects of PHSM, favouring mitigation as a priority over avoiding harms. The study concluded that there is a need for more systematic evaluation of PHSMs including their effectiveness and collateral damage before more robust pandemic measures are officially adopted at national, regional, and international levels.

WHO failures during Covid-19

"The World Health Organization proved close to useless in the face of a pandemic, the very challenge it was built to solve," Danielle Pletka, a distinguished senior fellow at the American Enterprise Institute, wrote in the *National Review* on 23 September 2025.[114] This is not a view that is generally held around the world. But it is a view that is widely enough shared in many circles to be a matter of concern to all who believe in the necessity of an international health organisation. The WHO is at the centre of the existing international public health architecture. Its credibility in managing the Covid-19 pandemic was badly damaged by tardiness in recognizing the reality of human-to-human spread; by the initial investigation that whitewashed the origins of the virus; by flip-flops on masks and lockdowns; and by a gross failure to emphasize potential impacts of the PHSM measures on other public health priorities, equality, and human rights: the very reasons WHO had previously avoided such responses.

China first reported an outbreak of an unidentified strain of pneumonia in Wuhan on 31 December 2019. From then until 20 January, Beijing denied any evidence of human-human transmission and the WHO followed that line. Yet on 13 January a Chinese patient who travelled to Thailand

114 https://www.aei.org/op-eds/the-u-n-deserves-a-trumpian-reckoning/

was diagnosed with the virus even though the person had not been to Wuhan's wet market. Despite being made aware of that case and alerted to the possibility of human-human transmission, the WHO publicly repeated the official Beijing line until 21 January, by which time cases had been confirmed in Japan, Singapore, South Korea, Thailand, the US, and Vietnam. On 30 January it did declare Covid-19 a "a public health emergency of international concern" (PHEIC), but even then advised against travel restrictions on China, while later becoming an advocate of the same without any change in evidence.

A second, and possibly the most critical, explanation for the disillusionment with the WHO's Covid performance is the way in which it walked back from its own existing institutional repository of scientific knowledge and pandemic management experience. Instead of challenging the radical departures from the existing scientific consensus and pandemic preparedness plans, the WHO validated the untested interventions – sometimes through strategic silence rather than active advocacy – despite their great potential for harms.

For example, the WHO's 2019 report affirmed that "there was no evidence that face masks are effective in reducing transmission of laboratory-confirmed influenza."[115] Yet, the WHO "conditionally recommended" the use of disposable, surgical face masks in severe pandemics, saying: "Although there is no evidence that this is effective in reducing transmission, there is mechanistic plausibility for the potential effectiveness of this measure." This is a strange statement as surgical masks do not stop passage of aerosolized viruses. The overall conclusion on the ineffectiveness of face masks in community settings was common in many national pandemic preparedness plans until 2020. An Australian Department of Health document in July 2020 advised that face masks are most likely to be effective for source control when worn by an infected person, if worn correctly and consistently (no touching the front of the mask, no pulling it down intermittently – both extremely common real-world behaviour), but

115 https://www.who.int/publications/i/item/non-pharmaceutical-public-health-measuresfor-mitigating-the-risk-and-impact-of-epidemic-and-pandemic-influenza

less effective in protecting uninfected people.[116] A US CDC meta-analysis, published in early 2020, found a similar lack of effect.[117]

It's worth quoting in full paragraph 4.15 from the *UK Influenza Preparedness Strategy 2011* that succinctly encapsulated the scientific and policy consensus:[118]

> *Although there is a perception that the wearing of face masks by the public in the community and household setting may be beneficial, there is in fact very little evidence of widespread benefit from their use in this setting. Facemasks must be worn correctly, changed frequently, removed properly, disposed of safely and used in combination with good respiratory, hand, and home hygiene behaviour in order for them to achieve the intended benefit. Research also shows that compliance with these recommended behaviours when wearing face masks for prolonged periods reduces over time.*

Lockdowns were imposed on and off for two-three years by many countries, with the goalposts of justification shifting from flatten the curve in 2-3 weeks to protect the health system, wait for the vaccine, and stop new variants. They were neither based in good science and best-practice medicine, nor were they commensurate with the age-stratified threat from the novel coronavirus to individuals and public health. By contrast the health, mental health, social, educational, and economic harms caused by the lockdowns have locked in generational poverty and inequality within and among states. As early as October 2020, the World Bank noted that an extra 88-115 million people would be pushed into extreme poverty (living on less than $1.90 a day) in 2020, rising to 150 million by 2021.[119] Over

116 https://www.covidmedicalnetwork.com/coronavirus-facts/masks/coronavirus-covid-19-are-cloth-face-masks-likely-to-provide-protection-against-covid-19_0.pdf

117 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7181938/

118 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf

119 https://www.worldbank.org/en/news/press-release/2020/10/07/covid-19-to-add-as-many-as-150-million-extreme-poor-by-2021

80 percent of the total added to the numbers of extremely poor would be in LMICs. Yet, real-world data showed little appreciable difference in Covid-19-related health metrics between jurisdictions that locked down and those that did not. Sweden among countries and Florida among US states resisted the lockdown groupthink and came out markedly better on the balance of overall benefits versus harms.

Under the global cover of the WHO's technocratic legitimacy, states dictated severe restrictions on people's lives, down to the most ridiculous and absurd details. Lockdowns were a euphemism for a wholesale shutting down of all social and most economic activities and locking up entire populations under de facto house arrest. People were told how close they could get to others, how many could get together in groups of permitted size, whether they could attend weddings, funerals, birthday celebrations, concerts, and sporting events, if children should go to school or stay home, the hours during which they could shop, what they could purchase, and which direction they could move in while shopping by following arrows on the floor. Governments also stepped into nations' bedrooms, to dictate with whom people could and could not be intimate. Moving from the bedroom in the personal sphere to the boardroom in the economic, the state determined which businesses and services were essential and which were not, which enterprises could keep operating and which must close down, the hours of operation, and so on.

People embraced compliance with draconian directives from politicians. Key institutional bulwarks against the assault on freedoms crumbled. Media and governments amplified fear, cancelled critics, silenced dissenting voices, and shamed the non-compliant. The result was a collapse in trust in public institutions, as documented in multiple surveys in several countries. To be clear, these actions were done by governments and not by the WHO. However, the WHO as the epistemic authority for global health helped to promote by showing implicit or explicit approval, and failed in its duty to criticize most of these measures.

A third important reason for the widespread post-pandemic disenchantment with the WHO is the lasting harms done to children by the Covid interventions. UNICEF published *The State of the World's Children*

2023 report[120] with the alarming conclusion that in the previous three years, lockdown-induced disruptions to healthcare had resulted in a total of 67 million fewer childhood immunizations: "in just three years, the world has lost more than a decade of progress."[121] Up to 10 million additional child marriages are expected over the post-Covid decade.[122] Large-scale independent studies documented a two-decade reversal in children's educational progress in the US,[123] while schools were shuttered for up to 2 years in African countries, entrenching future poverty. Japan experienced a jump in female suicides between July 2020 and January 2023, especially among women in their 20s but also among men in their 50s and over 80.[124] The WHO, with its requirement to defend "*physical mental, and social well-being"* criticized relaxation of restrictions whilst future health was undermined.

In almost all Western countries, the average age of Covid-19 deaths has been higher than the average life expectancy and the mortality risk to children is lower by several thousandfold. For the first time in history, children were made to bear the heaviest costs, with futures mortgaged to massive debts, educational opportunities drastically curtailed, and exposure to potentially harmful and even lethal medical interventions, in the hope that the old, now frequently isolated from their families, could cling on to life for a few more months and years. The vanishingly small mortality risk to healthy children and youth was known very soon after the onset of the pandemic and published by Imperial College London in the *Lancet* in March 2020.[125] On 30 June 2021, Professor Robert Dingwall, a member of the UK's Joint Committee on Vaccination and Immunisation, said that letting children catch Covid-19 would be better than vaccinating

120 http://www.unicef.org/state-worlds-children-2023

121 https://www.unicef.org/reports/state-worlds-children-2023#Reportarea

122 https://data.unicef.org/resources/covid-19-a-threat-to-progress-against-child-marriage/

123 https://www.nationsreportcard.gov/highlights/ltt/2022/

124 https://www.sciencedirect.com/science/article/pii/S016517812400091X

125 https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30243-7/fulltext

them, as their intrinsically low risk from Covid-19 means they may be "better protected by natural immunity generated through infection than by asking them to take the 'possible' risk of a vaccine."[126] In December 2021, Stanford University's Cathrine Axfors and John Ioannidis published their estimate that survivability of infected under-20s is 99.999 percent, falling to 99.958 percent for the under-50s.[127] Such orthodox public health positions, fully in line with the WHO's 2019 pandemic influenza recommendations, were cast as "fringe" and those stating them were vilified.

A fourth reason to be sceptical about the WHO's pandemic performance is its willingness to manipulate definitions of "herd immunity" in relation to vaccines and natural immunity in order to fit with the experimental pharmaceutical and non-pharmaceutical interventions that dominated Covid policy around the world, and its self-interest in common with any externally-funded bureaucracy in expanding and cementing its budget, authority, and role, in this case by means of a new international treaty.[128]

A fifth ground for scepticism is that the WHO, along with most governments, frequently ascribed the total death count to the direct effects of Covid-19 "due to the disease" and indirect effects "due to the pandemic's impact on health systems and society." The first part is questionable because it fails to distinguish between deaths with and from Covid-19. The second is disingenuous because the indirect toll of the PHSMs (lockdowns, masks, induced fear, lost schooling, lost jobs, cancelled screenings and operations, aborted immunization programmes, disruptions to global food production and distribution, deaths of despair among the isolated elderly, etc.) and vaccine-related adverse events could prove to be significantly higher than the direct effects of the disease *per se*. Any study that fails to disaggregate deaths caused by the disease and by policy interventions to mitigate it lacks credibility.

There was one additional notable feature. Governments were able

126 https://www.telegraph.co.uk/news/2021/06/30/letting-children-catch-covid-may-safer-exposing-vaccine-risk/

127 https://www.medrxiv.org/content/10.1101/2021.07.08.21260210v2.full-text

128 https://www.aier.org/article/who-deletes-naturally-acquired-immunity-from-its-website/

to mobilize members of the public to exert peer pressure and societal coercion to enforce compliance, backed by often brutal police coercion against pockets of resistance and protest. Sceptics were shamed, critics cancelled, dissenting doctors dismissed. Health includes mental and social health and well-being and is highly dependent on a robust economy, yet the WHO-backed package of measures to fight Covid-19 proved damaging to health, children's immunization programmes in developing countries, mental health, food security, economies, poverty reduction, and educational and social well-being of peoples. The Covid-19 vaccine push has similarly downplayed accumulating safety signals about the scale of adverse reactions,[129] on the one hand, and rapidly dwindling efficacy,[130] including after successive doses,[131] on the other.

In general, the WHO did not explicitly call for lockdowns, but did so indirectly by praising those countries that did, for example China, and issuing warnings of dire consequences when locked-down countries considered lifting restrictions. Throughout, it failed in its role of promoting their own holistic definition of health and oversaw a devastation of economies in the name of public health in full knowledge of the long-term negative health consequences. The WHO lost an opportunity to stand as an international institutional bulwark against these harmful measures. Had it done so, as domestic institutional safety guardrails failed, its prestige and credibility might have been enhanced.

V.3 Pandemic accords

The longstanding International Health Regulations (IHR) have been bolstered with the Pandemic Agreement (that is, treaty) on pandemic prevention, preparedness, and response (PPPR) adopted in 2025. In this report, "pandemic accords" is used collectively to refer to the amended IHR and the pandemic treaty. The pandemic accords were negotiated by national and international public health officials and experts. Those

129 https://www.openvaers.com/

130 https://www.sciencedirect.com/science/article/pii/S0140673622000897

131 https://academic.oup.com/ofid/article/10/6/ofad209/7131292

negotiations operated under the assumption that the frequency and severity of pandemic risks are accelerating and intensifying. Building resilience into health systems against future pandemic shocks is then claimed to require more resources and powers for health bureaucrats, technocrats, and experts, both within nations and in international organisations. Conversely, to say that pandemic risks are modest and can be adequately contained by existing budgets and institutional arrangements could have been damaging to institutional, professional, and individual self-interest.

The IHRs are an international legal instrument that covers measures for preventing the transnational spread of infectious diseases and defines the reporting, surveillance, and response obligations and rights of states in managing public health events and emergencies with the potential to cross borders. They are legally binding on 196 countries. Their stated purpose is to prevent, protect against, control, and provide a public health response to the international spread of disease. They also aim to strengthen the preparedness and capacities of countries to detect, assess, report, and address acute public health threats early. They seek to balance the sovereignty of member states with the common good of the international community within the added new principles of "equity" and "solidarity."

The IHR was first adopted in 1969, but built on prior understanding of a clear role of the WHO as defined in its constitution in coordinating responses to cross-border outbreaks of infectious diseases, and revised in 2005 IHR (2005) in response to the 2003 SARS outbreak.[132] Its non-binding recommendations required states to report outbreaks to the WHO likely to constitute a PHEIC. The WHO DG could declare a PHEIC against the wishes of the state in whose territory the event is occurring and recommend specific measures, including quarantine, border closures, testing of individuals, and vaccination. Although free to adopt or reject specific recommendations of the DG, states were obligated to develop core capabilities including surveillance and a response plan.

After the Covid-19 outbreak, the United States initiated efforts to amend the IHR to redress a perceived lack of coordination, rapid response

132 https://iris.who.int/bitstream/handle/10665/246107/9789241580496-eng.pdf?sequence=1

capability, and ability for the WHO to require action in a PHEIC. After intensive negotiations and consultations, an amended text was adopted on 1 June 2024 and came into force on 19 September 2025 (except for eleven countries that had rejected them: Argentina, Austria, Brazil, Canada, Czech Republic, Germany, Israel, Italy, Netherlands, Philippines, and the USA).[133] Repeating the platitude that "no one is safe until everyone is safe," Tedros said to mark the occasion, the IHR amendments are "a historic commitment" that "reaffirm our shared responsibility and solidarity in the face of global health risks."[134] The amendments maintain the status of recommendations for actions during a declared PHEIC but strengthen national requirements for monitoring and surveillance core capacities. They also introduce a formal monitoring mechanism to assess compliance, add commitments to increase spending and provide resources to the WHO and other states, and confer authority on the WHO to manage the distribution of a wide range of medical products.

The Pandemic Agreement, accepted provisionally in 2025, is complementary to the 2024 IHR amendments.[135] It was originally drafted with proscriptive language and intended as a treaty to impose requirements on countries for cooperation with one another and the WHO. After three years of negotiation under the auspices of the WHO secretariat, an incomplete version was agreed in 2025 that postponed decisions on a number of contentious articles, including the required financing, sharing of intellectual property and biological samples, and transfer of manufacturing know-how, to follow-up negotiations. The objective of the treaty "is to prevent, prepare for and respond to pandemics" and, to this end, its provisions "apply both during and between pandemics." Parties have also committed to developing a Pathogen Access and Benefit Sharing System (PABS) through current negotiations in order to promote rapid and timely sharing of materials and sequence information on pathogens with pandemic potential. In return, as part of benefit sharing, participating

133 https://apps.who.int/gb/bd/pdf_files/IHR_2014-2022-2024-en.pdf

134 https://www.who.int/news/item/19-09-2025-amended-international-health-regulations-enter-into-force

135 https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf

manufacturers commit to donating 10 percent of their real-time production of safe, high quality, and effective vaccines, therapeutics, and diagnostics for the pathogen causing the pandemic emergency; and another 10 percent to be made available to the WHO "at affordable prices."

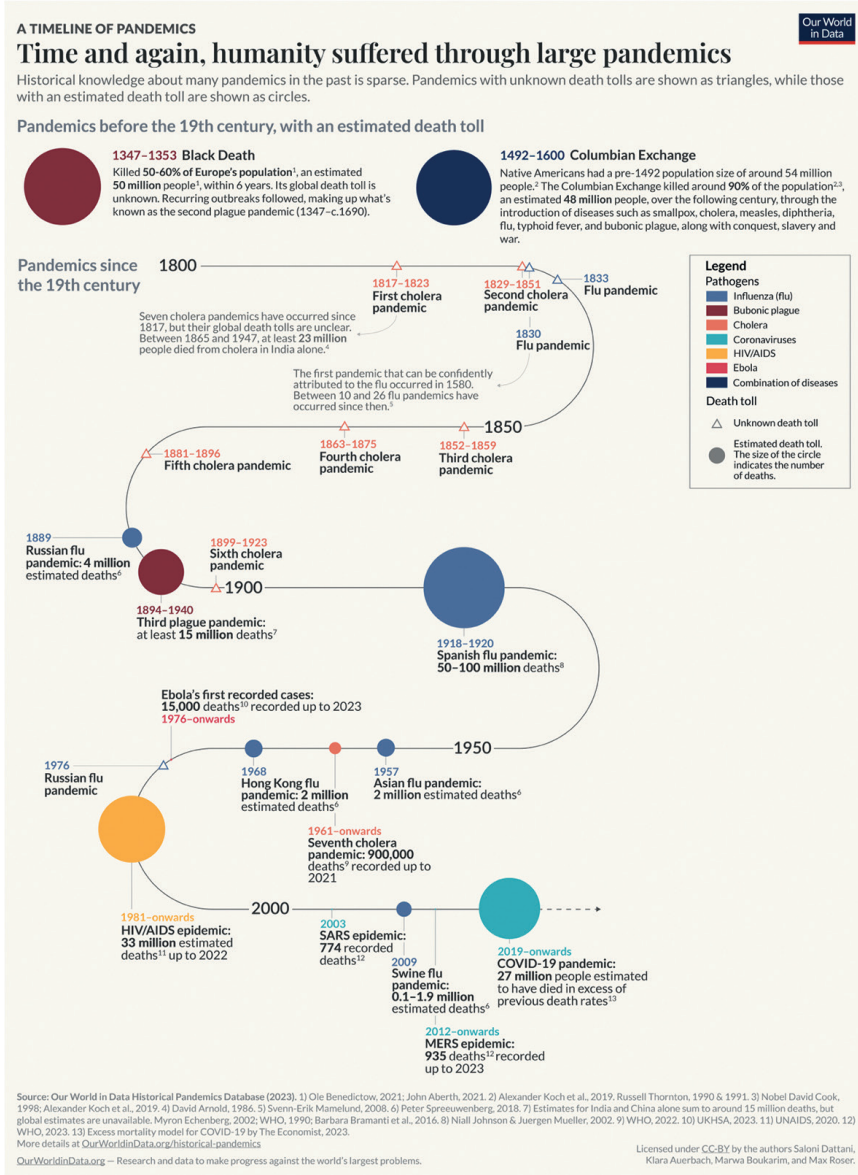
The treaty will be open for signature only after the PABS has been negotiated and adopted. It will enter into force 30 days after the 60th ratification. A party may withdraw from the treaty at any time after two years from membership by giving a one-year notice.

Flaws in the pandemic accords

The WHO pandemic accords are a good example of the type of global governance initiatives on which there is a consensus among the world's governing and technocratic elites but against which there is growing scepticism. The flaws of the accords include false claims that greatly inflate the frequency and mortality tolls of pandemics; a self-serving overreach with respect to new powers and resources for the WHO and global health experts; a contribution to global bureaucratic sprawl; and a resort to an international censorship framework to counter criticism.

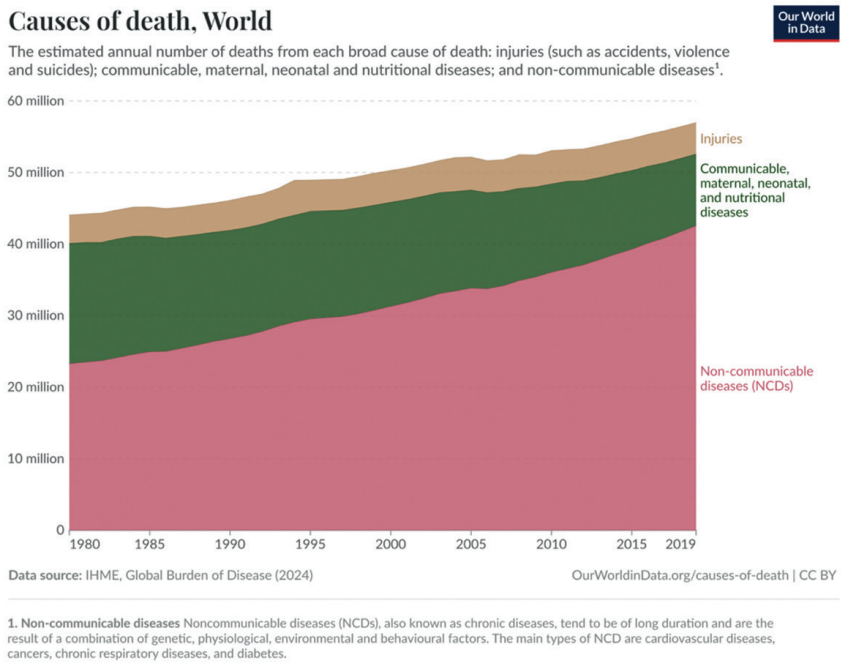
Pandemics are rare events that impose a low disease burden compared to endemic infectious and chronic diseases. Yet, the rationale for the accords depends almost entirely on the false understanding that the risk of pandemics is rapidly growing, predominantly from increasing zoonotic spillover events in which pathogens move from animal reservoirs to humans. This undervalues concerns that SARS-CoV-2 arose from gain-of-function research,[136] while a laboratory misstep negates the second part of this justification. While further laboratory-related pandemics may occur, the main surveillance pillars of the accords are designed for naturally-arising phenomena.

136 https://www.whitehouse.gov/lab-leak-true-origins-of-covid-19/



The assumption of increasing pandemic risk is also seriously challenged by work from the University of Leeds and elsewhere, in which the data and citations on which the reports of the WHO, World Bank, and G20 backing the pandemic agenda have been shown to poorly support the

agencies' claims.[137] Data show reducing mortality and outbreaks in the decade prior to 2020. Much of the recorded "increase" in frequency reflects the development of improved diagnostic technologies and communications. WHO publications backing increased concentration on pandemics and epidemics, such as *Managing Epidemics 2nd Ed*.[138] and *Future Surveillance*,[139] misrepresent risk in order to reinforce the WHO's claims, suggesting previously major epidemic diseases such as yellow fever, plague, influenza, and cholera are increasing rather than continuing an overall decline in trajectory.



The relative disease burden of pandemics as measured by disability adjusted life years (DALYs) has had a low salience over the past century,

137 https://essl.leeds.ac.uk/directories0/dir-record/research-projects/1260/re-evaluating-the-pandemic-preparedness-and-response-agenda-reppare

138 https://www.who.int/publications/i/item/9789240083196

139 https://www.who.int/publications/i/item/9789240080959

covering the period during which the WHO has been in existence.[140] According to *the WHO's 2019 Pandemic influenza recommendations*, the only other pandemics of significant mortality to have occurred were the Asian and Hong Kong flu pandemics in 1957–58 and 1968–69, in each of which between one and two million people died; and the swine flu pandemic in 2009–10 that was discussed in the last chapter, having far lower mortality than annual seasonal flu.[141] The historical timeline of pandemics (Figure V.2) shows a massive reduction in the morbidity and mortality of pandemics since the Spanish flu (1918–20) in which fifty million people are estimated to have died.[142] The dramatic drop in pandemic mortality is attributable mostly to improvements in sanitation, hygiene, potable water, antibiotics, and other forms of expanding access to good healthcare.

1980–2019		1/3/2020–15/4/2024	
Cardiovascular diseases	577.2	Coronary heart disease	38.14
Cancers	275.2	Stroke	26.59
Chronic respiratory	133.9	Lung disease	13.86
Pneumonia	112.7	Influenza & pneumonia	11.13
Neonatal disorders	107.1	Lung cancers	7.66
Diarrhoeal diseases	95.4	Pandemics**	7.10
Tuberculosis	65.0	Alzheimer's & dementia	7.04
Pandemics*	0.20	Diabetes	6.42

Table V. 1. No. of people killed by leading causes of death, 1980–2024 (million)

Sources: 1980–2019: compiled by Ramesh Thakur from *Our World in Data*: https://ourworldindata.org/grapher/annual-number-of-deaths-by-cause?time=1998&tableSearch=world ; 2020–2024: worldlifeexpectancy.com.

* H1N1 (swine) flu, 2009–10; **Covid-19, 2020–24. The annual global death toll from all causes has risen from 47 million in 1980 to over 60 million in the 2020s and is projected to cross 100 million around 2058 under the UN's medium-fertility scenario.[143]

140 https://ourworldindata.org/burden-of-disease

141 https://ourworldindata.org/historical-pandemics

142 https://ourworldindata.org/historical-pandemics

143 https://ourworldindata.org/grapher/number-of-deaths-per-year

Please note:

1. As will be immediately obvious, the disease classification in the two periods (1980–2019 and 2020–2024) are not directly comparable. The first source ends in 2021 whereas the second source begins from March 2020. But together they demonstrate the relatively low impact and infrequent salience of pandemics.
2. Professor Carl Heneghan and Dr Tom Robertson from Oxford University's Centre for Evidence-Based Medicine (29 April 2022): There is "no consistency in the definition of cause of death or contributory cause of death across national bodies and in different bodies within the same nation."[144] They identified no fewer than 14 different ways of attributing Covid-19 causes of death. Nor do most countries distinguish between those who came into hospital already infected and those who came in with some other ailment but were infected in the hospital (nosocomial Covid-19 deaths). Finally, the reliability of data collection across nearly 200 countries of the world is highly uneven.
3. The share of Covid-19-attributed deaths in which Covid-19 was the sole listed cause is rarely over ten percent the total number of deaths recorded as Covid-19-related. Furthermore, in the 2020–2024 period, with more than 90 percent of deaths occurring in people with several comorbidities and at or above average life expectancy, a substantial number would have died from other causes in that timeframe, with Covid-19 having brought deaths forward by a short period. Moreover, a number of audits of Covid-19 mortality (Greece,[145] Germany,[146] USA[147]) indicate significant over-attribution in some populations, while

144 https://www.medrxiv.org/content/10.1101/2022.04.28.22274344v1.full

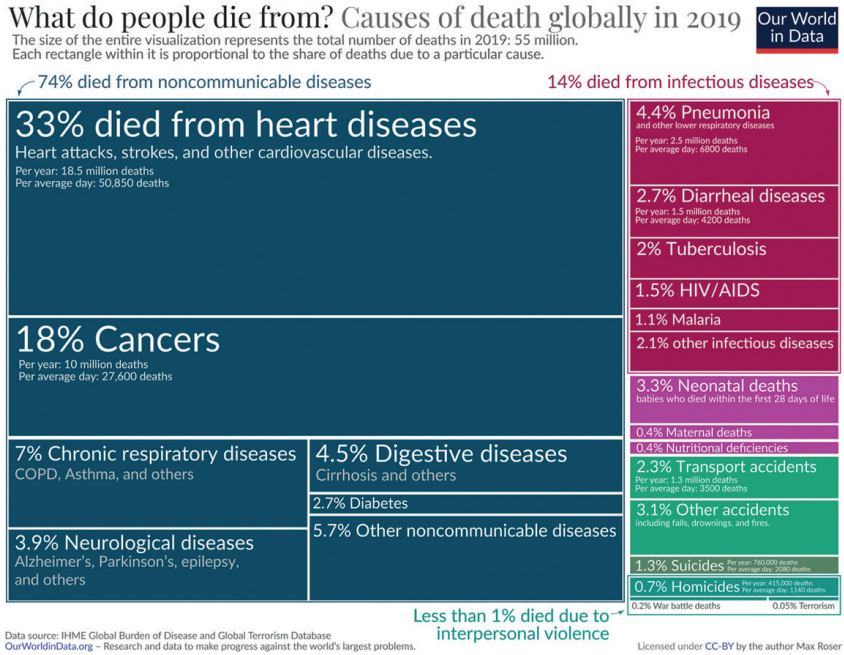
145 https://pmc.ncbi.nlm.nih.gov/articles/PMC12012217/

146 https://www.cureus.com/articles/149410-estimation-of-excess-mortality-in-germany-during-2020-2022#!/

147 https://www.westernjournal.com/county-counted-car-crash-covid-death-finds-inflated-virus-death-toll-25-percent/

other countries will have under-reported due to poor health data systems. The 7.1 million quoted in the table is consistent with mortality attributed to the WHO (WHO Covid-19 dashboard[148]). The total deaths during 2021 and 2022 were roughly 15 million above expected, but this includes the effects of health system deterioration, income loss, and supply line interruptions during the Covid-19 response. True attribution to Covid-19 and non-Covid causes during this period is controversial.

According to *Our World in Data*, the broad classification of communicable, maternal, neonatal, and nutritional diseases have been falling steadily, down from 16.8 million in 1980 and 14.6 in 2000 to 10.03 million in 2019 before Covid-19 hit (Figure V.3).[149] During that period, non-communicable diseases have continued to climb steadily, up from 23.3 and 31.3 to 42.5 million in the same timeframes.



148 https://data.who.int/dashboards/covid19/cases

149 https://ourworldindata.org/grapher/total-number-of-deaths-by-cause

In the 105 years since the Spanish flu, a grand total of 10-14 million people have died around the world in pandemics including Covid-19.[150] To put this in perspective, in 2019 alone, 10.1 million people died from infectious, maternal, neonatal, and nutritional diseases: pneumonia and other lower respiratory diseases, 2.5 million; diarrhoeal diseases, 1.3 million; tuberculosis, 1.2 million; HIV/AIDS, 910,000; malaria, 650,000; and other infectious diseases, 1.2 million.[151] Another 40.7 million deaths were caused by non-communicable diseases. The three leading causes of deaths in the year before Covid-19 were heart diseases (18.5 million), cancers (10 million), and chronic respiratory diseases (3.8 million). These trends were not greatly changed by the coming of Covid-19, as shown in Figure V.4.

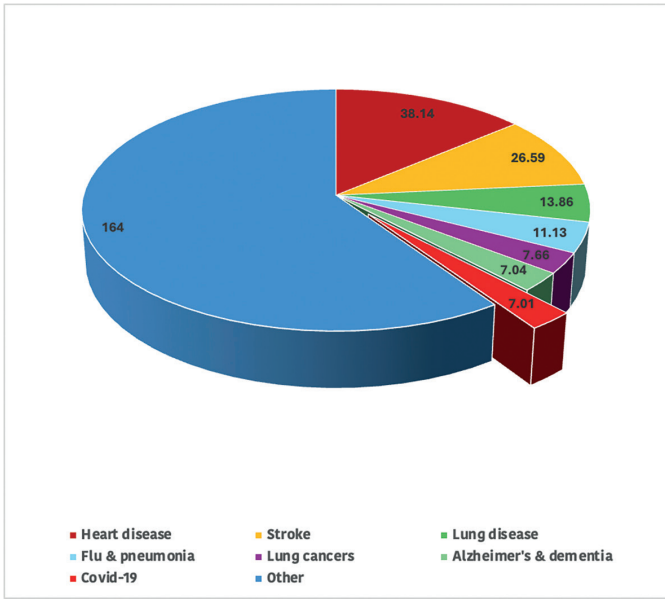


Figure V. 5. Causes of death, global, 3 Jan 2020–15 Apr 2024 (million).

Sources: https://www.worldlifeexpectancy.com/selected-deaths-vs-covid-19-world ; https://database.earth/population/world/deaths

150 https://ourworldindata.org/historical-pandemics

151 https://vizhub.healthdata.org/gbd-results

Extrapolating from trends until 2020, between 250-300 million people would have died worldwide in the five years 2020–24. According to *Our World in Data* the total number of Covid-19 deaths until late 2025 was 7.1 million. Covid-19 accounts for just 2.5 percent of the total number of people who died in this pandemic period, compared to nearly 14 percent who died from coronary heart disease (Figure V.5).[152] The single worst calendar year for Covid-19-related deaths was 2021 (the year of the vaccine rollout), with 3.55 million deaths – exactly half the cumulative total until the end of 2025. The second-worst year was 2020, with 1.93 million deaths. Yet, in 2021, in the low-income countries, WHO data show that the Covid-19 mortality toll was not in the top five killer diseases, after lower respiratory diseases, stroke, ischaemic heart disease, malaria, and preterm birth complications.[153] In the high-income countries, by contrast, Covid-19 was the second biggest killer after ischaemic heart disease.

In the three broad bands of deaths – from injuries (accidents, violence, suicides); communicable, maternal, neonatal, and nutritional diseases; and chronic (non-communicable diseases) – disaggregated by the six WHO regions, we can see that in the four decades before Covid, infectious diseases were dominant but declining in Africa; and substantial but declining in the eastern Mediterranean and South-Southeast Asia (the three left columns in Figure V.6). Chronic diseases were dominant in the other three regions and rising in all six.

152 https://ourworldindata.org/grapher/cumulative-deaths-and-cases-covid-19

153 https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death

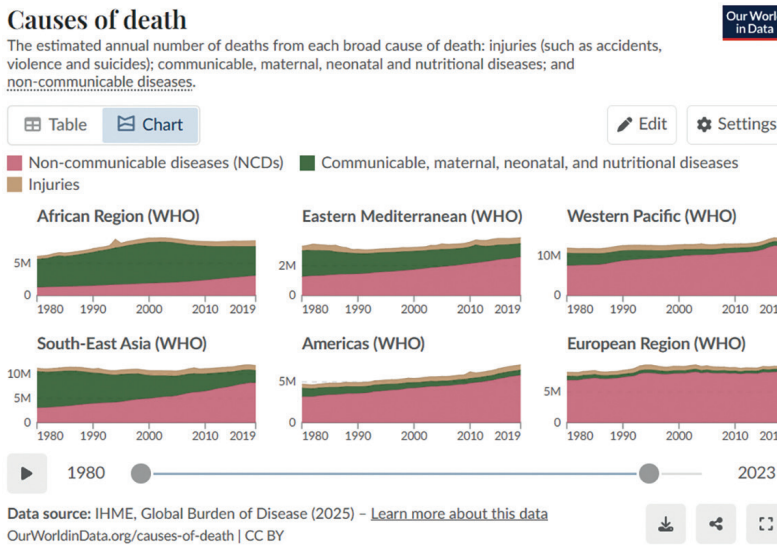


Figure V. SEQ Figure_V. * ARABIC 6 – Causes of deaths by WHO regions, 1980-2019.

Source: https://ourworldindata.org/grapher/total-number-of-deaths-by-cause?time=1980..2019&country=African+Region+%28WHO%29~WHO_EMR~WHO_WPAC~WHO_SEAR~WHO_AMR~European+Region+%28WHO%29&tableFilter=who

The return of investment on which the justification for investment in WHO's pandemic instruments rests is further undermined by examination of the costing provided by the WHO and World Bank,[154] again reviewed by the University of Leeds REPPARE project.[155] While calculations are opaque, the key claims of massive costs from pandemics compared to endemic infectious diseases (malaria, HIV, tuberculosis) include all economic costs including incentive packages of the Covid-19 response, whilst massively

154 https://thedocs.worldbank.org/en/doc/5760109c4db174ff90a8dfa7d025644a-0290032022/original/G20-Gaps-in-PPR-Financing-Mechanisms-WHO-and-WB-pdf.pdf

155 https://essl.leeds.ac.uk/directories0/dir-record/research-projects/1260/re-evaluating-the-pandemic-preparedness-and-response-agenda-reppare

underplaying the costs of endemic infections. This inflates the return of investment with the impression that all economic costs from an outbreak can be mitigated via the requested investment (see below), which is an untenable assumption. Moreover, heart diseases, cancers, strokes, lung diseases, influenza, and pneumonia killed more people around the world over the last five years than Covid-19. Also, as is well known and unlike the earlier pandemics, the vast majority of the Covid-19-related deaths were in people with comorbidities at or above average life expectancy.

The WHO (jointly with the World Bank) has costed the pandemic agenda's plans at US $31.1 billion annually, of which about $10.5 billion would be required from official development assistance (ODA).[156] Establishing a dedicated, treaty-based, and resource-intensive international machinery to prepare for a low-burden and infrequent disease outbreak will distort public health priorities and divert scarce resources and finite attention from more urgent policy goals. Given the poor evidence[157] for the costing base on which it has been built,[158] the entire agenda raises important questions about the direction of the WHO and international public health, and the influences that now drive it.

The pandemic accords provide the WHO with new legal authority to declare an actual or potential "pandemic emergency" and the power thereafter to commandeer resources for itself from sovereign states and redirect resources funded by the taxpayers of one country to other states, on the basis of what the DG alone considers simply a risk of potential harm. It is a basic axiom of politics that power that can be abused, will be abused – some day, somewhere, by someone. The corollary holds that power once seized is seldom surrendered back voluntarily.

156 https://thedocs.worldbank.org/en/doc/5760109c4db174ff90a8dfa7d025644a-0290032022/original/G20-Gaps-in-PPR-Financing-Mechanisms-WHO-and-WB-pdf.pdf

157 https://essl.leeds.ac.uk/downloads/download/234/the-cost-of-pandemic-preparedness-an-examination-of-costings-and-the-financial-requests-in-support-of-the-pandemic-prevention-preparedness-and-response-agenda

158 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01368-6/fulltext

It is arguable that this "pandemic playbook"[159] creates vested interests that are incentivized to overreact to new threats: scientists win research grants and promotions by identifying and detecting additional threats of lethal infectious diseases, while vaccine and drug manufacturers win lucrative government contracts to research, make, and stockpile pharmaceutical products at scale. Yet, the reality is that the prevalence of chronic diseases makes a population more prone to higher mortality rates while "a metabolically healthy population, physically active and eating nutritious food, will cope far better in the face of a novel pathogen than a population facing a severe chronic-disease crisis."

There was remarkably little public debate on the far-reaching ramifications of the pandemic accords. Governments abdicated responsibility for pandemic policy to their health bureaucrats. The latter worked in collusion with or deferred to the international technocrats in and around the WHO. In doing so, they acted contrary to the principle of subsidiarity, from the individual and the state to the regional and the global. Yet, well capacitated, technically proficient, and democratically legitimate states in particular should be wary of ceding control of their policy agenda and decision-making authority to inefficient, cumbersome, and unaccountable international bureaucracies.

Moreover, there is a risk that the definition of public health emergencies can expand beyond what has traditionally been understood as strictly a health risk, to include items such as climate change, gun violence, and racism.[160] The definition of risks, all of which can be interpreted to come under the surveillance and early detection and response provisions, is expansive, including environmental, climatic, social, anthropogenic, zoonotic and economic factors, and hunger and poverty.

At a time of growing public disquiet about the expansion of the administrative state and its export to the world stage, the accords put in place

159 https://www.city-journal.org/article/nih-jay-bhattacharya-covid-pandemic-lab

160 https://news.un.org/en/story/2025/06/1164261 ;
https://www.apha.org/topics-and-issues/racial-equity/racism-declarations ;
https://www.worldbank.org/en/topic/health/brief/health-and-climate-change ;
https://a816-dohbesp.nyc.gov/IndicatorPublic/data-stories/violence/ ;
https://www.health.gov.au/topics/environmental-health/about/climate-change

requirements to add still more planks to the architecture of international health governance. The IHR calls for the establishment of a committee of States Parties, along with a technical subcommittee, to meet biennially to oversee implementation of the IHRs. States parties are to set up one or two entities to serve as a National IHR Authority and a National IHR Focal Point that will be responsible for the implementation and coordination of health measures within their jurisdictions. The treaty calls on each party to establish, strengthen, and maintain a national coordination mechanism for PPPR and to develop pre-, post-, and inter-pandemic plans, not forgetting consultations with Indigenous populations as appropriate, and then to have these regularly reviewed and revised – another self-perpetuating bureaucratic layer.

Furthermore, there is to be a Conference of the Parties (COP), with authority to establish subsidiary bodies, that will meet within one year of the treaty's entry into force and every five years thereafter to review and recommend additional measures to strengthen the treaty's implementation. States parties and the WHO secretariat, which will service the treaty, are also required to submit periodic reports to the COP on their implementation measures. States are mandated to maintain or increase PPPR funding and to mobilize additional resources for developing countries. A Coordinating Financial Mechanism will also be established. The emergency use authorization of Covid-19 vaccines has proven to be enduringly contentious. Yet, the treaty doubles down on this, requiring parties to have the technical capacity, and legal, administrative, and financial frameworks, to support the expedited regulatory review and/or emergency regulatory authorization of pandemic-related health products.

The accords could also potentially facilitate and underwrite censorship of health information and debate on response measures under the guise of combating "infodemics."[161] Lockdown was a policy pushed hard by politicians and health chiefs even against scientific orthodoxy, dissenting scientific voices, and substantial public opposition, claiming to oppose disinformation and lies whilst attacking and censoring truth. The depth of public opposition went unrecognized because the media did not report

161 https://www.who.int/teams/risk-communication/infodemic-management

on dissenting experts.

Government propaganda promotes a message and narrative with the view to changing public behaviour in line with government preferences regardless of the facts and the science. Australia's federal government intervened 4,213 times to restrict or censor posts about the pandemic on digital platforms.[162] The government censored posts that were factually accurate but contradicted official messaging, including: "Covid-19 vaccine does not prevent Covid-19 infection or Covid-19 transmission."[163] There are numerous examples of accounts being restricted or censored during the pandemic by Facebook and Twitter (now X), including prominent academics and those voicing opinions that had been mainstream public health understanding, and even supported explicitly by WHO, only shortly before.[164]

There seemed to be alignment on censorship between the WHO, governments, academia, legacy and social media, and tech platforms, all of which had imposed a high cost on the WHO in eroded public trust. The WHO convened an "Infodemiology" conference from 30 June–16 July 2020, pretentiously defining the term as "the *science* of managing infodemics" (emphasis added).[165] An infodemic in turn was described as "an overabundance of information – some accurate and some not – occurring during an epidemic." Because the Covid-related infodemic had escalated to a harmful level, the WHO called for "adaptation, development, validation and evaluation of new evidence-based measures and practices to prevent, detect and respond to mis- and disinformation."

Speaking at a media briefing in Geneva on 3 March 2020, Tedros

162 https://www.theaustralian.com.au/nation/antic-probe-reveals-canberra-silenced-4213-covid-posts/news-story/9afc4362197af63454bd3fa89285c282

163 https://www.theaustralian.com.au/nation/many-censored-social-media-posts-did-not-contain-covid19-misinformation/news-story/c47a8217ffada2cf576475aef3c12c63

164 https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf?ua=1

165 https://www.who.int/news-room/events/detail/2020/06/30/default-calendar/1st-who-infodemiology-conference

said Covid-19's case fatality rate (CFR) was 3.4 percent, against the seasonal flu's CFR of under 1 percent.[166] Addressing an internal meeting on 7 April 2025 of the body negotiating the new pandemic agreement, he said: "Officially 7 million people were killed [by Covid], but we estimate the true toll to be 20 million."[167] The two statements, delivered five years apart as bookends to the Covid pandemic, arguably constitute examples of misinformation. They are tantamount to catastrophization and fear-mongering that spread alarm around the world at a rapid pace. Neither was backed by solid data. For example, like former Prime Minister Jacinda Ardern's claim about New Zealand's health ministry, the WHO was effectively to be the single source of pandemic truth for the whole world.[168] In their Infodemiology conference, the purveyors of these examples of misinformation were claiming a role in countering those who adhered more closely to evidence.

The Pandemic Agreement recognizes "the importance of building trust and ensuring the timely sharing of information to prevent misinformation, disinformation and stigmatization." The IHR calls on states to develop core capacities for risk management to prevent the spread of misinformation and disinformation and to coordinate with and support authorities at the community, primary healthcare, and other local levels in responding to misinformation and disinformation. In this context, states might want to consider the full implications of the WHO concept of "social listening,"[169] defined in "the context of health" as "the capture and analysis of data from diverse sources to understand the conversations, feelings, attitudes, knowledge, beliefs and intentions of populations and communities with

166 https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020

167 https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-resumed-thirteenth-meeting-of-the-intergovernmental-negotiating-body-on-a-who-pandemic-agreement-7-april-2025

168 https://www.nzherald.co.nz/nz/coronavirus-jacinda-ardern-dismisses-nationwide-lockdown-speculation-on-social-media/I2FTKPSA36LJIDNLBFIYECXDHM/

169 https://www.who.int/publications/i/item/9789240108202

respect to health risks (e.g. disease outbreaks)." "The most common application of social listening as part of infodemic management," the WHO helpfully informs us further, "is to generate infodemic insights."

To this one should add that on 13 October 2025, the WHO launched Epidemic Intelligence from Open Sources (EIOS) 2.0 that is "used globally for the early detection of public health threats."[170] The upgraded surveillance system integrates the latest AI-generated tools for automated analyses and signal detection from a variety of open sources including websites and social media. The advanced and sophisticated system to scan "the health security landscape" has been developed in collaboration with the European Commission's Joint Research Centre and other partners and is hosted at the WHO Hub for Pandemic and Epidemic Intelligence in Berlin. The EIOS system is being used by more than 110 member states and 30 organisations and networks around the world. In other words, the WHO network is being integrated seamlessly into the advanced surveillance state. This raises reasonable concerns about increased integration of health monitoring, digital tracking, and centralized information control and manipulation.

V.4 WHO and claims of cultural and structural imperialism

The founding mission of the WHO was to alleviate existing health disadvantages of developing countries and to assist them to build their public health capacity to the point of self-sustaining resilience. It is to defend the interests of all peoples, respecting their diversity of cultural and religious beliefs, and avoiding preference for a narrow economic and cultural elite as occurred in prior iterations during the colonial period. Mission creep and increasing financial capture by private and vested national interests through specified funding discussed elsewhere has led to an erosion of such ideals.

An example is the WHO's close embrace and advocacy of carbon emission reduction and Net Zero, arguably working against the aspirations

170 https://www.who.int/news/item/13-10-2025-who-upgrades-its-public-health-intelligence-system-to-boost-global-health-security

of less-developed (low energy-access) populations to attain the economic and health benefits provided by the carbon economy in wealthier nations. The WHO is increasing emphasis on climate change, with one of its six priority areas under its new Fourteenth Global Programme of Work dedicated to helping hospitals in low resource settings become "Net Zero," even as new scientific debates have emerged. Net Zero will have opportunity costs and many governments have begun to scale back emission reduction ambitions and timetabled targets. Such targets look increasingly less feasible, economically costly for the nation and its people, and politically unsustainable as they begin to be perceived as economic self-harm with no practical contribution to global decarbonization goals. Moreover, the WHO website informs us that "Between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year."[171] In stating this, the WHO fails to take into account (as they should) a reduced mortality from cold, the rise in global food security thanks to the increased greening of the Earth from higher CO_2 levels, and the reduction in infectious diseases obtained elsewhere through fossil fuel-driven economic development. They also conflate harms from indoor air pollution (driven by poor solid fuel stoves) with carbon outputs from clear fossil fuel alternatives such as natural gas. The WHO's argument therefore constitutes poor public health science.

Recently, the WHO has waded into the even more emotionally fraught issue of transgender activism. As a result, it raises thorny issues of cultural imposition while giving credence to critics who suggest that the WHO has been captured by activists representing a narrow cultural belief system to push ideologies far beyond its core mission.[172] The origins of the WHO taking up this position go back to the document *Standards for Sexuality Education in Europe* funded by Germany's health ministry and published jointly with the WHO Collaborating Centre in Europe in 2010.[173] In 2023 the effort to universalize these Western-origin standards faltered in the UN

171 https://www.who.int/health-topics/climate-change#tab=tab_1

172 https://www.americanrhetoric.com/speeches/rfkjrworldhealthorganization.htm

173 https://www.bzga-whocc.de/en/publications/standards-for-sexuality-education/

Commission on Population and Development.[174] The European Union and certain Western countries (Sweden, Denmark, Norway, Canada) push to widen the gender agenda failed due to resistance from non-Western countries like Iran, Pakistan, and Nigeria, and the Holy See.

A particularly tense relationship between WHO guidance and cultural values is also evident in the WHO's abortion care guidance, which allows for babies (termed as "pregnancy tissue" in the WHO guideline) to be terminated up until the time of delivery (i.e. until the moment they emerge from the birth canal), without delay, whenever a pregnant woman requests it.[175] The very selective use of human rights law to justify this, requiring removal of any consideration of human rights for the unborn baby and also, to a large extent, for healthcare providers, is clearly controversial but presented by the WHO as settled. Regardless of one's personal view on abortion, the guidance clearly aligns with narrow Western liberal values with cultural concerns of it being a bureaucratic and a moral overreach.

If recent claims to decolonize global public health are to be taken seriously, then the imposition of narrow value systems arising within the West on local cultures and social norms requires serious scrutiny, ideally in concert with those at the receiving end of these policies. Yet, it also raises the question of whether it is the role of the WHO to involve itself in these debates, particularly if it undermines its efforts to deliver its core mission. An organisation such as the WHO must be accepted as an authority on science, medicine, and public health. An inability to clearly embrace generally accepted cultural norms such as definitions of man or woman and a recognition of who has babies (e.g. pregnant person or pregnant adult rather than pregnant woman) undermines public health messaging to most populations and suggests a disrespect for cultural norms.

As part of an expanding remit, the WHO has also determined that alcohol is dangerous for health, regardless of how little or rare the consumption. The WHO states that alcohol accounts for 5.1 percent of the world's disease burden and "contributes to 3 million deaths each year

174 https://press.un.org/en/2023/pop1109.doc.htm

175 https://www.who.int/publications/i/item/9789240039483

globally."[176] A WHO news release in January 2023 insisted that "no level of alcohol consumption is safe for health."[177] In the three years 2020–22, people were conditioned to accept that short-term public health safety trumps all other values and considerations, including liberty, free choice, and individual responsibility for one's health and lifestyle choices. On 15 April 2023, the WHO published *Reporting about alcohol: a guide for journalists* which attacked the notion of "responsible drinking" as "a marketing tool and a tactic to influence public beliefs about the alcohol industry" that neither tells people when to stop nor acknowledges the option of abstinence.[178] It also allegedly "ignores the inherent risks in consuming alcohol, mischaracterizing its harms as the result of a small minority of individual drinkers who cannot control their intake." It stigmatizes those who cannot hold their drink by putting "the entirety of the blame for alcohol problems on individual drinkers rather than more prominent...factors such as advertising, pricing or availability."

This approach was apparently based on studies that indicate low and dose-dependent attributable risks of cancer among people who drink alcohol, overlooking other studies that associate health benefits with low levels of consumption. The WHO uses a risk that is concentrated among chronic heavy users to influence those it knows to be at lower risk. Like exaggerations of Covid-19 harms, it is instilling fear to change behaviour without being honest regarding the risks and thus allowing people to make well-informed choices, based on their own context and culture. Thus, three key elements of the successful weaponization of Covid for ensuring compliance with Science™ edicts from the WHO – scaremongering, shaming, and controlling the media narrative around it – are being replicated to socially engineer human behaviour on drinking, behaviour that is as old as human civilization.

In terms of overreach and the claims of imperialism, there is a long and well-established literature on the WHO's role in designing, promoting,

176 https://www.who.int/health-topics/alcohol#tab=tab_1

177 https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health

178 https://www.who.int/publications/i/item/9789240071490

and/or colluding with other global health initiatives to roll out policies that result in structural inequities, imposition, and suboptimal health outcomes, particularly in low-resource countries. For example, the WHO has adopted and promotes results-based mechanisms for use within many health interventions despite evidence to show their indeterminacy in producing significant results, their inability to promote universal health coverage, the difficulty of contextualizing these models, and evidence showing inefficient and inequitable outcomes. Although these models are generally only recommended by the WHO, when coupled as a "condition" for receiving funds from a partner organisation, they can become a formidable form of power. Nevertheless, there are many examples of how particularly Western paradigms receive epistemic and policy authority via the WHO, including the perpetuation of a global health system reliant on externally-financed and -implemented interventions in most LMIC states, the use of market conditionalities that impose restrictions or force compliance (e.g. structural adjustments), the deprioritisation of traditional medicines, as well as Western-centric biomedical reductionism and securitization of health, as articulated in the WHO's latest Global Programmes of Work.[179] (see Part IV of the *Right to Health Sovereignty* Technical Report).

V.5 Realigning the WHO is a global common good

The pandemic accords have seemingly consolidated the gains of those who benefitted from Covid-19, concentrating private wealth, increasing national debts, and decelerating poverty reduction. They will expand the international health bureaucracy under the WHO; create a self-perpetuating global biopharmaceutical complex; and shift the locus of health policy authority, decision-making, and resources from the state to an enlarged corps of international technocrats, creating and empowering an international analogue of the administrative state that has already enervated national democracies. They have created a perverse incentive: the rise of an international bureaucracy whose defining purpose, existence, powers,

179 https://www.who.int/about/general-programme-of-work/fourteenth

and budgets will depend on emphasizing the frequency and gravity of outbreaks of pandemics.

Ministers may be in office but the reins of power are arguably in the hands of a permanent and unaccountable class of managerial technocrats and their implementers. Members cooperate with and support one another in enlarging the scope, scale, and complexity of bureaucratic organisations across the state, economy, markets, society, and culture. The risk of this at the global level is that it further removes decision-making from recipient populations who are most affected by its actions.

VI. PRINCIPLES OF PUBLIC HEALTH

VI.1 Medicine, public health, and population health

Public health as a discipline is not an end in itself, and is meant to serve the public. As such, like medicine or individual care, the rights and requirements of individuals and their communities must underlie its every action. This chapter sets out the ethical and professional standards against which the failures identified earlier in the report should be judged.

Medical care focuses on promotion of well-being – physical, mental, and social, including the treatment and curing of individuals who are ill by means of individualized care for patients who present with symptoms. Physicians review their medical histories and specific conditions, and order appropriate further tests like blood tests and scans. It encompasses accurate diagnosis, effective management (drugs, surgery, therapy, counselling), and prevention of illness, injury, and other physical and mental impairments in individual people. Medical care metrics include diagnostic accuracy, treatment efficacy, patient outcomes including symptoms, disability and survival, and patient satisfaction. The timeframe is generally immediate or short- to medium-term: antibiotics now for a bacterial disease, not a long-term strategy to study its causes and reduce its prevalence rate in the broader community.

Medical care can also draw on multidisciplinary fields but generally relies on clinical expertise within specific medical specialties like paediatrics, gynaecology, oncology, orthopaedics, etc. Medical care is focused on providing equal treatment to all patients while being open to background factors like barriers to education and access to healthcare where these might be relevant to understanding and treating the illness, for example members of marginalized communities living in remote settlements.

The central ethic of medicine is personal service, albeit conditioned by awareness of social factors and responsibility.

Medical practice or the promotion of health of the individual can also involve public health actions at the level of populations. The most spectacular long-term improvements in life expectancy have resulted from dramatic reductions in the prevalence and severity of infectious diseases, including acute outbreaks. Tuberculosis (TB) used to account for one-quarter of all deaths in Europe and the US from the 1600s to the 1800s.[180] The 2023 US incidence rate was 2.5 cases per 100,000 persons and there were 565 TB-related deaths.[181] Smallpox killed around 400,000 people annually in Europe in the 1800s.[182] The death rate from smallpox in London plummeted from over 18 percent in 1796 (when the vaccine was developed by Edward Jenner) to under 0.1 percent in 1900.[183] The global death rate from diarrhoea, malaria, respiratory infections, HIV/AIDS, and all other infectious diseases fell from 284 per 100,000 people in 1980 to 102 in 2019.[184] The main drivers of the improvements were better personal hygiene and nutrition, better public infrastructure for sanitation and drinking water, the discovery of antibiotics and, in the case of smallpox, vaccine. Vaccines have likely considerably accelerated infectious disease decline in low-income countries where the ecological improvements instrumental in industrialized countries have not occurred. The single best metric to illustrate the improvements in public health is global life expectancy. In the mid-18th century, it was estimated to be around 30 years.[185] In 1800, the life expectancy of almost all countries was below 40. By 2019 it had risen almost to 73 and for most industrial democracies it was above 80.

180 https://www.cdc.gov/world-tb-day/history/?CDC_AAref_Val=https://www.cdc.gov/tb/worldtbday/history.htm

181 https://www.cdc.gov/tb-surveillance-report-2023/tables/table-1.html

182 https://www.weforum.org/stories/2020/03/a-visual-history-of-pandemics/

183 https://ourworldindata.org/grapher/deaths-from-smallpox-in-london

184 https://ourworldindata.org/grapher/infectious-disease-death-rates

185 https://pmc.ncbi.nlm.nih.gov/articles/PMC7404362/

Public health and medical care are both essential for comprehensive healthcare delivery, for example initiatives targeting communities in the middle of an infectious disease outbreak as well as treating infected individuals. However, public health is particularly focused on the principle that prevention is more efficient and effective than treatment after the onset of disease. The WHO defines public health as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society."[186] It is a collective effort focused on protecting and improving the health of communities by encouraging healthy behaviours through policy development, research for disease prevention, responses to infectious disease outbreaks, creation and maintenance of potable water and hygienic sanitation, organisation of health services, public education messages such as good personal hygiene practices, nutritional diets, anti-smoking campaigns, surveillance and early detection of health threats, and community interventions.

Public health metrics include life expectancy and life years lost or disability, disease- and age-specific mortality rates, disease incidence and prevalence (for example lung cancer rates), as well as health service provision measures such as vaccination coverage. Long-term, sustained commitments, patience, and perseverance are required to produce improvements in health status metrics. Hence, policymakers and international organisations prefer setting targets at the level of health service provision rather than more meaningful metrics related to impact. Public health approaches are typically broad and multidisciplinary, drawing from the interconnected fields including epidemiology, biostatistics, behavioural science, sociology, and ethics. Public health often adopts equity-focused approaches to address inter-group disparities in disease prevalence and health metrics. The central ethic of public health is public service, albeit tempered by concerns for individual welfare.

Population health is again different but equally critical for enhancing health outcomes.[187] Both public and population health look to prevent and control disease by identifying the social determinants of health,

186 https://www.publichealth.com.ng/who-definition-of-public-health/

187 https://pmc.ncbi.nlm.nih.gov/articles/PMC11927948/

expanding primary care access to all those in need, and engaging in public education campaigns. However, public health prioritizes broader preventative measures and community-wide interventions to safeguard the health of the entire national population. By contrast, population health focuses on analysing health determinants and outcomes within specific groups (for example, indigenous or tribal or immigrant communities), employing data to guide targeted interventions and policies.

The Covid years demonstrated the abuses that can occur when the principle of patient-centric medical care is violated in practice. Western medicine has been predicated on the norm that the doctor's primary responsibility in assessing benefits against the risk of harms of treatment options is the welfare of the individual patient, and only secondarily community welfare. The messaging on "My mask/vaccine protects you and your mask/vaccine protects me" accelerated the erosion of this long-standing principle of Western medicine to turn it on its head. The story of mRNA Covid-19 vaccines highlighted how "the real divide" in public health today is between those who see public health as a race to maximize uptake at any cost as the fastest pathway to protect society in general and the entire population, and those who believe that patient safety, transparency, and informed consent free of any form of coercion must remain non-negotiable.

The prioritization of community welfare over individual patient care is also a violation of the Universal Declaration on Bioethics and Human Rights (2005): Articles 3, "The interests and welfare of the individual should have priority over the sole interest of science or society;" 5, "The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected;" and 6, "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information."[188]

188 https://www.unesco.org/en/legal-affairs/universal-declaration-bioethics-and-human-rights

VI.2 Foundational ethics

Ethics are fundamental moral principles that guide individual, professional, and societal behaviour, providing a framework for distinguishing right from wrong. As an institutional foundation, ethics provide a normative compass for how an organisation is designed, underwrite the legitimacy of its processes and scope, as well as act as a set of guardrails to ensure that implementation is appropriately aligned with its ethics-based mission. Although ethics are fundamental to institutional integrity, they are often assumed to be entrenched or sidelined in favour of technical or functionalist strategies. In this report, ethics remains a foundational core for any legitimate international health organisation and thus should be understood as necessarily explicit and immutable.

The evolution of medical ethics to guide the practice of medicine and research on human subjects has been articulated and codified into many texts and declarations. Some of the most important and influential international texts are briefly reviewed here, but not national documents like the Belmont Report (1978) that originated in and focused on the US context.[189]

Hippocratic Oath (antiquity)

Not every physician is required to take the Hippocratic Oath.[190] However, many medical schools in several countries still administer a version of it during graduation ceremonies. As a rite of initiation into the medical profession, it serves as the moral compass of new doctors and guides their approach to medicine throughout their careers, reminding them of their duties to their patient and the ethical dimensions of their profession. Tracing its lineage from ancient Greece, the Hippocratic Oath has transcended time and geography to remain a significant guiding document in modern medicine, calling on medical practitioners to uphold the value of human life, affirm human dignity, and promote health.

The injunction "First, Do No Harm," a bedrock principle in bioethics, does not exist in the Oath's literal text but is an extrapolation of Hippocratic

189 https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

190 https://www.britannica.com/topic/Hippocratic-oath

thought as found in the *Hippocratic Collection*.[191] The code of principles extends to the reciprocal duties of teachers and students of medicine to each other. Also known as the principle of non-maleficence, it affirms the physician's sacred duty to avoid causing harm or needless suffering to those in their care by pledging to prescribe only beneficial treatments, refrain from causing unnecessary suffering and hurt, and to live an exemplary personal and professional life. A touchstone against which every action is weighed, it imposes on physicians the moral imperative to hit the sweet spot between healing and harm, always striving to maximize the former and minimize the latter. Medical knowledge is to be wielded not as a weapon but as a tool for healing. It chisels into the institutional memory of the profession the foundational tenet of the duty to benefit the patient and improve their quality of life. The oath articulates the virtues that make a good doctor and the ends, means, and limits of good medical practice. It affirms that medicine exists in an interconnected web of relationships binding physicians to teachers, patients, and society. It is emphatic that the purpose of medicine and its practitioners is to help patients become healthy using only those means that respect the person.

Nuremberg Code (1947)

The Nuremberg Code, as its name suggests, is a ten-point statement that grew out of the experience of doctors in Nazi Germany who conducted human medical experiments in concentration camps.[192] The code is a landmark document on the medical ethics of studies conducted on human beings. It holds that medical experimentation on human subjects is justified only if the results benefit society and it is carried out in accord with basic principles that satisfy moral, ethical, and legal precepts. Developed by a panel of American judges at the Nuremberg Tribunal on war crimes, the code is designed to define the limits of permissible medical experimentation on human beings. The German doctors on trial argued that there were no international laws that distinguished legal from illegal use of humans in experimental research. Many prosecutors and expert witnesses

191 https://www.britannica.com/topic/Hippocratic-Collection

192 https://www.britannica.com/topic/Nuremberg-Code

were troubled enough by their claim that they initiated a search for legal principles to govern such experiments and came up with ten principles in August 1947.

The principles emphasize the overriding importance of the voluntary consent of the human subject in experimentation. The results of the study should yield results that benefit society and that are not procurable by other methods or means of study. (The latter is similar to the injunction in international humanitarian law in the principle of necessity.) Any experimentation should be designed and based on the results of animal experimentation. The methods used should strive to avoid any unnecessary physical or mental suffering and injury to the participants. No experimentation should be conducted where there is a prior reason to believe that disabling injury or death will occur. The degree of risk to the subjects of the study should never exceed the humanitarian importance of the issue under study. All proper preparations should be made and adequate facilities provided to protect the subject or subjects of the study against any possibility of injury, disability, or death. The experiments should be conducted by qualified persons. Any and all human subjects should be permitted to opt out of the study at any point during the experiment. The scientists in charge must terminate the experiment if they deem that continuation could result in injury, disability, or death to the subject.

Declaration of Geneva (1948 rev. 2017)

The modern version of the Hippocratic Oath was adopted by the World Medical Association at its second general assembly in 1948 and is known as the Declaration of Geneva.[193] Although it has been updated five times, the revisions have been few, far between, and carefully drafted. The current version from 2017 includes promises to practise medicine "with conscience and dignity," to make "the health and well-being of my patient…my first consideration," to maintain patients' confidentiality even after their death, "not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and

193 https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/

my patient," and to abjure using medical knowledge "to violate human rights and civil liberties, even under threat."[194]

International Code of Medical Ethics (1949 rev. 2022)

The Declaration of Geneva must be read alongside the World Medical Association's International Code of Medical Ethics.[195] This was adopted at the association's third general assembly in London in 1949 and the most recent version was adopted in Berlin in 2022. The code enjoins the physician to be aware of applicable national ethical, legal, and regulatory norms and standards, along with relevant international norms and standards. These must not, however, reduce the physician's commitment to the ethical principles set out in the code.

The code sets out the doctor's duty to the patient, other physicians and health professionals, society, and as a member of the medical profession. Those to the patient are the most extensive but mostly familiar: exhortations to patient health and well-being, harm minimization, balance of benefits over harms, informed consent, respect for privacy and confidentiality, avoidance of conflicts of interest, no transgression of professional boundaries, etc. Conflicting but conscientiously held personal beliefs may not be prioritized if they cause harm to the individual patient or disruptions to their care. Interactions with other healthcare professionals, teachers, and students must be respectful and collaborative. Duties to society include commitment to fair and equitable provision of health care, prudence in ensuring that public statements "are scientifically accurate," and avoidance of conduct that could "weaken public trust in the medical profession." As a member of that profession, finally, the physician is enjoined to "follow, protect, and promote the ethical principles of this Code" and support colleagues in upholding the code's responsibilities. Intriguingly in light of the Covid experience, Article 39 requires the physician to "help prevent national or international ethical, legal, organisational, or regulatory requirements that undermine any of the duties set forth in this Code."

194 https://www.wma.net/policies-post/wma-declaration-of-geneva/decl-of-geneva-v-2017/

195 https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/

The Declaration of Helsinki (1964 rev. 2024)

The Declaration of Geneva must also be read alongside the Declaration of Helsinki, a formal statement of ethical principles by the World Medical Association published in 1964 at its 18th general assembly in Helsinki to provide ethical guidance for the protection of human subjects in medical research.[196] It has exerted considerable influence. While the Helsinki Principles are not themselves legally binding, they have been codified into law in many countries as a guide to medical research in nations. The initial declaration was under 2,000 words and focused mainly on clinical trials. Most importantly, it relaxed the Nuremberg Code's stringent requirement for consent as "absolutely essential" to "if at all possible," and inserted the possibility of proxy consent that may be obtained, for example, from a legal guardian.

As the document was updated in subsequent iterations – the most recent, tenth amendment was adopted by the association at its 75th general assembly back in Helsinki in 2024 – it expanded in length, breadth, and depth of coverage. The original version in 1964 contained a short introduction and eleven articles divided under three headings: basic principles (five articles), clinical research and professional care (two articles), and non-therapeutic clinical research (four articles).[197] The 2024 version sets forth a total of 37 principles, grouped into a preamble; general principles; risks, burdens, and benefits; individual, group, and community vulnerability; scientific requirements and research protocols; research ethics committees; privacy and confidentiality; free and informed consent; use of placebo; post-trial provisions; registration of research, publication, and dissemination of results; and unproven interventions in clinical practice.

This took the declaration away from the initially elegant guiding principles in the direction of more detailed prescriptive recommendations. For example, Article 37 of the current version allows for unproven interventions to alleviate suffering of a patient where approved options are inadequate or ineffective. "Physicians participating in such interventions must first seek expert advice, weigh possible risks, burdens, and benefits,

196 https://www.wma.net/policies-post/wma-declaration-of-helsinki/

197 https://www.wma.net/wp-content/uploads/2018/07/DoH-Jun1964.pdf

and obtain informed consent." And research should subsequently be undertaken to evaluate the safety and efficacy of the unproven intervention.

Inevitably, venturing into more detailed prescriptions eroded consensus and created some internal dissension and controversy in the medical community, for example in relation to placebo-controlled trials and on the question of whether current standards of care in the developed industrialized countries should apply also in lower-income countries. This has important practical implications, including with respect to the sustainability of diagnostic and therapeutic equipment in countries much farther behind in their human and material medical and scientific infrastructure. Alternatively, can it be ethical to relax the levels of care for the treatment of patients in countries where the trials might have been conducted or from where the raw ingredients for making drugs might have been sourced? In general, nevertheless, the Declaration of Helsinki too prioritizes the rights of individual research participants over all considerations as the core guiding principle of research and human experimentation ethics.

Universal Declaration on Bioethics and Human Rights (2005)

The Universal Declaration on Bioethics and Human Rights was adopted under the auspices of UNESCO.[198] Its aim is to provide a universal framework of principles and procedures that can guide governments when making laws and policies in bioethics and the actions of individuals, groups, and public and private entities. It calls for full respect for human dignity, rights, and fundamental freedoms and elevates the welfare of the individual over "the sole interest of science or society" – an interesting perspective for UNESCO. Equality, equity, justice, and cultural diversity and pluralism must be respected in access to health care and the treatment of patients. Benefits are to be maximized and harms minimized. The autonomy of persons must be respected, and their "prior, free and informed consent" must be obtained for any medical intervention or scientific research. The privacy of patients and confidentiality of their health information must be respected. The benefits of scientific research

198 https://www.unesco.org/en/legal-affairs/universal-declaration-bioethics-and-human-rights

and its applications should be shared with society as a whole and with the international community, in those with less research capacity. Ethics committees should be set up to help guide decisions on laws and actions that touch on bioethics. Finally, transnational health research should be responsive to the needs of host countries and contribute to the alleviation of urgent global health problems.

VI.3 Core principles

The International Code of Medical Ethics begins with a statement of general principles.[199] The physician's primary duty is to promote the health and well-being of individual patients by providing competent, timely, and compassionate care in accordance with good medical practice and professionalism. That said, the physician also has a responsibility to contribute to the health and well-being of society as a whole. The care must be provided "with the utmost respect for human life and dignity, and for the autonomy and rights of the patient," without discrimination on grounds of the usual list of racial, religious, gender, and age attributes, and without considerations of personal benefit. Physicians must take responsibility for their medical decisions and should provide help in medical emergencies. Doctors are prohibited from taking part in or facilitating "acts of torture, or other cruel, inhuman, or degrading practices and punishments."

Primum non nocere (First, do no harm) and non-maleficence

The principle of non-maleficence is derived from the aphorism *primum non nocere*, a Latin phrase that is a principal precept of bioethics. All healthcare students learn it in school. It reminds them to weigh the possible harm that any intervention might do, especially in circumstances where the chance of benefit is less than certain. Dr Robert Shmerling, an editor of *Harvard Health Publishing*, noted in June 2020 that when difficult decisions must be made in real time, the command is hard to apply as estimates of risk

199 https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/

and benefit are uncertain and prone to error.[200] Nonetheless, it serves as an ever-present reminder of the necessity to better understand the balance of risk and benefit for the tests and treatments that are recommended, and of the abiding reality that doctors should neither overestimate their capacity to heal nor underestimate their capacity to cause harm.

Strictly speaking, the aphorism "First Do No Harm" is more folklore than Hippocratic. The classical version of the oath does contain the pledge that "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."[201]

Beneficence

The corollary of non-maleficence is beneficence. For many healthcare practitioners, in practice beneficence takes precedence over non-maleficence: not "First, do no harm," but rather, "First, do good." The ethics underlying the principle of non-maleficence prohibits dangerous non-therapeutic experiments, incompetence, and corruption in the treatment of the patient. The principle of beneficence flips this negative leash imperative into the positive duty to make every effort to heal the patient. Combining the two, if and when harm results, it must be in pursuit of and result in the greater good of the patient who must be left better off after consultation and treatment than before.

There is also a pragmatic calculation behind the twin principles. If encounters with healthcare professionals leave patients without visible improvement and worse off than before, public trust in the medical profession and health service will wane. Advice from health authorities will be more widely ignored. More people will then end up looking at unscientific treatment options from self-styled healers and quacks.

Patient confidentiality

As noted above, part of the Hippocratic Oath-derived modern pledge repeats the injunction to respect and protect the confidentiality of patient

200 https://www.health.harvard.edu/blog/first-do-no-harm-201510138421

201 https://www.britannica.com/topic/Hippocratic-oath

records. Healthcare providers must keep a patient's personal health information private unless the patient has freely consented to the release of the information. The pragmatic consideration behind the principle is that, if patients believe that their health facts are of an intimate nature or have the potential to cause embarrassment if revealed publicly (e.g. to family, employers, or the authorities), then they will be reticent on divulging those facts without the assurance that they are held in inviolable confidence. And any relevant health information withheld from the doctor cannot but contribute to poorer diagnostic, treatment, and health outcomes. In exceptional circumstances of threats to public safety, the doctor must resolve the conflicting duties on a hierarchy of ethical principles – a situation that must be resolved based on weighing individual and public good, and without deferment to authorities.

Informed consent

All the foundational texts written since the Second World War emphasize that voluntary consent is essential and, to be meaningful, it must be informed consent. This means that the person involved should have the legal capacity to give consent, should be able to exercise free power of choice without any element of force, fraud, deceit, duress, or other form of constraint or coercion, and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable an understanding of what is proposed, and make an enlightened decision. The last element necessitates that before the acceptance of an affirmative decision, the experimental subject should be made aware of and understand the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; the risks that might reasonably be expected; and the likely and potential effects that may come from participation in the experiment.

The physician is under the moral obligation to assist the patient to understand the benefits and risks of every medical procedure, but not to pressure the patient in any direction. The patient has the right to accept or reject the doctor's recommendation in coming to a decision, including seeking a second opinion. As a rational actor – the organizing principle of government-citizen relations – every human being has the capacity to evaluate competing claims and come to his or her own decision on

the preferred course of action. This is especially so as any harmful consequences of the decisions will be borne primarily by the patient and not by the physician. Both justifications – the claim to being a rational decision-maker and to owning responsibility for the consequences of one's choices – apply, for example, to people who are considering an intraocular lens after cataract surgery. The ophthalmologist can point out the pros and cons of distant or short vision corrective lenses and make a recommendation based on knowledge of the patient's lifestyle. But it is the patient who will have to live with the results and, as a free moral agent, has both the right and the responsibility to decide.

Ideally, a patient with full autonomy has the capacity to give consent directly to all essential medical decisions and to every invasive procedure. Nevertheless, many codes of conduct address the issue of individuals who may lack the capacity to make decisions for themselves, or who fear a future in which they may be impaired and incapacitated. Typically, when consenting to a medical procedure with some risk of harm, a patient, for example someone about to be administered a general anaesthetic, might be asked to consent in advance of the operation to a designated person to be authorized to consent to additional interventions that may prove necessary to deal with an unexpected emergency. That represents a transfer of autonomy to a trusted representative, such as a spouse or an adult son or daughter. In the case of those with limited autonomy who lack the capacity for independent decision-making, surrogate decision-making is both morally and legally permissible. If such proxy decision-making consent is granted ahead of time, either in writing or orally, in anticipation of future problems, its validity may be reconsidered if situations arise that were not and could not reasonably have been foreseen at the time of making the advance directive.

One of the most notorious examples of unethical experimentation on human beings was the so-called Tuskegee Study of black Americans for untreated syphilis that ran from 1932 to 1972.[202] Of 600 males who formed the initial study group, 399 were infected and 201 did not have the disease. Participants' informed consent was neither sought nor obtained.

202 https://www.cdc.gov/tuskegee/about/timeline.html

Participants were kept in ignorance of the nature of the study and those suffering from syphilis were not provided with any treatment for the disease, even after penicillin became the widely available drug of choice for treating syphilis by 1943. The study ended only after an Associated Press story broke the scandal.[203]

It is impossible to know how the Covid experience will be assessed by historians in the fullness of time on the criterion of informed consent. In a very real sense, selective and manipulated release of data ensured that informed consent was corrupted into misinformed and disinformed compliance. Fear was intentionally and unintentionally heightened via media sensationalism, daily press briefings on new cases, hospitalization, deaths, and containment measures. Absolute risk was conflated with relative risk reduction in highlighting the efficacy of vaccines. Efficacy in the lab was conflated with effectiveness in the real world. The steep age gradient of the mortality risk profile from the disease was known, or should have been known, by any diligent public health authority and expert. The mortality risk also varied widely across continents. Overstated assumptions were made on the benefits of pharmaceutical and non-pharmaceutical interventions as against the absolute worst-case doomsday scenarios of not going soon, hard, and long in responding to the grossly inflated threat. Although it has been officially acknowledged that some operating assumptions were incorrect and elements of fearmongering were used to elicit compliance, public inquiries have not fully addressed the questionable assumptions and tactics that underwrote Covid-19 response policies, nor addressed issues of accountability for these.

Sanctity of doctor-patient relationship

The WHO Pandemic Agreement and IHR are legal instruments intended to promote global public health. Some of their provisions impinge on the sanctity of the doctor-patient relationship, recommending that health authorities direct physicians on vaccines, therapies, and medical devices during pandemics. This codifies what in fact happened during the Covid

203 https://apnews.com/article/business-science-health-race-and-ethnicity-syphilis-e9dd07eaa4e74052878a68132cd3803a

pandemic. The IHR seeks to put aside long-standing principles that have guided doctors and health systems: the Hippocratic Oath's duty of "First, do no harm," informed consent of the patient based on a harm-benefit evaluation of different treatment options, the risks associated with them in the best professional judgment of the doctor, and the sanctity of the doctor-patient relationship.

This is centrally relevant, for example, to the benefit-harm equation of vaccines by age groups. In the absence of clear evidence of benefit, it violates core medical ethics to recommend vaccines to healthy children, adolescents, and young adults, and to pregnant women and women of child-bearing age, on the reasoning that doing so helps to protect the whole community. This is further reinforced by the Convention on the Rights of the Child[204] (1989: "the most widely ratified human rights treaty in history," says UNICEF), Article 3.1 of which affirms: "In all actions concerning children...the best interests of the child shall be a primary consideration."[205]

The primary consideration should always have been:

1. The risk of the Covid-19 disease to the individual
2. The efficacy of the vaccine for them against infection, hospitalization, ICU admission, and death
3. The number within their age group that would need to be vaccinated (NNV) to prevent one hospitalization, ICU admission, and death
4. The corresponding numbers of serious adverse events for that NNV.

The potential for protecting the wider community should not have entered the discussion unless the patient raised it with regard, for example, to a parent or grandparent. Then, any decision would have to ultimately be made by the patient, having been informed of these considerations.

204 https://www.unicef.org/child-rights-convention/convention-text

205 https://www.unicef.org/child-rights-convention

VI.4 Freedom of speech

Free societies flourish best with free speech. Freedom of speech is essential for scientific integrity and progress. Science is work in progress, not an encyclopaedia of facts and fixed assumptions. Progress is neither linear nor irreversible. Nor is science synonymous with the existing narrative.[206] Although the long arc of science bends towards truth, scientific progress requires the full supporting intellectual infrastructure of critical research and debate. This is why it is critical to promote intellectual and personal freedom in public debate and public policy, including the application of classical scientific methods to the analysis of medical questions, and the transparency, contestability, and accountability of public decision-making. Science has the power to set us free of the threat of mass killer diseases, but only if science and scientists are themselves allowed to be free to question, to shine a harsh light on existing inadequacies and flaws, and to pursue all promising leads and avenues of fresh discoveries.

Scientists must be free to challenge the prevailing dominant narratives. They must have the right and responsibility to subject the existing consensus to searching scrutiny in line with empirical observations. Rejection of attempts to suppress dissenting voices, together with encouragement of diverse viewpoints on contested elements of knowledge, provide necessary safeguards against reverses. The damage inflicted on the theory and practice of free societies by the creation of what some have labelled a censorship-industrial complex during the pandemic, in the name of waging a war on Covid, highlighted the dangers of muzzling science to impose intellectual conformism.[207] Freedom in science includes freedom of inquiry, freedom to be sceptical, and freedom to question established wisdom or the dominant worldview and set of beliefs. These liberties are integral to scientific advancement and progress. Freedom is also integral to the practice of medicine. It underpins the sacred twin duties to "First, do good" and "First, do no harm," which are indispensable to the principle of informed consent and fundamental to the sanctity of the

206 https://www.sciencedirect.com/science/article/pii/S2666535224000302

207 https://judiciary.house.gov/sites/evo-subsites/republicans-judiciary.house.gov/files/evo-media-document/shellenberger-testimony.pdf

doctor-patient relationship.

Some observers alleged that the mRNA Covid-19 vaccines violated the Nuremberg Code because they were experimental and consequently its recipients were not in any position to give informed consent.[208] The official view was to reject this contention, on the reasoning that the Nuremberg Code principles specifically address *experimentation* on human subjects. The large clinical trials conducted by vaccine manufacturers had been in line with the Nuremberg Code; they involved volunteers. No one was forced to take part in the study. All the volunteers were able to opt out of the study at any time. Nor did the fully qualified scientists conducting the trials ever believe the lives of participants to be in danger. The Nuremberg Code does not apply to the use of approved vaccines although, as discussed above, the ethics of practitioner-patient relationships are not greatly different.

The point here is not to provide "truth" within the above debate, but to raise the importance of open communication for the advancement of good science and policy. The aim of science is to understand and explain observed phenomena to achieve clarity. Science has four dimensions (epistemology, methods, ontology, and teleology) and is socially embedded and ultimately "constructed." This is not to say that there are no "facts," but merely to suggest that a level of intersubjectivity between ways of measuring the world is required for scientific inquiry to have social meaning, public resonance, and trust. As a result, there is no single "science" per se, rather various disciplines utilizing a set of formalized and systematic approaches based on continued interchange between theorizing and empirical (experimental) testing of hypotheses. Although this in some ways makes "science" an essentially contested concept, a key feature of any "scientific method" is that it remains self-reflective, dialogic, involving interchange, retesting, re-evaluation, validation and, over time, the formation of intersubjective understandings. Thus, the art of the scientific method is about finding new knowledge, not necessarily to find "the truth."

208 https://www.usatoday.com/story/news/factcheck/2021/08/10/fact-check-covid-19-vaccine-mandates-nuremberg-code-not-related/5530548001/

At its definitional core science examines doubts, complexity, and is constantly evolving. A key part of this process is open dialogue and engagement with disparate findings. Reducing this process to political expediency, corporate interest, corruption, fearmongering, and assumptions of "settled science" will not serve the interests of public health or of humanity. Instead, science requires acknowledgement of its limitations, recognition that new insights can and should be discovered, and that "good science" is a social and experimental process completely dependent on the free exchange of ideas.

In this context, aspects of recent policies of the WHO raise considerable concern. Front and centre is the WHO emphasis on what it considers a new area of public health science and one of the major threats to global health: infodemics. It defines infodemics as too much information, which may or may not be correct, the public health institution thus having a role as a gatekeeper of public information rather than a provider of advice. Restricting access to truth, or encouraging such restriction, is clearly antithetical to the concept of an individual having sovereignty and self-determination, or to fully informed consent. Restriction of information considered untrue puts the public health practitioner in the position of a technocrat making decisions on censorship who also removes free expression, but only at the risk of institutional corruption. Both are clearly against the tenets of science, which involves accumulation of knowledge and transparent testing of ideas to determine how well they describe reality.

VI.5 Subsidiarity

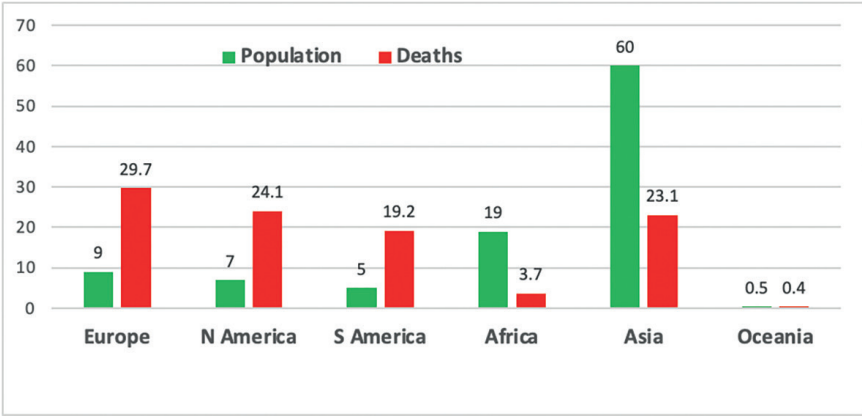


Figure VI. 1. Population size and Covid-19 deaths by continent, as at 7 September 2025 (percentages).

Sources: https://worldpopulationreview.com/continents (population), https://ourworldindata.org/covid-deaths (Covid-19).

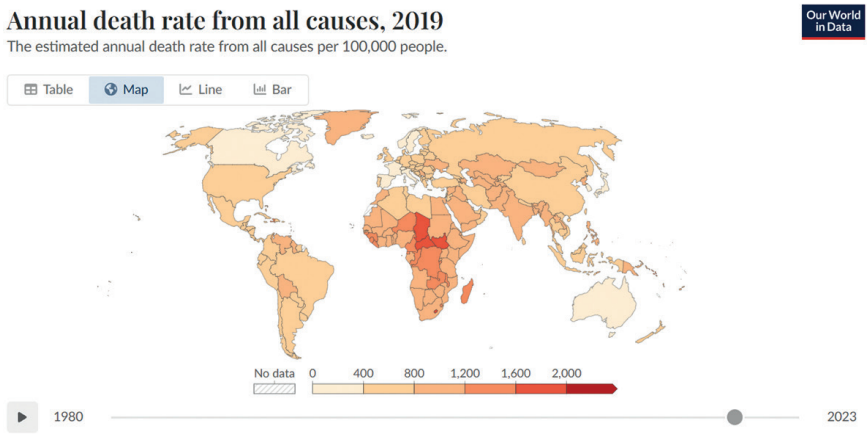
In Chapter 1, we defined subsidiarity as the principle that policy decisions are taken at the lowest possible level and closest to where they will have their effects. Figure VI.1 is a visual illustration of just how strikingly regional the Covid-19 mortality toll was compared to the different continents' shares of world population. Europe and the Americas experienced three to four times more Covid-19 deaths than their population shares while Asia and Africa were three to five times under-represented, and infectious disease mortality continued to be dominated by other causes. Rather than a central global health organisation, it is regional groupings like the African Union (AU), European Union (EU), the Pan-American Health Organization (PAHO, a functionally specific regional organisation) or the Organization of American States (OAS, the continent's general purpose regional organisation), the Pacific Islands Forum; and/or subregional organisations like the Southern African Development Community (SADC), the Association of Southeast Asian Nations (ASEAN), and the Association of Caribbean States that should have secondary responsibility for coordinating health policies and initiatives within their jurisdictions.

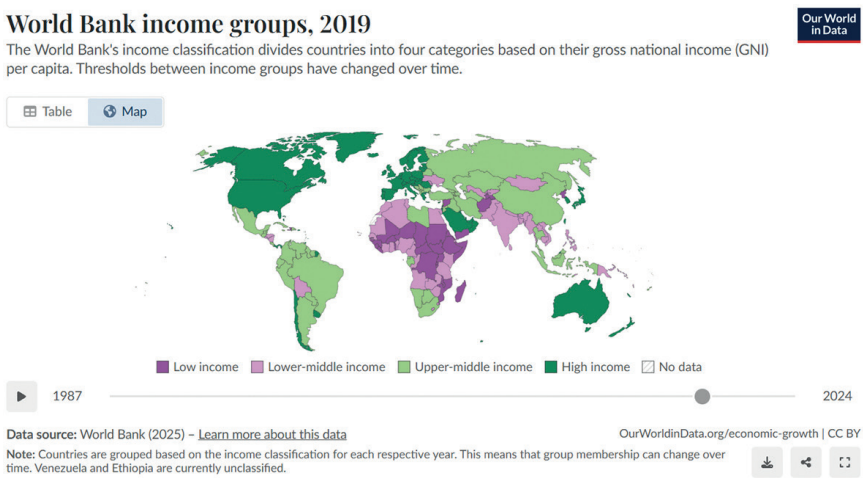
Country	*Disease, deaths*	*Disease, deaths*	*Disease, deaths*	*Disease, deaths*	*Disease, deaths*	*Covid-19 (rank)*
China	Stroke, 8.8mn	Heart disease, 7.6mn	Lung disease, 4.2mn	Lung cancers, 3.1mn	Stomach cancer, 1.7mn	5.3k (>25)
Egypt	Heart disease, 746k	Liver disease, 258k	Stroke, 188k	Liver cancer, 105k	Hypertension, 90k	24.6 (16)
India	Heart disease, 6.5mn	Lung disease, 3.8mn	Stroke, 3.0mn	TB, 1.9mn	F&P, 1.7mn	533.6 (15)
Indonesia	Stroke, 1.5mn	Heart disease, 1.1mn	Diabetes, 474k	TB, 387k	Liver disease, 385k	162k (10)
Japan	Heart disease, 703k	Stroke, 523k	F&P, 463k	Lung cancers, 342k	Lung disease, 336k	74.7k (14)
Nigeria	F&P, 890k	TB, 547k	Malaria, 433k	Birth trauma, 430k	Low birth weight, 412k	3.2k (>25)
Singapore	Heart disease, 22.7k	F&P, 22.3k	Stroke, 6.7k	Lung cancers, 6.6k	Colon cancers, 5.2k	2.0k (12)
UK	A&D, 421k	Heart disease, 308k	F&P, 174k	Stroke, 162k	Lung cancers, 153k	232k (3)
USA	Heart disease, 1.6mn	Stroke, 699k	Lung disease, 592k	Lung cancers, 578k	Hypertension, 534k	1.2mn (2)
World	Heart disease, 38.1mn	Stroke, 26.6mn	Lung disease, 13.9mn	F&P, 11.1mn	Lung cancers, 7.7mn	7.0mn (7)

Table VI. 1. Top 5 killer diseases compared to Covid-19-related deaths, 3 Jan 2020–15 Apr 2024, selected countries.

A&D = Alzheimer's & dementia; F&P = flu & pneumonia; TB = tuberculosis.

Source: https://www.worldlifeexpectancy.com/selected-deaths-vs-covid-19-world. The Covid-19 death toll for each country was double-checked against data from https://ourworldindata.org/covid-deaths. The only significant discrepancy was in the case of China: 122,400 instead of 5,300 (which also pushed the world total to 1.1 million). China had stricter criteria for diagnosis than many other countries. With this adjustment, Covid-19 remained outside the top 25 causes of death in China.





The primary responsibility should always remain with the countries directly although, in federal political systems, health is typically under the jurisdiction of state (provincial) governments. As can be seen in Table VI.1 and Figures VI.2 and VI.3a-c, there is a wide variation in the big killer diseases across countries divided by income levels and in selected countries. With respect to Covid-19 specifically, it varied widely. Based on officially reported data, it was the second biggest killer of Americans and the third biggest of the people of the United Kingdom in those four years. It fell outside the top ten for Egypt, India, Japan, and Singapore. And it did not even make it to the top 25 killer diseases reported for the

likes of China and Nigeria. In Table V.1 in the previous chapter, we noted the methodological problems of definition and measurement that reduce confidence in the reliability of data. This is especially so for the purposes of comparisons across nations. Overall, however, the problem should be less acute for understanding the relative burden of different diseases within countries, as the statistical collection and collation weaknesses would be common to all health issues in the population and reflect weak state capacity in general.

While standardization of data is important for comparisons and policy making, surveillance and other reporting requirements should be tailored to reflect contextual needs and priorities, which may be oversimplified with high opportunity costs under the obligations of the WHO pandemic accords. Structures therefore must be negotiated, set up, and maintained with local priorities in mind. This requires human and financial resources with appropriate justifications. Money spent on this policy item must either be diverted from another budget line, or else be raised from new taxes or borrowing. It does not and cannot represent equal value for money for all the world's 200 countries. It is more rational, efficient, and effective to leave the prioritization of attention, resources, and efforts, both within the health sector and between health and other social welfare sectors like education, in the first instance to the countries themselves as part of their responsibility of state sovereignty. Their governments bear the primary legal, political, and moral responsibility for the welfare of their peoples. The consequences of all health policy-related decisions on resource allocation priorities will most heavily affect the individuals and national populations of these countries. In the second instance the identification, implementation, and achievement of health policy goals and outcomes can be facilitated by the relevant subregional and regional organisations. Accordingly, a global health organisation should be there to coordinate and support local responsibility, functions, capacity building, resources, and powers.

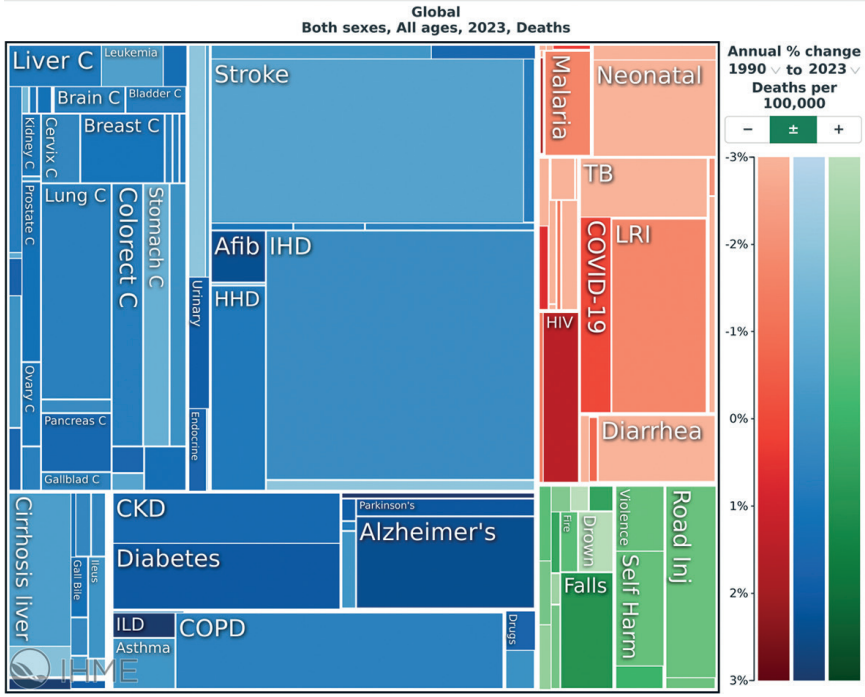


Figure VI. 3 a. Leading causes of death, globally.

Source: Institute for Health Metrics and Evaluation (IHME), University of Washington School of Medicine. https://vizhub.healthdata.org/gbd-compare/

Afib: atrial fibrillation; ALS: motor neuron disease (acute lateral sclerosis); C: cancer; CKD: chronic kidney disease; COPD: chronic obstructive airways disease; Digest: digestive system diseases; Elect (for Nigeria): electrocution; F body: foreign body; Hep: acute hepatitis; HHD: hypertensive heart disease; IHD: ischaemic heart disease; ILD: interstitial lung disease; Ileus: paralytic ileus and intestinal obstruction; LRI: lower respiratory infections; Mech: exposure to mechanical forces; Other MN: other malignant neoplasms; Oth Un Inf: other unspecified infectious diseases; PAD: peripheral artery disease

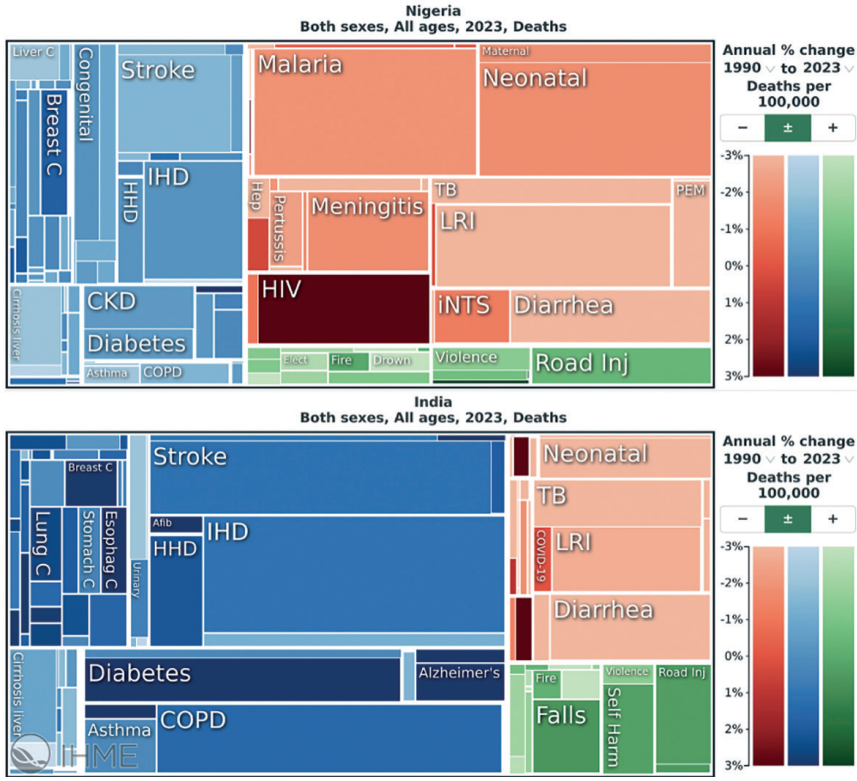


Figure VI. 3 b. Leading causes of death, Nigeria and India.

Source: Institute for Health Metrics and Evaluation (IHME), University of Washington School of Medicine. https://vizhub.healthdata.org/gbd-compare/

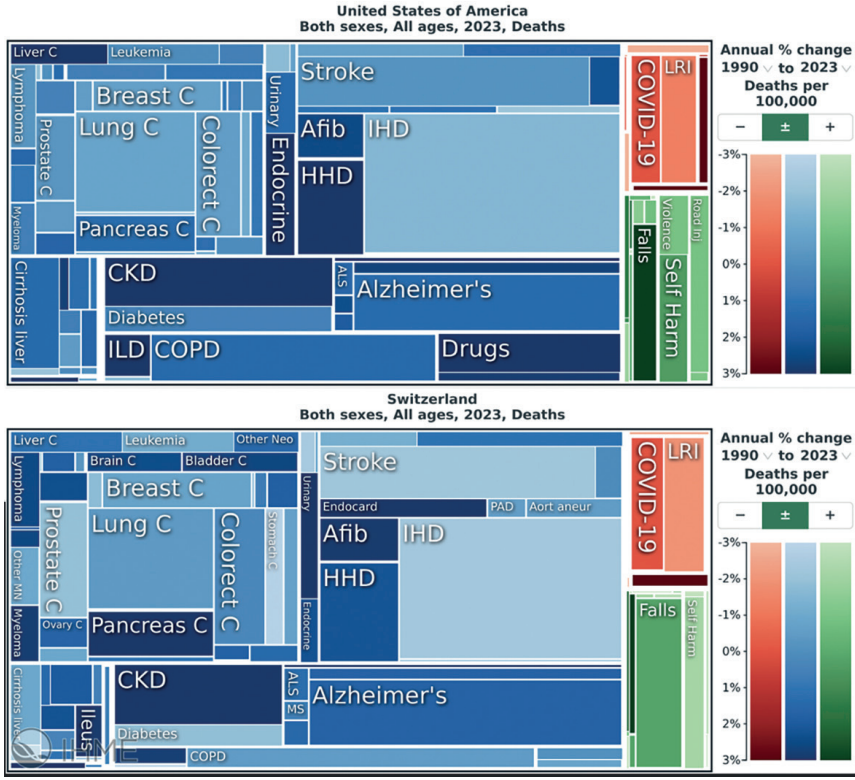


Figure VI. 3 c. Leading causes of death, USA and Switzerland.

Source: Institute for Health Metrics and Evaluation (IHME), University of Washington School of Medicine. https://vizhub.healthdata.org/gbd-compare/

VI.6 Conclusion

Law establishes hard boundaries with external sanctions. Medical ethics is different, in that it represents aspirational ideals. Both law and medical ethics contain permissive elements (licence function) and restrictive elements (leash functions). Both law and medical ethics share common ground in respecting self-determination, beneficence, and fairness to all patients. Principles of medical ethics are unavoidably and intentionally broad. The breadth permits different moral frameworks and ethical traditions to support them. Of course, as in all walks of life, challenges arise when

different principles come into conflict, one of the most common being when patient autonomy contradicts beneficence. All modern medical codes emphasize respect for patient autonomy, consent, privacy, and confidentiality; behaving with professional competence and judgment; acting with personal integrity; avoiding conflicts of interest; respecting human life; and maintaining proper communication with patients and colleagues.

The problem in many countries is the heavy corporatization of the practice of medicine and institutionalization of the medical profession. This has resulted in a diminished respect for the doctor-patient relationship which several codes, starting with the Hippocratic Oath, sought to safeguard. Healthcare practice managers employed by corporate health service providers and professional medical bodies with ties to government and financial links to pharmaceutical companies can be tempted to influence health policies in directions that benefit them institutionally rather than patients. This relationship is often repeated within global health governance and policy, cascading downward into health systems and service delivery in low- and middle-income countries, particularly through conditionalities associated with development assistance. One of the guiding principles of an international health organisation should be to ensure that the health and well-being of patients is returned to being the foremost priority and not sacrificed at the altar of institutional aggrandizement, personal financial and career inducements, and corporate profits. They should, therefore, set a standard of complying with, and defending, core medical and public health ethics against the pressures that seek to erode them.

VII. AN INTERNATIONAL HEALTH ORGANISATION

The institutional core of global health governance is the WHO, founded in 1948 shortly after the UN's establishment. Reflecting the universal nature of its mandate and concern, the WHO is one of the UN's largest (see Figure VII.1), most professional, and most respected specialized agencies. After a century in which respiratory virus pandemics had little impact on humanity, the world adopted a new strategy to the outbreak of the SARS-CoV-2 virus. This approach introduced measures such as prolonged lockdowns and universal masking and promoted population-wide mass vaccination. These were often accompanied by restrictions regarding the ability to maintain employment, travel, and engage in social activities. The focus was put on a single virus and disease, especially its transmissibility, in the process de-emphasizing pre-existing health burdens and the broad view of physical, mental, and social well-being laid out in the WHO constitution.[209]

The Covid-19 pandemic response suspended democratic norms and contradicted established WHO guidance developed for pandemic influenza, including the implementation of border closures, confinement of healthy people, and prolonged interruption of employment and education.[210] It was accompanied by a large shift in wealth, predominantly from low- and middle-income people to a smaller and wealthier minority, including those

209 https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

210 https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf?ua=1

invested in industries that promoted the novel pandemic response. The effects of Covid-19 policy on future health, including deferred screening to detect and prevent onset of treatable diseases early, increases in poverty, reduced education, disrupted childhood immunization programmes, and rising rates of other infectious diseases will become evident over time to current and future generations.

The WHO and other international, 'philanthropic,' and commercial organisations are now proposing a vast diversion of resources to pandemic (and other health emergency) preparedness through the amended International Health Regulations[211] and the Pandemic Agreement,[212] as discussed in Chapter 5. The accords seek to further centralize authority to declare and manage health emergencies by public health and social measures (PHSMs) including an expanded cycle of intensive surveillance, threat identification, strongly recommended restrictions on populations that states will implement as mandates, and targeted medical responses. These will operate above national jurisdictions and outside the direct control of the populations they impact. This follows a growth in private and corporate control over the WHO and international health policy through an increased use of voluntary and specified funding outside the system of assessed contributions, and the parallel growth of large public-private international health partnerships. The profession of medicine within nations has changed from a calling and a vocation to heal into a corporatized ethos that manages transactional relations between providers and consumers. In a matching vein, international public health is moving from a model of community and country-driven prioritization to a more prescriptive biomedical model that reflects interests of commercial and private entities.

Humanity can benefit from international forums for data-sharing and provision of technical expertise to support countries. Such forums can play an important supportive role in building health system capacity, understanding the causes of poor health and managing the spread of disease across borders, and have historically done so. However, the

211 https://apps.who.int/gb/bd/pdf_files/IHR_2014-2022-2024-en.pdf

212 https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf

adoption of prescriptive approaches to countries and their citizens, and the centralization and standardization of health decision-making, risk the removal of decision-making power from individuals, communities, and states. This is contrary to foundational principles of public health and norms of state sovereignty. Influence on public sector intergovernmental institutions by vested private or commercial interests is contrary also to the basic principles of good governance. Active cooperation between states and other sectoral actors can deliver public health benefits where the process respects the decision-making and self-determination of states, communities, and citizens.

VII.1 Principles

We saw in the previous chapter that the Nuremberg Code listed ten principles, the World Medical Association's International Code of Medical Ethics in its original version in 1949 was just a simple two-page document of some 500 words that had expanded in 2022 to nearly 2,000 words with a preamble and 40 principles. Similarly, the Helsinki Principles were just over 700 words in 1964 and contained eleven principles but by 2024 had expanded to almost 3,000 words and 37 principles. We do not believe that more is better in this context and for this purpose. The pledge in the Declaration of Geneva has remained short at 222 words and 13 promises. The principles and the total word count should be fewer rather than more in number. They should provide general ethical guidance for physicians and other colleagues from the health professions. They should avoid being overly prescriptive and detailed. The general principles can be fleshed out by regional organisations and codified in law or other binding norms by the governments of member countries, in the contexts of their respective jurisdictions, restraints, and cultural priorities.

The UN Ethics Office has a 58-page booklet, *Putting Ethics to Work: A Guide for UN Staff* (2017), that describes in considerable detail the UN's ethical framework, how to apply the framework, and how to make ethical

decisions.[213] It begins with a 92-word Oath of Office for UN employees as international civil servants. All members of staff are required to make the following declaration to be witnessed by the Secretary-General or an authorized representative:

> *"I solemnly declare and promise to exercise in all loyalty, discretion and conscience the functions entrusted to me as an international civil servant of the United Nations, to discharge these functions and regulate my conduct with the interests of the United Nations only in view, and not to seek or accept instructions in regard to the performance of my duties from any Government or other source external to the Organization.*
>
> *"I also solemnly declare and promise to respect the obligations incumbent upon me as set out in the Staff Regulations and Rules."*

The most substantial section (13 pages) of the UN code of ethics is on how to avoid conflicts of interest in personal relationships; gifts, hospitality, awards, and honours; outside employment and external activities; working with external partners and donors; political activity; financial disclosure; and post-employment activities. Components of the UN's ethical framework are the United Nations Charter, the Staff Regulations and Rules,[214] the standards of conduct promoted by the International Civil Service Commission, and the principles of independence, loyalty, impartiality, integrity, accountability, and respect for the human rights, dignity, and worth of all persons. WHO staff are required to abide by the WHO Code of Ethics.[215]

Ethical principles for an international health organisation

A key aim of this report and its associated Technical Report is to establish

213 https://www.un.org/en/ethics/assets/pdfs/Attachment_2_EN_Putting%20Ethics%20to%20Work.pdf

214 https://hr.un.org/content/staff-regulations-11

215 https://cdn.who.int/media/docs/default-source/ethics/code-of-ethics.pdf

a set of public health principles against which the policies of institutions working in the field can be assessed. This is an indicative template.

Aim

Based on fundamental principles of human rights and healthcare ethics, an International Health Organization's structure and function should be based on the following principles:

Health governance and human rights

1. All people are of equal concern, with sovereign rights over their own bodies. Each person therefore has a right to decide on their own healthcare, and to interpret public health advice within their own context.
2. States have sovereign responsibility for public health policy within their own borders in their role as representatives of, and expressions of, the self-determination of individuals comprising the population within states.
3. The role of public health, and public health institutions, is to advise individuals on their health risks and management, and populations on their joint health risks and management, to enable those individuals and populations to make evidence-based decisions, taking into account the context in which they live and their own expectations and preferences regarding health matters.

Voluntary informed consent and absence of coercion

4. Individuals or their legal guardians must not be forced or coerced into medical examinations or medical management, including prophylactic and preventative care. A legal guardian can only act in the interests of the subject.
5. Voluntary informed consent is a fundamental right of all people and a requirement for the provision of medical care.
6. All individuals have a right to interpret health advice applying to themselves according to their cultural and religious beliefs

and customs, geographical context, and individual health status and experience.

Role of public health institutions

7. Communities are the primary focus for public healthcare, as it is essential that healthcare be tailored to local contexts. They should be the primary decision-making level for public health policies that impact them. They should also represent, but not override, the health preferences of the individuals within them.
8. Health is influenced by a broad range of determinants, including physical, environmental, and social. Responses to individual threats, such as biomedical threats, must be considered always in the context of their effects on these broader determinants.
9. Public health must be free of ideological or commercial conflicts of interests and give health advice based on a summation of available evidence and expertise. This summation should include the expected impact of alternate approaches, tailored to local conditions, and free of influence of entities that stand to benefit financially from such advice. Evidence and expert advice must be available and transparent to ensure opportunities for voluntary informed consent.
10. Public health and the health sciences rely on free and open dialogue, transparent testing and analysis of data, and balancing of risks and benefits within these. The public, and those within the health field, have a right to free expression of ideas regarding all matters touching on health. Censorship is therefore contrary to the principles of public health and must not be used by health institutions to develop or implement policy.

International public health institutions

11. The role of international health institutions is to advise states and communities on areas of healthcare based on available expertise and evidence, to support populations in coordinating areas of cross-border and international health concern, and to provide

technical support when requested by states and within the institution's capacity, while respecting the states' and communities' specificities and preferences. In doing so, international health institutions should not override the laws and rules of states and peoples, or directly address the healthcare of individuals within states and communities without their consent.

12. Where states are unable to build strong and efficient health systems and to promote the health of their people, it is the role of international institutions to assist those states in the promotion of public health.
13. International health institutions formed by states must be free of conflicts of interests from private and for-profit entities, and transparent regarding the affiliations of those offering advice. Private and for-profit entities must not have control, direct or indirect, over the functions and activities of such institutions, or the salaries and benefits of their employees.

All negotiation on health governance should adhere to these basic principles and be designed in such a way as to enhance deliberation among the widest possible set of experts and stakeholders, recognizing that at times the application of policy to an individual can require careful and transparent consideration on a case-by-case basis. The constitutions and operations of international health bodies should similarly be in such compliance if they are to be supported by member states and respectful of human rights. As a result, the pandemic accords need to be reviewed in light of these considerations, conflicts of interest identified and removed, inclusive deliberative and evidence generation procedures enhanced, and then proceed only within the good practice that these principles ensure.

The literature on WHO reform often identifies "entrenched sovereignty" by Member States as the primary driver of gridlock in global health policy making. As a result, criticisms of the WHO tend to argue that it requires more centralized authority with the power to enforce compliance. This report argues the opposite. Namely, if states are the main beneficiaries and stakeholders which an IHO is designed to serve, then the emphasis should be on legitimate political processes and not maximizing centralized efficiency. In other words, the aim of an IHO is not to get things done

fast in accordance to rules designed in the Secretariate, but to assure that rules reflect the will of its constituents, that processes and their outcomes are deemed legitimate, and that the rules that are created capture a form of self-legislation in concert with others under a law making process. Although this results in slower policy making, it will increase legitimacy and compliance, making for a more effective and reputable IHO in the long term.

VII.2 Secretariat

A permanent secretariat distinguishes an international organisation (e.g., the United Nations, International Labour Organization, WHO) from ad hoc conferences and informal groupings (e.g., the G7, G20, BRICS).

Max Weber's idealized bureaucracy

In administrative theory as described by the German social scientist Max Weber (1864–1920) and which serves as the foundation of modern organisation theory, the decisive reason for the advance of bureaucratic organisation was its purely technical superiority over any other form of organisation.[216] 'Bureaucracy-free' structures can indeed achieve collective goals, but only in small and decentralized local communities. If we wish to pursue administrative and productive goals in a large and extensive society, then we need a bureaucratic organisation. The modern state is the professional state. Ministers, being politicians, generally lack expertise and experience in administration. Professionalism in the art of government requires that policy development, formulation, and implementation be placed in the hands of technocrats with the requisite specialist skills and knowledge of the principles of public administration.

A bureaucracy is an organisation purposefully adapted to attaining a single functional goal. It is organized hierarchically with a clear and strict chain of command from top to bottom. Moreover, the hierarchy is pyramidal in form, with several subordinates carrying out functionally

216 https://pubadmin.institute/administrative-thinkers/max-webers-principles-of-bureaucracy

related tasks under one superior at each level. Reflecting this, there is an elaborate division of labour throughout the organisation, with specialist tasks being assigned to appropriately skilled personnel, with the responsibilities becoming increasingly generalized and managerial higher up the hierarchy. All conduct in the pursuit of official duties is governed by a detailed set of rules and regulations and not arbitrary choices, with precedent being accorded almost mystical reverence. The official owes no personal loyalty to the boss. Recruitment into the service and advancement up the career ladder are on the basis of competence, specialized training, and performance, rather than by birth, privilege, or personal connections. Typically, office-holding in the organisation tends to be a lifelong vocation; that is, a career. These principles of a bureaucracy are meant to ensure rational decision-making, efficiency, and predictability.

The stylized version of a bureaucracy as described in the preceding paragraph is open to the criticism that it overestimates the rationality and efficiency of standing organisations staffed by faceless experts who follow standard operating procedures. It also downplays the elements of "red tapism" that produces rigidity and inflexibility, the petty conservatism of officials, and the insidious effects of such processes as exemplified in Parkinson's law that work expands to fill the time available for its completion. There is also the related Peter principle that each person rises to her or his level of incompetence. Bureaucracies generally, and international bureaucracies in particular, act on caution over courage, are prone to risk aversion that prioritizes protocol and precedent over substance and initiative, hierarchy and seniority over merit and competence, and, for the sake of maintaining good relations with them, deference to member governments over mission goals. Such objections may well be valid, if to lesser and greater degrees in different bureaucracies. Yet, they are also irrelevant to the point at hand. The essential argument is that, under modern conditions, few of the activities entrusted to bureaucracies could be carried out by non-bureaucratic organisations.

A bureaucracy tenders expert advice to policy-makers so that decisions can be made on the basis of the most informed choices. Once the decisions have been made, responsibility for implementing them is again vested in the bureaucracy. That is, even though a bureaucracy is part of the policy-making structure, bureaucrats are advisers and implementers of

public choices made by the policy-makers and decision-makers. The permanence of the career civil servant brings stability and continuity to the task of administration. When contrasted with the itinerant nature of many political 'masters' (that is, ministers), the very permanence of the civil servant confers an important measure of political influence over public policy.

Information is power, and the bureaucracy is the repository of a vast store of information collected over the course of many years. Any single individual, especially one with years of service in the department, is the repository of its institutional memory acquired over the period of its existence. The minister or chief executive might call for all relevant information, but the choice of what is all the relevant information, and the retrieval and transmission of that information, is made by the civil servant. The information can be presented in such a manner as to skew the choices towards the option favoured by the bureaucracy. Similarly, civil servants can interpret policy directives in such a manner as to delay and thwart the implementation of government policy that is not to their liking (dismissed as sabotage by the 'blob' in currently fashionable but pejorative language). Bureaucracies act so as to maximize their own budget, for example by increased size of staff and enlarged scope of action. The bigger the bureaucracy, the more significant can be the factors of bureaucratic inertia and slippage between executive directives and policies implemented (or not).

Dag Hammarskjöld, the second and most highly-rated UN Secretary-General (SG, 1953–61), justified a special and rapidly growing role for the organisation by its neutrality, impartiality, and technical competence. On the one hand, this meant that the United Nations was not encumbered by the baggage of special interests which guided the actions of individual member states. On the other hand, this neutrality permitted – perhaps even obligated – the UN to step in as a mediator and facilitator between warring factions.

An international bureaucracy has distinctive attributes, requires its own set of rules to operate by, and faces distinct challenges. It is multilingual and its staff also come from very different civilizational and political cultures with locally-grounded legitimating ideologies. There is no equivalent to the minister or the head of government or state to

serve as the overall political chief above and on top of the departmental head. Nor is there the equivalent of a parliament to pass laws or of multi-level judicial structures to adjudicate authoritatively on disputes. There is no single and settled system of rules and precedents to guide the interpretation and administration of organisational tasks. Another consideration is whether, for an international bureaucracy, guaranteeing long-term tenure over several decades causes more harm than good by disconnecting officials from a national anchor and desensitizing them to legitimate concerns over the erosion of sovereignty. It might be better to ensure term limits, or encourage periodic leaves of absence from service within nations interspersed with short-term rotations to an international entity; and to facilitate this with appropriately tweaked superannuation schemes. More so in the case of an organisation such as the WHO, where a technical advisory role is included. A strong argument can be made for introduction of new personnel with new knowledge and experience, over long-term retention of advisers trained and experienced in contexts that existed decades ago.

WHO Structure

The Secretariat of the WHO is the most tangible evidence of the continuous existence of the global health organisation. The identity of an international organisation resides in its staff. Member states control the organisation; its professional staff *are* the organisation. The "chief technical and administrative officer of the Organization" is the Director-General (DG) who is appointed by the World Health Assembly on the nomination of the Executive Board (Article 31 of the constitution).

The WHO global headquarters and secretariat is located in Geneva. In addition, there are six regional offices for Africa, Europe, the Americas, Southeast Asia, Eastern Mediterranean, and the Western Pacific, and 150 country and other offices around the world. The total number of WHO employees was 9,577 in 2023, making up 7.2 percent of 133,126 UN system staff.[217] (The UN Secretariat itself had 34,669 staff accounting for 26 percent of all UN employees.) The number of staff at the WHO head

217 https://unsceb.org/hr-organization

office in Geneva was 2,400. An additional 800+ WHO Collaboration Centres exist as research partners within specified topic areas.

Figure VII. 1. Personnel in the UN system by organisation, 2021 (percent of 119,870 United Nations employees).

Source: https://unsceb.org/hr-organization

The governance structure includes the World Health Assembly (WHA) as the top decision-making body comprising all member states. It sets WHO policies, appoints the DG, supervises financial policies, and reviews and approves the programme budget. The Executive Board is composed of 34 "technically qualified" experts elected for three-year terms. It meets annually in January to agree on the agenda for the Health Assembly and the resolutions to be considered by it. In a "non-exhaustive" list as at 18 October 2025, the WHO website identifies 186 "networks, committees, advisory groups, working groups, and task forces," including 17 whose

names begin with "Global."[218]

Some improvements could be made in these aspects of the WHO's decision-making structure. Article 11 specifies that the size of a national delegation to the WHA must be limited to three, including a designated chief delegate. "These delegates should be chosen from among persons most qualified by their technical competence in the field of health, preferably representing the national health administration" of the member state. To reduce the risk of sector capture by health experts, it may be better to restrict the number of technically qualified delegates to one of the three, and to encourage one delegate who is not from the national health administration. The Covid experience underlined the dangers of leaving health policy decisions solely to health experts without balancing arguments from other policy domains.

With respect to the Board, 34 is unwieldy as an efficient executive body. It should be cut back to around half that number. Moreover, as with the Health Assembly, the prescription of a technical qualification in the health field is double-edged. It might be better instead to tweak the final sentence of Article 24 as follows: "Each delegate may be accompanied by alternates and advisers who are technically qualified in the field of health."

VII.3 Director-General (DG)

Dr Tedros Adhanom Ghebreyesus has served as the WHO's eighth DG since 1 July 2017. He was renewed for a second five-year term in May 2022. The next election for the position of DG is scheduled to be held in 2027. Whoever the incumbent, the director-general of the WHO is the personification of global health and the custodian of the world's public health conscience. The DG is required to be a public health professional, chief administrative officer, diplomat, and international civil servant all rolled into one. Solidarity, empathy, integrity, decency, moral compass, intellect, administrative competence: words to define a good and effective DG who speaks as the conscience of common humanity on health as a fundamental human right. Yet, because of the nature of the responsibilities

218 https://www.who.int/groups

and burdens placed on the shoulders of the DG, the incumbent is bound to attract critical scrutiny and harsh judgment on occasions for doing too little and too late, or too much, too soon, and for too long.

The political science literature informs us of the fallacy of the rational actor model of decision-making. This is even more true of the United Nations system. The organisation is not a unitary actor. There is no such thing as *the* United Nations. Instead, there are several UNs. The WHO is one of them. The political masters of the UN system, including the WHO, are member states, not its officials, not even the DG. This makes the WHO a political and not just a health organisation. As such, its decisions result from political bargaining and accommodation based on power equations, financial considerations, and personal ambitions. The hope is that the global health interest will somehow emerge from this dynamic interplay.

There is a central paradox at the heart of the office of the DG. The WHO chief is elected to office as an individual, not as the representative of a government or a region; yet the regions demand "their" turn at the office. Upon election, Tedros was widely hailed as the first African to become the WHO's DG. The WHO, like the UN, is an organisation of, by, and for states. What are the bases of the DG's power and authority and what means of action are available? Is the DG mainly a symbolic figurehead or an influential actor in the world of international health politics?

The origins of the office of the CEO of an international organisation in both its administrative and symbolic roles lie in the League of Nations whose first SG was Sir Eric Drummond. A product of the British civil service culture, he was influential on policy issues, but largely from behind the scenes. He viewed his role as a career civil servant and administrative head of the new international civil service. The first DG of the ILO, by contrast, was a leading French politician, Albert Thomas. He became a public leader in a highly political manner, outlining programmes like a head of government, often joining in the ILO debates and constantly cultivating constituencies outside the formal governmental structures, including trade unions. While some drafters of the UN Charter would have preferred to restrict the SG's role to the traditional model of an apolitical head of a civil service, obedient and deferential to the political masters, others argued for a more clearly political and activist conception. In the end both conceptions found expression in the Charter. The same duality

extends to most of the UN agencies, funds, and programmes.

The status, authority, and powers of the WHO DG are derived chiefly from the clauses of the WHO constitution but depend also invariably on the skills and personality of the incumbent and the state of relations among the major powers. The political role of the DG in turn is a function of the interplay between the charter functions and powers, the personal attributes, and the political equations among the member states. On the one hand, the DG's authority is less than that of a cabinet minister. The DG has neither the trappings nor the accoutrements of power of a state but is instead an aide to governments through national health ministers. The DGs' role is to assist and facilitate the Health Assembly and national governments to make informed and sound public health decisions. A DG may suggest but cannot prescribe courses of action to member states, and can appeal to their better instincts to realize the hopes and aspirations of the peoples of the world for good health without pointing the finger of judgment if they fall short.

On the other hand, the DG has greater authority than the head of a national bureaucracy, in that he has no cabinet of ministers as the final political and policy boss. The DG also has greater scope to expand his power and influence through allocating resources among the different programmes and activities, appointing senior staff, and creatively interpreting the directives and preferences of member states to maximize the scope for privileging his own and the organisation's preferences and priorities. Under Article 32 of the constitution, the DG is ex officio secretary of the Health Assembly, the Board, and all WHO commissions, committees, and conferences. As such he attends and takes part in the debates in the Bureau and the Assembly as a constitutional right and duty. He may urge particular courses of action and does provide the logistical and intellectual basis for many resolutions and decisions.

The DG is also at the nerve centre of a sensitive communications network, able to speak directly to governments, civil society representatives, philanthropists, commercial entities, and the media, and required to submit reports and analyses on a vast range of topics. The DG has the responsibility to prepare and submit financial statements and budget estimates of the organisation to the board (Article 34). As well as using the budget as a vehicle for inserting priorities into the organisation's

work agenda, the DG's annual reports on the work of the organisation are a useful instrument to outline his/her vision for the WHO. All these avenues allow the DG to shape the institutional context and normative milieu within which personal influence must be wielded.

The chief constitutional basis of the powers and authority of the DG is the WHO constitution. As in other parts of the UN system, tensions exist between international idealism and state-based realism; the evolution of the concept of global public health; the role of global norms; and the sense of cosmopolitan solidarity. A skilled CEO can broaden and stretch the DG's executive authority based on creative interpretations of the clauses of the WHO constitution and through force of personality. The DG must combine pragmatism and humility with a guiding vision of progress and solidarity rooted in deep humanism. Ideally, the DG should assemble a talented group of senior advisers and inspire their loyalty and respect.

The single most important role and responsibility of the DG is to provide leadership: the elusive ability to make others connect emotionally and intellectually to a larger cause that transcends their immediate self-interest. Leadership consists of articulating a bold and noble vision for a community and establishing standards of achievement and conduct, explaining why they matter, and inspiring or coaxing others to adopt the agreed goals and benchmarks as their personal goals. Unfortunately, some heads of UN entities have been notorious for the opposite traits of nepotism and careerism, interested more in the pomp and trappings of high international office than in seeking the office for the greater good of humanity.

On 14 July 2025, the WHO announced that Saima Wajed, director of the South East Asia Regional Office in New Delhi, had been placed on leave.[219] The daughter of the ousted former Bangladesh Prime Minister Sheikh Hasina is accused of fraud, forgery, and abuse of power. She was elected to the WHO post in November 2023. Of course, this is not a uniquely South Asian or Asian syndrome. It requires extraordinary faith in the integrity of international institutions to believe that the nomination of candidates to international office is always free of kinship and partisan

219 https://www.ft.com/content/47189af4-a705-4071-85f2-058391ff46e8

influence from governments in power. The same comment holds with respect to opposition from successor governments to people appointed with the backing of ousted governments. The example therefore raised a broader general question: What are the chances that if the WHO is granted more authority and resources, the posts of DG and regional directors will attract more candidates associated with political corruption (misuse and abuse of entrusted power), financial impropriety, and nepotism? Effective accountability mechanisms to guard against corruption and nepotism are few and far between in international bureaucracies.

VII.4 Personnel policy

Article 35 of the WHO constitution prescribes that "The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible." Their conditions of service are expected to "conform as far as possible with those of other" UN organisations (Article 36).

WHO staff participate in the common UN pension scheme. This is structured such that both the employer and staff member (by salary deduction) contribute monthly. If the staff member leaves before 5 years of service, the institutional component is withdrawn, while they must remain employed a further 10 years (15 in all) to receive the full pension entitlement after reaching a sufficient age. This structure incentivizes staff to remain in the organisation for at least 15 years (or lose a substantial part of their pension). This is a self-harming approach for an organisation that aims to prioritize recruitment of technical staff with recent external experience and cutting-edge expertise, but instead ends up prioritizing a bureaucracy made up of long-staying, loyal staff with a vested interest in the organisation's stability and maintenance of staff numbers. These dangers are exacerbated by the repeated failure to ensure rotation policies, by means of which, for example, the many staff based at the WHO head office in Geneva, Switzerland, might obtain first-hand experience of conditions in less well-resourced member states.

The wide geographical basis is supported by the use of country quotas, based partly on population size and resources provided to WHO. This serves an important function of ensuring a diversity of backgrounds among WHO staff, and direct representation from states that may be net recipients of WHO resources. A downside is that it can hamper selection of people with the highest expertise or technical ability. This enables the bureaucracy to be more representative of the diversity of member states and grounded in their problems, but it also tends to undercut the WHO's ability to maintain the highest level of technical competence among its staff.

VII.5 Funding

As per information available on the WHO website, its total approved budget for the 2024–2025 biennium was $6.83 billion,[220] up from $5.8 billion in 2020–2021 and $6.1 billion in 2022–2023.[221] As at September 2025, the combined total of contributions received under all the different categories (programme budget, core and voluntary contributions, pandemic influenza preparedness, etc.) for the 2024–2025 biennium was $7.1 billion.[222] Total revenue declined in 2023-24 after a Covid-19-related surge, leaving a deficit of $591 million (Figure VII.2).[223] The top ten funders in total in 2020–2023, in order, were the USA, the Bill & Melinda Gates Foundation, the UK, Germany, the European Commission, Norway, France, India, Sweden, and South Korea.[224]

220 https://www.who.int/about/accountability/budget

221 https://iris.who.int/server/api/core/bitstreams/ef157b2e-c722-4e3d-8b12-a90bb431a5bd/content

222 https://open.who.int/2024-25/contributors/contributor

223 https://iris.who.int/server/api/core/bitstreams/ec4b6dc4-71c6-4868-9449-1da553c70df9/content

224 https://www.who.int/about/funding

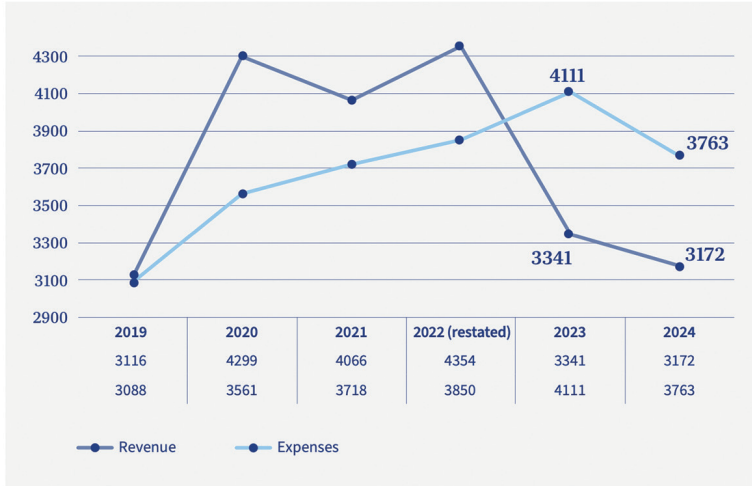


Figure VII. 2. World Health Organization summarized financial performance for 2019–2024 (US$ millions).

Source: WHO, Audited Financial Statements for the year ended 31 December 2024, Figure 1, p. 10, https://iris.who.int/server/api/core/bitstreams/ec4b6dc4-71c6-4868-9449-1da553c70df9/content

As detailed in the Technical Report, the analysis of the WHO General Programme of Work (GPW) documents from 1996 identified three budgetary trends in WHO strategies: (1) An increased biomedical securitization of health; (2) A continued overreliance on voluntary contributions with policy influence, and (3) A shift towards the greater use of results-based metrics to guide budgetary allocations. A focus on the first two trends is useful here.

As background, GPWs are high-level documents that outline the WHO's strategic direction, resource allocations, agenda, and decision-making in global health for a specified period. The GPW is approved by the WHA and is developed in consultation with member states, experts, and stakeholders in global health. As a strategic document, the GPW acts as the basis for the WHO's biennial Programme Budget to meet its strategy and

justifies the resources required (see above).[225]

The most obvious shift from 1996 to the current GPW14 is on pandemic preparedness as a measurable priority. In GPW13 (2019-2023), for example, the WHO adopted a clear "all hazards" approach using the wider language of "health emergencies" rather than an emphasis on outbreaks and pandemics. Although outbreaks were featured, GPW13 displayed a better balance between the various types of health emergencies addressed. Given that the GPW13 was written prior to the Covid-19 outbreak, and given the high personal, social, and economic costs of Covid-19, a focus on pandemics in GPW14 is understandable. Nevertheless, it does signal that GPW14 places high priority on pandemic-related policies, which will undoubtedly create resource shifts, opportunity costs, and potential misalignment away from endemic diseases and other health risks.

Furthermore, when examining the budget allocations across the six strategic priorities of GPW14, it is possible to find health security programmes embedded in all six priorities. This represents a further securitization of the GPW14 in general, which is an acceleration from GPW12 (2014-2019) and GPW13. As two examples, programmes related to zoonosis prevention and One Health integrated surveillance are incorporated into strategic objectives 1 and 2 and budget allocations dealing with climate change adaptation and determinants of health respectively. In addition, programmes associated with preparedness via improved access to outbreak countermeasures and related system capacities are linked to strategic objectives 3 and 4 to improve system strengthening and service coverage. Although this does reflect a more integrated and systems approach, which is to be commended, the prioritization of programmes for health security diverts scarce resources and thus threaten to undermine a more holistic approach to health policy.

Consequently, a closer analysis of GPW14 reveals an increasing tension within the strategic vision of the WHO. On the one hand, like earlier GPWs, GPW14 uses the explicit language of strengthened health systems as being the key foundation for health security from all hazards and places emphasis on the positive spillover effects that health system strengthening

225 https://www.who.int/about/accountability/budget

can have on routine service delivery and everyday health. Moreover, GPW14 clearly reasserts a preventative logic based on a primary health care approach. Namely, that healthier people will promote long-term population and system resilience, able to both withstand and "bounce back" from any acute health emergency. This in theory pivots GPW14 away from traditional health security policies,[226] which have historically focused on preparedness via improved surveillance, diagnostics, and the discovery, production, and rollout of medical countermeasures.

However, the language of GPW14 does not match the current reorganisation and policy prioritization taking place at the WHO, nor is it reflected in many of its post-Covid emergency policies. This is because recent reorganisation of the WHO has placed increased emphasis on health emergencies and security, reducing the WHO into four operational "pillars" (business operations and compliance; health promotion and disease prevention and control; health systems and health emergency preparedness and response). Within this new structure, GPW14 budget commitments now favour health emergencies, communicable disease control, climate harm risk mitigation and preparedness, and disease prevention through vertical inoculation programmes.

Much of the disconnect between the WHO's normative vision and practice is again arguably a result of voluntary specified contributions (see Part IV of the *Right to Health Sovereignty* Technical Report), which have historically favoured health security related interventions, particularly vertical programmes for communicable disease. For example, a recent BMJ study of where the Bill & Melinda Gates Foundation targeted its voluntary specified contributions found that 82.6 percent of its money between 2010 and 2023 focused on infectious diseases, whereas "relatively little" of its "funding went to non-communicable diseases, strengthening health systems, and broader social determinants of health, despite their importance to WHO strategy and to global health more generally."[227] The ability of specified financing to steer GPWs is not limited to non-state actors and was used to establish the new WHO Hub for Pandemic and

226 https://link.springer.com/article/10.1186/s12992-022-00840-6

227 https://gh.bmj.com/content/bmjgh/10/10/e015343.full.pdf

Epidemic Intelligence in Berlin as a key pandemic initiative. Although it is officially a WHO "partnership," the WHO Hub was largely underwritten by German voluntary specified funding, technical expertise, and in partnership with European pharmaceutical collaborators.

This exposes four concerns. First, assessed (core or mandatory) contributions account for only a modest share of the budget, ranging from a high of 16.4 percent in 2019 to a low of 11.2 percent in 2020 (Figure VII.3).

Second, the top ten contributors for 2024 to the programme budget were the Gates Foundation, UK, GAVI, Germany, the European Commission, the European Investment Bank, US, World Bank, Rotary International, and China.[228] This understates the size of the Gates Foundation's contribution. For in the five years 2016–20, the Foundation gave $1.56 billion to the GAVI Alliance, worth 17.6 percent of its total income.[229] In the group of top ten donors, 78.3 percent of the $1.74 billion in total contributions is for specified programmes and activities. The Gates Foundation has funded many worthwhile causes, promoting and supporting health-improving research and initiatives in many countries and enabling the WHO to expand beneficial programs. Nevertheless, it is simply not possible for any organisation to set and work to its own priorities and avoid being donor-driven when around 80 percent of its contributions are directed towards donor priorities. An analysis published in *BMJ Global Health* on 28 October 2025 showed that in the 25 years 2000–24, the Gates Foundation awarded 64 grants worth $5.5 billion to the WHO, amounting to 6.4 percent of all Gates Foundation grants for the period.[230]

228 https://iris.who.int/server/api/core/bitstreams/ec4b6dc4-71c6-4868-9449-1da553c70df9/content

229 https://www.gavi.org/investing-gavi/funding/donor-profiles/annual-contributions-and-proceeds

230 https://gh.bmj.com/content/10/10/e015343

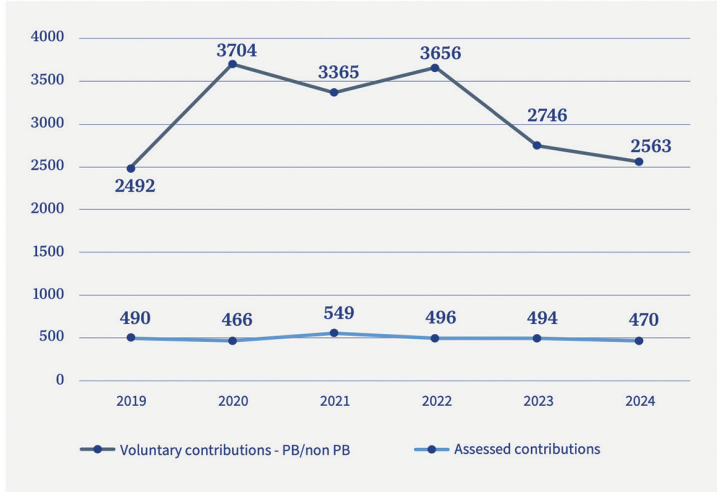


Figure VII. 3. WHO assessed and voluntary contributions, 2019–2024.

Source: WHO, Audited Financial Statements for 2024, Figure 5, p. 14. https://iris.who.int/server/api/core/bitstreams/ec4b6dc4-71c6-4868-9449-1da553c70df9/content

The Gates Foundation's approach to global public health is to use the WHO as a delivery vehicle for its own focus on technical solutions to infectious diseases. The authors of the *BMJ Global Health* study conclude that "WHO's reliance on earmarked voluntary contributions means that global health challenges favoured by major donors are well funded while other issues receive insufficient funding." Only modest amounts of the grants were awarded for non-communicable diseases, strengthening national health systems, or broader determinants of health that are meant to be important in the overall WHO health strategy. For example, polio was contained in Western countries not just through vaccines but equally important through major advances in drinking water and public sanitation infrastructure, and good personal hygiene habits and septic tanks.[231] For poor countries, the latter improvements could well be more effective than

231 https://www.malone.news/p/bill-gates-polio-and-the-who

vaccination programmes in reducing the polio burden. Thus just a few donors get to drive the agenda of the WHO and most other countries have in essence acquiesced to being public health agenda-takers and not setters.

Third, among the top ten contributors, funding from non-state and non-intergovernmental actors accounted for 39.2 percent of the total, a share that is likely to increase with the US withdrawal. Again, member states have voluntarily surrendered much of their sovereignty by going along with this arrangement. If they want to assert their sovereignty, states must pay the accompanying price and meet the budgetary requirements for the desired programmes and activities from national and intergovernmental funds.

GAVI is a global alliance to promote vaccines for immunization. It proudly boasts of having supported nearly two billion vaccinations through preventative vaccination campaigns between 2000 and 2023,[232] including more than 1.2 billion children vaccinated in 78 low-income countries.[233] There can be no doubt that vaccines have been a powerful preventative tool against many crippling and fatal diseases. But this does not negate the fact that Covid-19 vaccines proved to be extremely and enduringly controversial. There are many dimensions to the controversies that attended and still swirl around the introduction and promotion of Covid-19 vaccines using mRNA platforms. First, there were allegations about misleading claims on their efficacy, the duration and robustness of their effectiveness, and poor efforts to tailor them to the risk profile of populations, especially by age. Second, arguments continue to rage about their safety profile and the widespread suspicions about the extent and severity of vaccine injuries.

Fourth, suspicions persist that in order to grant them emergency use authorization, the potential effectiveness of repurposed drugs was deliberately dismissed on spurious grounds. It is worth noting in this connection that as well as direct lobbying power through donating substantial funds, the pharmaceutical industry can also influence the WHO via advocacy

232 https://www.gavi.org/sites/default/files/programmes-impact/our-impact/Gavi-Facts-and-figures-October-2024.pdf

233 https://www.gavi.org/our-alliance/about

from states that host major pharmaceutical companies and through connections to philanthropic foundations operating in the global health space.

Fifth, there is cynicism about the profits that were made by some leading vaccine manufacturers. In April 2021, Forbes reported that among the 493 new billionaires in the previous year, the pandemic had helped to create 40 Covid billionaires,[234] including 14 from China. In January 2024, Forbes returned to the subject to report a $3.3 trillion boost to the world's billionaires since 2020, with their wealth growing three times faster than inflation.[235] According to one report that was widely covered at the time, the Gates Foundation acquired BioNTech (the company that makes Pfizer vaccines) shares at a pre-IPO price of $18.1 in September 2019. BioNTech's stock price skyrocketed after the pandemic hit and BioNTech became a household name for its Pfizer Covid-19 vaccine. Two years later, the Gates Foundation sold 18 percent of its shares at an average $300 each, making a 15-fold profit of $260 million, of which $242 million was tax-exempt because it had been invested through a philanthropic foundation.[236]

On 23 July 2025, *BMJ Global Health* published an article[237] that looked at funding for the WHO from the WHO Foundation.[238] The Foundation was set up in 2020 with the goal of broadening the WHO donor pool. According to the analysis by Nason Maani, Emily Adrion, and Jeff Colin, by the end of 2023 it had received donations totalling $82,783,930. Of this amount, $51,554,203 (62.3 percent) was from anonymous funders and $39,757,326 (48 percent) were described as anonymous donations of over $100,000 each. The proportion of anonymous donations had increased each year from 9.6 at the end of 2021 to 62.9 and 79.8 percent in the following two years, downgrading the Foundation's transparency

234 https://www.forbes.com/sites/giacomotognini/2021/04/06/meet-the-40-new-billionaires-who-got-rich-fighting-covid-19/

235 https://www.forbes.com.au/news/billionaires/billionaires-5-trillion-richer-post-covid/

236 https://www.dossier.today/p/bill-gates-secured-hundreds-of-millions

237 https://gh.bmj.com/content/10/7/e018932

238 https://www.who.foundation/

rating by Open Democracy from B (at least 85 percent of donors above the $100,000 threshold are named with the exact amounts received from them) in 2021 to D (below 50 percent) in 2024. It is a reasonable inference that these donations, characterized as "dark money" in the mainstream media, are based on donor rather than WHO priorities that expose the organisation to conflicts of interest, undue influence, and reputational risks.[239] Funding from Meta to the WHO department of communications and digital health, for example, is questionable at a time when the role of social media in facilitating health misinformation and contributing to child and adolescent mental health problems has come under heightened scrutiny.

In May 2016, the World Health Assembly adopted the FENSA (Framework of Engagement with Non-State Actors) Resolution to encourage non-state actors (NGOs, private sector entities, philanthropic foundations, academic institutions) to protect and promote public health.[240] In the discussions ahead of the FENSA resolution, concerns were voiced over the risks of undue influence, reflecting longstanding broader concerns in the UN system about this in relation to earmarked funding.[241] After the establishment of the WHO Foundation, an early large donation from Nestlé resurrected the concerns.[242] As Maani, Adrion, and Colin note, there is considerable evidence that pharmaceutical firms and other entities that make products that are harmful to health use donations "to distract or reframe product health harms, to complement marketing plans and to assist in wider lobbying efforts against public health regulations."[243] Corporate social responsibility initiatives and partnerships can easily be disguised efforts to prevent or dilute health regulations.

239 https://www.theguardian.com/world/2025/sep/09/who-foundation-dark-money

240 https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_r10-en.pdf

241 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31141-2/abstract

242 https://www.bmj.com/content/379/bmj.o2468

243 https://gh.bmj.com/content/10/7/e018932

VII.6 From a culture of dependency to long-term country ownership

As countries emerged from colonial possessions of European powers into independence, they looked for and received considerable foreign assistance to resume interrupted economic development or recovery, establish state capacity, and progressively assume full responsibility for all the functions of sovereign statehood. For prosperous countries, high levels of national wealth and comfortable levels of average household incomes provide the economic wherewithal to fund good public health systems and infrastructure with regard to, among others, numbers and quality of healthcare professionals, an adequate number and quality of primary care centres and public hospitals, and a good stock of medical supplies to be able to meet the needs of the population. On the other side of the equation, poverty levels in low- and middle-income countries meant that ODA was crafted both to assist with economic development directly and also to help build health infrastructure, emphasizing primary health needs.

The WHO mission of coordinating technical assistance and identifying and directing resources to alleviate the suffering and reducing the outbreaks of the big infectious killer diseases, addressing underlying drivers of health such as basic nutrition and hygiene, was a priority. From the very start, nevertheless, donor governments, recipient governments, international agencies, and health experts all accepted that the long-term strategy and goal had to be to build health systems that were resilient and locally owned, so that foreign assistance for health programmes became progressively integrated into the recipient countries' healthcare systems. This would allow responsibility for health policies, programmes, and delivery to be transferred from international agencies and donor countries to national governments. Instead, after nearly eight decades of the WHO's existence, a de facto culture of long-term dependency has emerged. Were it not so, there would not have been the ripples of shock created by the suspension of the substantial US assistance for numerous health programmes around the world.[244] A study by a team of ten international scholars, published

244 https://www.whitehouse.gov/fact-sheets/2026/01/fact-sheet-president-donald-j-trump-withdraws-the-united-states-from-international-organizations-that-are-contrary-to-the-interests-of-the-united-states/

in the *Lancet* on 19 July 2025, carried a grim warning of 14.06 million deaths by 2030 caused by the cuts, including 4.54 million children under five years old.[245] Putting aside the reliability of this modelling, it is hard to see how the pandemic accords will not further entrench the culture of dependency instead of helping all parties to break free from it.

Accordingly, the mission of a fit-for-purpose international health organisation should be much more tightly defined to create long-term country ownership, with clearly timetabled benchmarks for measurable deliverables. It may well be that a different focus that prioritizes bilateral health collaboration agreements with a built-in requirement for co-investment from recipient countries, as is proposed in the US global health strategy document published in September 2025 for 71 US-supported countries, promises a more efficient route to this goal than an international health organisation with continually expanding mandates, resources, and staff.[246] It may also be easier to build monitoring, evaluation, and accountability mechanisms into bilateral than multilateral healthcare foreign assistance programmes, although mechanisms for harmonizing or sharing these will be important to reduce duplication and waste. The US strategy document states:

> *The intensity and complexity of each agreement will be tailored to the context, based on disease burden, current dependence on U.S. government assistance, and current health system capacity. Most agreements will include requirements around co-financing from recipient governments, and all agreements will include requirements around developing data systems and setting program benchmarks for relevant diseases including HIV/AIDS, TB, malaria, and polio. Agreements for the majority of the 71 U.S.-supported countries will include a full transition to country self-reliance over the timeframe of the agreement.*

245 https://www.bbc.com/news/articles/cx2jjpm7zv8o

246 https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf

If this is taken at face value, then there is no reason why an international health organisation should not adopt a similar strategy.

VII.7 An IHO constitution

Constitutionalism is the technique of striking the proper balance between establishing a system of government which has sufficient permissive authority and power to enable it to perform the necessary political tasks, and restricting the scope of governmental authority with a system of restraints to preclude the creation of a tyranny. It represents a fundamental commitment to the norms and procedures of the constitution and to the decisions made by the authorized agents of the political community to act for the public good in the stewardship of national affairs. A *constitution* articulates the social purpose of a political community in the form of core principles and practices, and establishes the institutions, procedures, and rules for regulating practices and behaviour.

The constitution of an international organisation articulates the social purpose of the international community in a system of sovereign states. These are typically expressed in the form of a preamble or an introduction that sets out the vision, mission, and organizing principles that underpin the community concerned. The constitution-equivalent charter of an international health organisation should incorporate the 13 principles, or variations thereof, listed earlier in this chapter.

The operative articles and paragraphs of the constitution specify the principal and subsidiary organs of the organisation; their membership, composition, and terms of office; their rules of procedure and who is empowered to determine these; their powers and limits in relation to one another and to the members of the community; the rights and obligations of member states; and so on. The articles and clauses of the constitution should provide procedural stability, with all members being made aware of the rules and accepting the outcomes of decisions made according to the prescribed rules in order to ensure a fair and impartial exercise of international public power, with clearly defined limits on its extent and reach. They should ensure accountability of the decision-makers to the subjects of the rules and decisions. They must make clear that those who are entrusted with international public power must conduct themselves as

the representatives of member states who are the principals of the international organisation, acting on their behalf and in their collective interest.

Thus, a constitution is the set of fundamental rules – or rule book – that outlines the mission and purpose of the organisation, determines how the organisation is to be structured and how it will work, and distributes powers and responsibility among the various organs of the entity, and between the organisation and member states. It is simultaneously a social declaration, a political instrument, and a legal instrument. Because a constitution describes the most fundamental rules to govern international society, it is generally very difficult to amend its provisions.

VII.8 Conclusion

The task of drafting a model constitution for an international health organisation is beyond the scope of this report. The next chapter discusses the two options of reforming or replacing the WHO to address the shortcomings and organisational requirements discussed above. That decision is for the sovereign states to make. If they choose to attempt deep reform of the existing organisation, they would need to activate Article 73 of the WHO constitution that deals with amendments.[247] Texts of any proposed amendments are to be communicated to member states by the DG at least six months in advance of their consideration by the Health Assembly. They require a two-thirds majority of votes for adoption and come into effect for all members after acceptance by two-thirds of member states in accordance with their respective constitutional processes. The amendments should aim to clarify and sharpen clauses to address principles, structures, funding arrangements, and relationships with stakeholders, including those discussed in this report. Alternatively, if they choose to negotiate a new organisation, then the substance of the provisions would still need to engage with the discussion, but the procedure for convening a new meeting to debate, negotiate, and finalize a new constitution would be for the main sponsoring states to clarify.

247 https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

VIII. A REFORMED WHO OR A NEW IHO

On 20 May 2025, as the 78th meeting of the World Health Assembly got underway in Geneva to vote on the new Pandemic Agreement, the US Secretary of Health and Human Services explained the reasons behind the US decision to withdraw from the organisation. Addressing his counterparts from other countries in a brief video message on X, he said that the US withdrawal should serve as "a wake-up call" to other countries that, "like many legacy institutions," the WHO has been corrupted by political and corporate interests and "is mired in bureaucratic bloat."[248] It has accomplished important work since inception, including the eradication of smallpox. More recently, however, its "priorities have increasingly reflected the biases and interests of corporate medicine" and "political agendas" have hijacked its core mission. Rather than come to terms with its failures during Covid, it has doubled down with the Pandemic Agreement "which will lock in all of the dysfunctions of the WHO pandemic response." Yet, this was not intended as a rejection of the premise of or commitment of international cooperation. Global cooperation on health remains critically important and the US intends to "reboot the whole system," shifting focus to the prevalence of chronic diseases that are sickening peoples and bankrupting health services, whilst strengthening national health systems to build sustainability and eventual independence. "Whether it's an emergency outbreak of an infectious disease or the pervasive rot of chronic conditions," the US is ready to work with others, the secretary concluded.

The United States has the heaviest normative weight, military might, geopolitical heft, market power, financial muscle, technological prowess,

248 https://x.com/SecKennedy/status/1924790453682970951

and strongest gravitational pull of any country in the world. For better or worse, the policy directions set out by the leading US public health agencies are bound to have ripple effects in other countries in recalibrating the normative settling point of national and global public health policy. A return to concentration on diseases of high burden and broad health system strengthening will have broad effects beyond health. As we have stressed repeatedly in this report, malaria, tuberculosis and HIV/AIDS are in a very real sense essentially diseases of poverty, while the burden they impose makes it doubly hard to escape poverty's grip. The financial burdens imposed by the pandemic prevention, preparedness, and response (PPPR) agenda will exacerbate the difficulty of escaping the poverty trap for the low-income countries, in pursuit of a health security agenda that is disconnected from their major diseases.

VIII.1 An international health organisation fit for purpose

There's almost a palpable feel in the air of one era of world order closing and another opening. Or perhaps the situation is more comparable to the revolutionary moment that exists in the aftermath of systemically significant wars between the great powers that mark the transition from one era to another. History's major revolutionary moments have also been midwives to the birth of new structures of domestic governance and international institutional arrangements. Increasing numbers of people seem to feel a loss of agency over their lives by citizens, including the ethical frameworks that they are comfortable with. Values help to ground policy choices in an ethical framework. What are to be the international health organisation's binding principles and how are these to be translated into a clear programme of actions for contemporary health challenges? Liberalism as a philosophy posits individuals as the primary unit of society and agent of actions regarding their own welfare. In collectivist philosophies, the community is the end point of society against which to measure policy outcomes and work backwards from that to make the appropriate choices.

As already noted, the US withdrawal from the WHO does not necessarily imply a retreat from international cooperation on shared health objectives. The *America First Global Health Strategy*, released in late

2025 by the US administration, presents itself as an alternative approach rather than a rejection of engagement, maintaining a broadly comparable level of commitment to overseas development assistance but channelled primarily through bilateral rather than multilateral arrangements. This report does not judge the strategy as inherently superior or inferior. It contains elements that align closely with the principles advanced here, alongside aspects that sit in tension with them. Nonetheless, it represents a direct response to perceived failures within the WHO and creates space for a broader reconsideration of how global health strategy is organized.

The strategy has two principal components. The first involves a shift towards bilateral country support, with explicit requirements for recipient-country co-financing and a strong emphasis on building domestic capacity. The stated objective is to foster self-sufficiency and reduce long-term dependence on external assistance. Where feasible, cooperation is to occur with permanent government institutions rather than short-term non-governmental actors, increasing the likelihood that skills and systems developed through assistance are retained. These principles broadly reflect the direction set out in earlier aid-effectiveness frameworks, including the Paris Declaration and subsequent reform efforts discussed elsewhere in this report.[249] They also point towards a model of health development that contrasts with the growing centralization seen in the WHO and in the expanding network of global public-private health initiatives.

The second component of the strategy differs markedly in orientation. It centres on pandemic preparedness and response and reflects many of the centralizing features, and associated sovereignty concerns, that characterize the WHO's own approach in this area. Under the US strategy, recipient states are expected to establish surveillance systems, report outbreak data rapidly to the United States, and cooperate with externally directed response measures. A parallel emphasis on the use of US-manufactured health commodities reinforces the perception of a standardized response model resembling the surveillance–lockdown–vaccination paradigm advanced by several major global health initiatives during the Covid-19

249 https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html

pandemic. This approach risks diverting attention from more pressing and persistent health burdens within recipient countries, as well as from the broader social and economic determinants of resilience. Recent scrutiny by the Supreme Court of Kenya of data-sovereignty provisions in the US–Kenya bilateral health agreement illustrates these concerns.[250]

If all major donors were to pursue similar bilateral strategies simultaneously, the risk of fragmented and internally inconsistent health policies within recipient states would be substantial. However, as the world's largest single donor, the United States occupies a unique position and may influence the direction others take. Certain aspects of the strategy are consistent with the type of international health organisation proposed in this report – one grounded in respect for national sovereignty, self-determination, and domestic capacity. While the strategy is likely to evolve, and the initial document suggests that internal consensus is still forming, its existence alongside the WHO creates meaningful pressure for institutional reform.

In parallel, the US withdrawal from the WHO and reductions in development assistance by other major donors have accelerated local and regional initiatives aimed at increasing self-reliance, strengthening regional cooperation, and prioritizing shared interests. The 2025 Accra Reset mentioned earlier is an African-led effort to overhaul health development assistance by moving away from entrenched models of aid dependency towards greater local ownership and accountability.[251] Its objectives include reinforcing "health sovereignty," broadening governance arrangements, expanding innovative financing mechanisms, and shifting development assistance from externally driven aid towards domestic ownership. Central to this effort is the recommitment by African governments to meet the 2001 Abuja Declaration, by African Chiefs of State, to allocate 15 percent of national budgets to health, reflecting the well-established social and

250 https://www.reuters.com/business/healthcare-pharmaceuticals/kenyan-court-suspends-health-pact-with-us-hear-data-privacy-case-2025-12-11/

251 https://presidency.gov.gh/statement-african-health-sovereignty-in-a-reimagined-global-health-governance-architecture-a-co%E2%80%91creation-summit-under-the-leadership-of-his-excellency-john-dramani-mahama-president-of-the/

economic benefits of healthier populations.[252]

Related themes emerged at the G20 leaders' summit in South Africa in November 2025 which called for reimagined financing models and a move beyond traditional aid structures to build resilient, sovereign health systems across the Global South.[253] At the same time, reductions in US funding have underscored the importance of regional coordination, both among neighbouring countries and with multilateral partners. The African Union, for example, has signed a new memorandum of understanding with the Global Fund to strengthen cooperation and expand the African Union's role as a continent-wide coordinating body for health. Comparable arrangements are emerging in parts of Southeast Asia.

Whether or not the United States intended to stimulate these developments – and there is reason for scepticism – the recent contraction in external funding has exposed long-recognized weaknesses in global health governance and financing. In doing so, it has again acted as a catalyst for reconsidering how international health cooperation should function. The opportunity for a genuine reset therefore extends well beyond Accra, raising fundamental questions about what an international health organisation should do to support emerging regional and national initiatives, rather than continuing to reinforce an underperforming system that has too often enabled vested interests to undermine health sovereignty.

Thus, an IHO (including the WHO) should focus on the global, not the national; and more on public health and less on healthcare in the clinic and hospital, but with the flexibility to provide technical assistance to low-resource states to build local health capacity. National governments should be fully responsible for state-specific distribution of resources and policies between national, population-specific, and clinic-centred healthcare, and held accountable for health outcomes on mutually-agreed reference points, free from all forms of overt and covert coercion.

To reverse the decades-long advance of global health institutions and personnel into a sector that lies "essentially within the domestic

252 https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf

253 https://www.consilium.europa.eu/media/yfyd2czp/declaration-g20-south-africa-summit-22-23-november.pdf

jurisdiction" of states (Article 2.7 of the UN Charter),[254] international health governance must be reorganized on the basis of the principle of subsidiarity and community-led people-centred health. Health policy and healthcare that use subsidiarity as the organizing principle would begin with individual agency and autonomy, informed consent, and prioritization of people's individual health outcomes over collective public health benefits. The doctor-patient relationship must be sacrosanct and inviolate if trust and effective medical care is to be maintained. If medical regulators violate that sanctity to invade the clinical relationship, for example by prohibiting the doctor from discussing risks of collateral harms because this could increase vaccine hesitancy, they destroy patient faith in the doctor's professional integrity, increase public distrust of health experts, and promote cross-vaccine hesitancy. Such loss of trust has been documented in multiple surveys in several countries.

Medical and drug regulators should prioritize patient safety over every other consideration. On this criterion, there was an unacceptable dereliction of the duty of care during Covid. To enable emergency use authorization of vaccines, regulators exaggerated health risks and threats, refused to draw accurate risk profiles by age and regions, dismissed legitimate concerns and questions about side effects and harms, condemned and mocked efforts to identify promising possible repurposed drugs like hydroxychloroquine and ivermectin (e.g. "horse dewormers" in the US)[255] as dangerous, and short-circuited the normal multi-year stringent safety and efficacy trials for mRNA-based and other Covid-19 vaccines. The vaccine strategy also required costly and socially harmful public health and social measures. Remarkably, all this was done in the name of science.

254 https://www.un.org/en/about-us/un-charter/chapter-1

255 https://firstfactcheck.substack.com/p/fda-officially-rescinds-statement

VIII.2 The UN as an example of the difficulties of organisational reform

The United Nations is the biggest incubator of global norms to govern the world and the vital core of the rules-based global multilateral order. The organisation has been a graveyard for almost all major reform proposals. The last great push for major reform was in 2005. (IHRP panel member Ramesh Thakur was intimately involved in that exercise.) The most optimistic had hoped for a San Francisco moment in New York in September 2005, one no less decisive and momentous than the signing of the UN Charter sixty years earlier. The most critical concluded that instead the UN had an Albert Einstein moment, recalling his apocryphal definition of insanity as doing something over and over again and expecting a different result each time. Some of the achievements were genuine enough. One could interpret the 2005 outcome generously and, gathering rosebuds of consolation, note that it could have been worse.

However, the organisation's most important organ with the legal authority to make decisions that bind all countries, up to and including going to war, is the Security Council. Its accelerating obsolescence and irrelevance are arguably the primary explanation for the UN's failure to reach its hypothetical potential. They are also centrally relevant to the discussion of a more appropriate WHO or replacement international health organisation. Students of global governance point to five analytical gaps that need filling: knowledge, normative, policy, institutional, and compliance. The last has shown the widest and growing gap of the five. The Security Council sits at the centre of the world's compliance mechanisms.

The controversy that attended the adoption of the amended IHR and the Pandemic Agreement focused attention on the binding legal obligations on states and their implications for state sovereignty. Yet hardly anyone seemed to raise the obvious follow-up question: what happens if the obligations are not honoured? How, by whom, and against whom, can they be enforced? Alternatively, what is the substantive status of legal obligations if they are habitually ignored with no penalties? A discussion on legal obligations in itself without addressing this is abstract and sterile. Consequently, there seems virtually no awareness of how each and every additional international legal obligation gives yet another tool to the world's powerful countries to enforce their will over the vast majority

without any real loss of their own sovereignty.

This is so because in the current architecture of global governance, the UN Security Council is both the ultimate and the only international entity with enforcement authority over sovereign states. Furthermore, its authority extends to states that are not UN members, are not members of the Security Council when the decision to authorize enforcement by means of diplomatic, economic, and/or military sanctions is made, or are a member but voted against the authorizing resolution. Except, of course, if the negative vote was cast by one of the five permanent members (P5), with the power of veto. Cases can be decided by the World Court and the International Criminal Court (ICC) on the legal obligations and liabilities of sovereign states. But if they reject the judicial decisions and defy the courts, the only recourse to enforce them is the Security Council acting under Chapter 7 of the UN Charter. Nor is the ambit of the veto power limited to actions by one of the P5. Any one of them can veto enforcement action to protect an ally or a client state.

One of the early and sustained criticisms of the WHO in managing the Covid pandemic was failure to hold China accountable for perceived non-cooperation with the inquiry into the origins of the virus, in particular if it might have been a leak from the laboratory of the Wuhan Institute of Virology. But the WHO has no enforcement power, any more than the World Court, ICC, the IAEA vis-à-vis violations of the non-proliferation obligations, etc. And laws and legal obligations that are binding and have been so affirmed by the relevant judicial organs, but fail to be enforced, damage the authority and credibility of the specialized agency concerned, the UN system more generally, and the overall architecture of global governance. A 'law' that is habitually broken but rarely or only selectively enforced, is a law in name only. It is a legal fiction and not an empirical or 'lived' reality.

For the World Health Assembly to approve additional legally binding obligations under the pandemic accords without a careful consideration of the enforcement implications comes close to neglect by oversight or by intent. On the one hand, agreeing to give legal authority and practical means for additional parts of the UN system beyond the UN Security Council would be a truly revolutionary transformation of the entire basis of world order. There would be zero prospects of success for such

an endeavour. On the other hand, a successful major structural reform of the Security Council to bring legal authority, legitimacy, and reliable effectiveness into alignment seems equally unlikely. If the case for Security Council reform is compelling and the need for it urgent, then the lack of enforceability to ensure compliance with legally binding obligations triggers a negative feedback loop that has a cascading effect on the credibility and legitimacy of the entire normative architecture.

A pertinent example of this pitfall with a suboptimal result is the 2005 IHRs. By 2015 129 of 196 countries (65%) were unable to comply with the 2005 IHR requirements despite a five-year extension.[256] Countries such as the UK, US, China, and France failed to meet their commitments, particularly in their overseas territories. As a result, a disproportionate compliance rate was in LMIC countries which often implemented the IHRs as a condition of ODA while having to divert part of that ODA and national budgets to IHR implementation regardless of local priorities. Thus, a perverse dynamic was arguably in effect within the IHRs, where they could be largely ignored by powerful states like China and the US, while lower-resource countries were economically pressured to adopt them as a form of aid compliance. It is unclear whether the revised 2024 IHRs will manage to address this inherent inequity, but signals from management of the pandemic fund and other financial discussions associated with the IHR coordination financial mechanism suggest that more of the same is likely.

Furthermore, where the P5, the notional great powers in 1945, are in agreement, they can enforce whatever global norm, law, treaty, or even behaviour they favour on the smaller and weaker states of the world by utilizing and sometimes abusing their uniquely privileged perch in the UN Security Council. This erodes the legitimacy of the global normative architecture for the opposite reason. By analogy from domestic jurisdictions, for the rule of law to prevail, no one is above the law but no one is below the law either. In his report *The rule of law and transitional justice in conflict and post-conflict societies* (2004), Secretary-General Kofi Annan defined the rule of law as "a principle of governance in which all persons, institutions and entities, public and private, including the State

256 https://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22-en.pdf

itself, are accountable to laws that are publicly promulgated, equally enforced and independently adjudicated."[257] Every individual in national systems governed by the rule of law, and every state in an international order subject to the rule of international law, is simultaneously subject to the law and protected by it against arbitrary actions of the powerful. In a broken system where the law is habitually weaponized by one particular group against another, the latter will resent and rebel in time and under the right circumstances.

The case for a major structural reform of the Security Council is compelling and widely accepted in principle. Achieving such reform however has proven impossible in practice, for a number of reasons. First, the broad but shallow consensus begins to break down as soon as any concrete proposal is put forward, with the losers greatly outnumbering the winners. The politics are much easier for the opponents than the advocates of reform. Amending the UN Charter requires a two-thirds majority of the entire membership, not just those present and voting. Opponents thus merely need to muster a combination of votes against, abstentions, and absentees that total one-third, or 65 of the 193 member states, for a proposal to fail. A two-step favoured tactic of opponents is to enmesh advocates in protracted negotiations and process issues, and to make the seemingly innocuous suggestion to set aside the difficult and contentious items on the reform agenda and agree to adopt numerous "doable" reforms. Security Council reform is central to, not peripheral to nor a distraction from other structural and operational UN reforms, and global governance reforms more broadly. Tackling incremental reforms that are doable, while shelving the one transformational reform that is the most imperative, has become a political tactic of deflection. Also, structural reform of the Security Council's composition must necessarily include dropping some as well as adding others from permanent membership; otherwise it will remain unrepresentative and become more unwieldy. Yet, no major reform proposal has identified which of the P5 should be dropped, why, and how, for the simple reason that candidates for defenestration would veto the proposal.

257 https://digitallibrary.un.org/record/527647?ln=en&v=pdf

The history of UN reforms to date strongly suggests that the necessary Security Council reforms are neither likely nor feasible. Yet, the history of the rise and fall of great powers was not permanently paused in 1945. The 1945 structure cannot survive indefinitely for another 10, 20, 50, 100, or more years. The most likely trajectory is that with failure to reform, the UN's legitimacy, effectiveness, and authority will continue to erode and the organisation will become increasingly marginalized and irrelevant with each passing year. This matters, for something like the UN remains our best hope for unity-in-diversity in a world in which global problems require multilateral answers: solutions without passports for problems without passports.

As noted, the last big but unsuccessful push for UN reform was at the UN world summit in 2005. Delegations left the summit not merely disappointed and deflated at the meagre results, but also jaded and exhausted. The momentum for reform lost then has not yet been regained twenty years later. Between the ossified hard place of an increasingly illegitimate and ineffective existing Security Council, and the immovable rock of a reform-proof Security Council, is there a third way? The majority of the world's countries could give up on UN reforms and convene a new conference for a replacement international organisation more fit for purpose in addressing and solving today's challenges and threats. The key fact is not that the choice between reform and replacement with 'a new improved formula' is painful. Rather, the issue at hand is this: At which point does the choice become unavoidable and norm entrepreneurs begin to organize a new coalition of civil-society and nation-state actors to convene a global conference to design United Nations 2.0?

VIII.3 The United Nations is a reformed League of Nations

The two major international organisations of the 20th century were the League of Nations after the First World War and the United Nations after the Second World War. In both instances, people horrified by the destructiveness of modern wars decided to create institutions for avoiding a repetition of such catastrophes.

The victors of the First World War shied away from rearming until too late to deter rather than appease; the defeated powers embraced rearmament with enthusiasm even while weaponizing victimhood and

grievance against the democracies. German rearmament proceeded apace as the backdrop to Anschluss with Austria and the conquest of Sudetenland from Czechoslovakia; Italy's defiance of the League in committing aggression against Abyssinia met with success; and Japan's aggression in the Far East failed to meet any effective League response. These were all preludes to the Second World War with the North Atlantic and the Pacific as its two main theatres.

The League was itself a casualty of the war and was succeeded by the United Nations. In essence, the UN is a reformed League of Nations. But political equations would have made the agenda of reforming the League a non-starter. For the objective to be realized, the process had to be started afresh and a different nomenclature given to the international organisation. However, the legacy of the former international organisation lives on in the United Nations. The most important part of the legacy was the concept, by now firmly entrenched, yet revolutionary in 1919, that the community of nations has both the moral right and legal competence to discuss and judge the international conduct of its members. The closeness with which the UN was modelled upon the League was testimony also to the fact that while the League had failed, people still had faith in the *idea* of an umbrella international organisation to oversee world peace and facilitate international cooperation. Collective security, pacific settlement of disputes, arbitration, and adjudication as the four principal mechanisms for preventing or resolving disputes and conflicts were carried over from the League to the UN.

Many provisions of the UN Charter were borrowed directly from the Covenant of the League of Nations. Others represented substantial codifications of League procedures or logical developments of nascent League ideas. Some of the other innovative ideas that were carried over from the League experiment to the United Nations included respect for the rights of small nations, economic and social cooperation, the habit of public debate on international crises, the formation of an international civil service, and the establishment of a world court and a tripartite international labour organisation bringing together government, business, and labour.

There is remarkable structural continuity in the principal organs

from one to the successor organisation.[258] The UN General Assembly is a direct structural continuation of the League Assembly, albeit decisions of the latter had to be unanimous unless specified otherwise. The major difference is in the composition of the membership, with the majority today coming from the postcolonial Global South. The Security Council is essentially the same as the Council of the League, with some important modifications of structure and procedure. There were four permanent members of the League Council and non-permanent members increased from four to six, nine, ten and eleven between 1922 and 1936. The UN Security Council has fifteen members, five permanent and ten elected. Decisions of the League Council had to be unanimous. That is, even the elected members could veto a resolution, whereas in the UN Security Council only a permanent member can do so.

The UN Secretariat is virtually identical to that of the League, with a corps of international civil servants and a Secretary-General at the top. The International Labour Organization (ILO), independent of but attached to the League, is still in existence. The world court merely changed its name from the Permanent Court of International Justice to the International Court of Justice but stayed in The Hague. The Mandates system of the colonial era transitioned into the UN Trusteeship Council for the age of decolonization. Several auxiliary bodies, variously called organisations, commissions, institutes, committees, etc, were set up during the League's brief existence to facilitate cooperation in specific and technical fields. Many UN entities – agencies, funds, programmes – can trace their lineage to the League subsidiary bodies. Some physical assets, most notably the Palais des Nations in Geneva, were transferred to the UN.

The League of Nations Health Organization

Among the lesser known facts about the League is the existence of the League of Nations Health Organization (1923–46) as a technical organisation.[259] It was the first international health organisation with a broad

258 https://www.ungeneva.org/en/about/league-of-nations/organs

259 https://www.academia.edu/798208/The_League_of_Nations_Health_Organisation_from_European_to_Global_Health_Concerns

mandate and global responsibilities and was taken over by the WHO. Its executive body was the Health Committee, one of the League's permanent advisory committees. Staffed by medical and public health experts, it advised the League's Council on health-related matters. The health section of the League's Secretariat served as its administrative body. The League's Health Organization played a fundamental role in stabilization policies in the aftermath of the First World War and the Great Depression, when millions, weakened by scarcity and nutrition poverty, died from diseases like the Spanish flu, cholera, and typhus, especially in eastern Europe (Poland, Latvia, Russia, Ukraine, Greece) and the Far East (China).

The League's Health Organization was the cornerstone of international action in epidemics; biological and dietary standard-setting; the fight against malnutrition, infectious diseases, infant mortality, and drug abuse; and compilation of epidemiological data and public health statistics. In the 1930s its work expanded into conducting social medicine projects such as nutrition, housing, and rural hygiene. One of its major challenges was the parallel existence of the two other interstate health organisations, the Pan American Sanitary Bureau at Washington, DC, founded in 1902 to formulate sanitary agreements and regulations, and the Office International d'Hygiène Publique at Paris, founded in 1907. The WHO was set up as the single global health organisation, taking over from the League and the Paris-based organisation and converting the Pan American Sanitary Bureau into the secretariat of the WHO Regional Office for the Americas in 1949, the Pan American Health Organization (PAHO), that is still based in Washington.[260]

Why was a new organisation created?

The obvious question that arises is: If the United Nations was essentially a reformed League of Nations, why was a new organisation created after an international conference in San Francisco? The answer is four-fold. The first is concessions to sovereignty were required in order to bring on board the United States. Owing to the historical legacy of US suspicions of overseas entanglements and residual isolationist sentiment embedded in

260 https://www.paho.org/en

the institutional memory of the US Senate in particular, the US refused to join the League. The Senate rejected ratification of the League Covenant even though US President Woodrow Wilson had been one of the prime movers behind its establishment. Second, the experience of other major powers had also left a problematic legacy. Germany, as a defeated power, joined only in 1926 but left in 1933 under the shadow of Hitler. The Soviet Union joined in 1934 as a replacement for Germany, only to be expelled in 1939. Japan and Italy, half the permanent membership, left in 1933 and 1937, respectively. Third, the outbreak of the second World War was a failure on the most basic criterion of the League's very purpose. Fourth, developing countries viewed, with justification, the League of Nations as part of the European imperial system. All these factors combined to make it so much easier, simpler, and cleaner to start afresh. To call it the same would have been an indelible stain that ensured the United Nations was born in sin in the eyes of many member states.

VIII.4 The WHO: reform or replace?

The explanation for why a de facto reformed League was 'bluewashed' with a newly-created United Nations, and the failure to implement the most critical and urgent UN reforms, together indicate why contrary to intuition, replacement can sometimes be the more strategic choice than reform. *The Structure of Scientific Revolutions* by Thomas S. Kuhn has been one of the most influential books on the philosophy of science. Kuhn outlined the process by which a dominant paradigm in science is replaced by a new paradigm. Normal science is concerned with solving puzzles within a particular framework. However, in the course of ongoing research, anomalies are uncovered, reflecting an empirical variance with the dominant theory that suggests deficiencies in the existing paradigm. This generates auxiliary hypotheses within the dominant paradigm to explain the anomalies. But if there comes a point where the old paradigm proves unable to accommodate the anomalies, the pressure grows for a new paradigm to emerge. At this point "the anomalous has become the expected."

What if an analogous situation occurs with an institution or organisation that has been in existence for an exceptionally long time in world history? In particular, have the United Nations itself, and the WHO as

one of its specialized agencies, accumulated a debilitating set of anomalies and "pockets of apparent disorder," that make wholesale replacement both easier to achieve and potentially more productive in outcomes than investing time, effort, and resources in incremental, inconsequential, and easily sabotaged reforms? Disagreements over purpose, core values, governance structure, lack of accountability, and unequal influence of member states, and also of some member states compared to private entities cloaked in philanthropic garments, erode the legitimacy of the organisation and severely hamper its performance.

Of course, states could also unilaterally withdraw entirely from WHO-centric multilateral cooperation on global health. This would certainly address concerns regarding national policy autonomy, but only at considerable cost. Unless offset by substitutes, unilateral withdrawal from the WHO network would introduce vulnerabilities. Most immediately, withdrawing states would lose access to the WHO's internal outbreak verification, prioritization, and informal analytical exchanges. While open-source surveillance inputs would remain available, the loss of vetted interpretation may weaken early situational awareness at the stage when rapid judgment matters most for early responses. Withdrawal would also constrain access to multilateral emergency coordination. WHO-facilitated response mechanisms provide political legitimacy, logistical pathways, and the potential for operational neutrality that bilateral or ad hoc arrangements may struggle to replicate, particularly in low-capacity or diplomatically sensitive settings. States outside the system would retain technical capacity but lose visibility into WHO-led planning and the credibility that often enables cooperation during emergencies. Finally, absence would reduce influence over the evolution of WHO-centred global health norms and structural reforms of the organisation, allowing changes in emergency and country-level capacity to proceed without external input. Revised IHR and pandemic instruments will shape expectations around surveillance, sample sharing, travel measures, and emergency thresholds even for non-members. As experience in other international policy domains demonstrates, accumulated interpretations and soft-law practices can generate de facto standards affecting non-participating states indirectly through trade, travel, procurement, and scientific collaboration, yet these states would lose influence in shaping them.

Owing to its resources and capabilities, the United States is uniquely positioned to offset many of these costs of withdrawal from the WHO. Very few other states can absorb most of the losses resulting from withdrawal. Consequently, for most states the real choice is not whether to remain a party to the WHO or withdraw, but to attempt to reform the organisation or replace it with a new international health organisation. There have been many calls for WHO reform and a few discussions about whether it might be better to replace it. Both indicate dissatisfaction with either the structural and institutional design of the organisation as the world's leading health agency, and/or else with its performance. Reform means tinkering with a system that is broken. To the WHO-affiliated technocratic elites as indeed to any self-respecting bureaucracy, "reform" means more bureaucracy, resources, authority, administrative discipline meted out to dissenting voices, and encroachments on member state sovereignty. The pandemic accords are a good illustration of this syndrome.

For those who value and believe in the original mission, would the better alternative be to abolish the WHO and move on to a new IHO? Calls to replace it indicate that the dissatisfaction with the basic design is at the severe end of the scale, not unhappiness with transient failures of performance, and a loss of faith in the possibility of making it fit for purpose without a wholesale redesign. Should it be retired or reinvented, asked one article in *Public Health* in 2014?[261] K. Lee and T. Pang came down in support of reinvention, but were pessimistic about the prospects: "The current trajectory suggests that WHO and powerful donors will continue their slow dance of death, with the organisation becoming increasingly irrelevant and sidelined by other institutional players." Should the WHO be overhauled or dismantled, asked another article in the *American Journal of Public Health* in 2016.[262] The latter two authors, Suwit Wibulpolprasert and Mushtaque Chowdhury, did not really answer the question, but hinted at dismantlement in their conclusion: "the world needs a strong global health agency, but WHO, in its current state, seems unable to cope with the dynamics of the rapidly changing global health landscape."

261 https://www.sciencedirect.com/science/article/abs/pii/S0033350613002631

262 https://www.scopus.com/pages/publications/84990862181

Of course, replacement would also have its geopolitical challenges, high transaction/opportunity costs, and could simply result in wasteful duplication and/or fragmented systems, with no guarantee that power and influence wouldn't co-opt any new process. Whichever course is adopted, the broad task will be essentially the same. First, to articulate the vision animating the organisation and write it into the mission statement. Next, specify the main principles of global public health. Third, amend or draft and negotiate a new constitution for the organisation that lays out an appropriate structure including its principal organs and subsidiary bodies, to ensure its member states remain its guiding and driving force. Fourth, outline the governance arrangements including the plenary assembly(ies) as policy-setting organs, executive management, the appointment procedures, roles, and powers of leadership. This will include a description of functions and powers, along with the relations between various organs or regional bodies and with member states. Questions regarding personnel policies and funding arrangements will also have to be addressed.

Much of the WHO's authority comes from its technical expertise. Its convening power is derived from the universal legitimacy of its UN identity that gives it enviable capacity to mobilize the world's leading health experts. And it possesses priceless 'soft power' authority from the universal buy-in of its normative mandate to improve the health of the peoples of the world. Its mandate is to assist member states to safeguard the health of their populations by leading on international aspects of public health. This is qualitatively different from the responsibility for safeguarding global health. The first operates within the overarching normative framework of sovereign states and takes the form mainly of advice to countries and facilitation of cooperation across borders. The second requires the WHO to transcend state sovereignty as and when necessary.

The tension between the two becomes acute whenever the WHO sets out to create legal frameworks and international standards on health issues, as with the post-Covid push to amend the IHR and adopt a new pandemic treaty. At the point where states ignore legally binding WHO obligations and pursue independently assessed national interests instead, analysts become divided in their reactions. Some bemoan the WHO's lack of sanctioning and enforcement capacity over recalcitrant member states. Others reject the WHO's right to issue commands to sovereign states in

the first place. As one review of the WHO reform literature by Fabian Moser and Jesse B. Bump in *Social Science & Medicine* in 2022 concluded, the "WHO is endowed with technical and normative authorities, but in the absence of financial independence and effective legal powers, it is too weak to influence states unwilling or unable to cooperate, and faces difficulties in dealing with corporations and other non-state actors."[263]

Critics complain about the organisation's strategic vision, accusing it of pursuing programmes that are ad hoc, disjointed, reactive, and driven by donor priorities even when those priorities can change dramatically with changes of government or top leadership. Governments, experts, and analysts disagree over whether the health organisation's focus should be on global normative work or operational assistance to countries. Lacking strategic direction and follow-up implementation measures, it falls victim to mission drift, pursues too many disparate goals, and ends up being overstretched. The structure is complex and lacks integration across the many layers of staff and units at headquarters in Geneva that compete for budgetary allocations. It tends to be top heavy, with disconnections between the headquarters and the regional offices that have their own lines of communications with health ministers of member countries. Recruitment and promotion prioritize political calculations and the UN-wide requirement for equitable geographical representation often prevails over qualifications, skillsets, and competence.

As noted in Chapter 2, some international institutions have begun to seek legal redress against sovereign states alleged to have committed war crimes, while domestic activists have resorted to lawfare in international jurisdictions to compel certain courses of action on their own governments, for example with respect to climate liability. But we also saw that international judicial bodies lack practical enforcement capabilities. Instead, all they can do is refer non-compliance with international legal obligations by states, whether a member or not, to the UN Security Council. For example, in the concluding reflections after their review of the WHO reform literature, Moser and Bump advocate for the WHO to "assert" its "legal authority in health areas" against "obstructive Member

263 https://www.sciencedirect.com/science/article/pii/S0277953622007626

State behaviour."[264] The latter allegedly "capture WHO for short-term pet projects" and "undercut collective success by breaking legally binding health rules." They urge states "to counter actions made in the national self-interest" by setting up "mediation and adjudications functions."

Let us set aside the extraordinary call for an intergovernmental organisation to compel member states to act against their national interests, or to deem to decide those interests on their behalf. What is more pertinent for present purposes is that the only lawful enforcement mechanism available to the international community in the existing world order is the UN Security Council. But the unreformed, and seemingly unreformable, Council increasingly lacks legitimacy and in practice cannot enforce binding judgments and orders issued by international courts and tribunals against China in a maritime territorial dispute with the Philippines; nor against Russia's President Vladimir Putin for the invasion of Ukraine; nor against Israel's prime minister for alleged war crimes in Gaza; nor against President Trump during his first administration for non-compliance with the multilaterally negotiated and Security Council endorsed (unanimously, that is, including the United States) 2015 nuclear deal with Iran.

In the case of the WHO, compliance and enforcement is not a direct feature of its remit or authority. Instead, the WHO is in the privileged position to set global health policy, which guides the policies of the UN and its agencies such as UNESCO and UNICEF, the Bretton Woods institutions the World Bank and IMF, as well as other global health initiatives such as The Global Fund, GAVI (the vaccine alliance) and CEPI (Coalition for Epidemic Preparedness Innovations). Where the WHO gains compliance is through a combination of epistemic authority, convening power, and agenda setting. When combined with the financial power of its global health partners, compliance is generated through conditionalities attached to financial assistance, where "performance" against a set of indicators and benchmarks can be a condition of continued financing. Difficulties arise when low-resource countries have little alternative than to agree to conditionalities, which is particularly problematic when the indicators are not aligned with local priorities and national strategies. Under any

264 https://www.sciencedirect.com/science/article/pii/S0277953622007626

definition of power, this equates to a condition where the WHO and its proxies can force a country to adopt policies when they would prefer to do otherwise.

VIII.5 Wider implications for global health

The current US administration's critical scrutiny of global health programme performance will undoubtedly have profound impacts on future policy and outcomes. As a reboot of US engagement in global policy, the United States released the *America First Global Health Strategy* (AFGHS) in September.[265] Although there are wider concerns with how its policies will be implemented, the first half of the document aligns with established global public health evidence in four ways:

1. There is strong evidence suggesting that increased national ownership of health programmes results in greater effectiveness and health outcomes. National ownership allows for better alignment with national health strategies, support to broad sectoral reforms (e.g., human resource management) and health system development, contextually appropriate health interventions, reduction in fragmentation and paperwork, increased predictability in health investments including co-financing, more efficient health systems, and long-term programme sustainability.
2. There is overwhelming evidence that current global health initiatives largely fail to fully support efficiency, localized capacity building, health system strengthening, and self-reliance in low-resource settings. Global health initiatives require large, centralized bureaucracies, diverting a significant proportion of resources from the intended recipients while failing to build local administrative and technical capacity. Alternatively, three outcomes persist. First, as externally funded programmes are scaled up, low-resource recipient countries become increasingly

265 https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf

reliant on development assistance for health, external technical support, and the delivery of health services from external actors. Second, global health initiatives tend to operate in parallel to local systems creating misaligned policies, duplication, and distortions, while also creating avenues for rent capture, task shifting, and brain drain. Third, categories of beneficiaries of externally funded programmes become dependent on services provided by those global health initiatives.

3. Although there is widespread recognition of the link between national ownership and aid effectiveness (such as the Paris Declaration on Aid Effectiveness,[266] the Lusaka Agenda,[267] and Accra Reset[268]), global health initiatives have been unwilling or unable to institute needed reforms, notably due to their short programming cycle and replenishment models, focus on short-term and visible impact, and narrow disease-control approach (in opposition to supporting health promotion and consolidation of health systems). In this context, assistance programmes need to create a development "bridge" with built-in exit strategies and short- to medium-term objectives to make global health initiatives obsolete.
4. Recipients of health foreign aid are not passive agents and shoulder levels of responsibility. Although colonial legacies have no doubt created baseline disadvantages and challenging operating environments, as recognized in the Accra Reset, national governments will still need to take responsibility and ownership, investing resources to gain independence from development assistance for health and foreign aid more widely. Moreover, recipients will require a vigorous and sustainable approach to domestic resource allocation and domestic political

266 https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html

267 https://africacdc.org/news-item/statement-on-continental-secretariat-for-lusaka-agenda-implementation-launch/

268 https://presidency.gov.gh/statement-african-health-sovereignty-in-a-reimagined-global-health-governance-architecture-a-co%E2%80%91creation-summit-under-the-leadership-of-his-excellency-john-dramani-mahama-president-of-the/

economy, since many recipient treasuries underfund their health systems knowing that donors will fill gaps. For example, despite most African countries signing the Abuja Declaration in 2001 pledging 15 percent of their national budgets for health, recognizing its corresponding positive effect on educational and economic performance,[269] only two countries in Africa had met this pledge in 2021 (South Africa and Cabo Verde – both of which are experiencing meaningful development gains).[270] As a result, development assistance for health can unintentionally interfere with local allocations in health due to scale and ability to meet budget shortfalls.

Wealthy industrialized countries addressed infectious disease and improved longevity predominantly through improvements in their economies and consequently living conditions, nutrition, sanitation, and access to basic health care. An early hope for the WHO, viewing health through its holistic physical, mental, and social well-being definition, was that it would accelerate these gains for countries emerging from colonial rule through a multilateral approach. Its drift in recent decades towards a concentration on relatively low-burden outbreaks discussed above does little to build national and individual resilience and reduce underlying health burdens, but it does further the interests of pharmaceutical and biotech interests concentrated in Western countries. The WHO is risking an increase in inequality, as its policies during Covid demonstrated, and there is an irony that it is the current US administration that is setting the emphasis back on capacity building and self-sufficiency, demonstrating the model that a multilateral health organisation should be based on.

Although the AFGHS[271] has potential positive implications for a renewed multilateralism, the US has decided to prioritize working through

269 https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdfhttps://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf

270 https://www.hrw.org/news/2024/04/26/african-governments-falling-short-healthcare-funding

271 https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf

bilateral agreements where possible with recipient countries. Of course, this could result in duplication of effort. Moreover, a major risk with such bilateral agreements is that donors will seek to lock in favourable conditions for themselves at potential cost to recipient countries, a concern that cannot be ignored, since it would merely continue what has been deemed historically as imperial practices in the delivery of development aid for health. Yet, *prima facie*, the overall thrust to build integrated and self-sustaining local capacity as articulated in the AFGHS is commendable, even at the cost of some inevitable duplication and missteps, and consistent with the philosophy espoused in this report as well as enshrined in the Paris Declaration on Aid Effectiveness (2005),[272] the Lusaka Agenda (2023),[273] and the Accra Reset (2025).[274]

By any understanding, creating a permanent dependency on financial and technical assistance from external actors, including but not limited to an international health organisation, who get funds that could otherwise help build resilience in the low-income countries, undermines self-reliance and is a de facto threat to health sovereignty. The growth in mandates, authority, resources, and personnel to match WHO mission creep has catered to the corporate interests of the profit-maximizing pharmaceutical industry, philanthropic foundations, health-related think tanks, management consultants, and the WHO as an international bureaucracy; and to the career interests of a continually expanding corps of international civil servants and technocrats. A WHO that has been successful in its core mission should reduce its relevance in many areas as countries build their own capacity, downsizing to functions that are still required at an international level. Continued growth would suggest failure, in which case deep reform or replacement would clearly be warranted in order to build capacity and national self-sufficiency whilst supporting reduction

272 https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html

273 https://africacdc.org/news-item/statement-on-continental-secretariat-for-lusaka-agenda-implementation-launch/

274 https://presidency.gov.gh/statement-african-health-sovereignty-in-a-reimagined-global-health-governance-architecture-a-co%E2%80%91creation-summit-under-the-leadership-of-his-excellency-john-dramani-mahama-president-of-the/

of major remedial disease burdens.

It is worth emphasizing that this pathology is not unique to the WHO. On the contrary, it is a widespread problem with institutions of global governance, many of which have become addicted to a model that seeks to continually expand their mandates, budgets, and personnel by perpetuating the problems that they were set up to solve. This enables them to operate in a permanent crisis mode by pointing to proliferating and worsening risks, and recasts their identity into advocacy platforms. Success is self-validating: "Why interfere with a model that is working?" Failure is self-negating: "See, exactly as we warned, cutbacks in resources have made the problem worse." The answer to both success and failure is a continual bureaucratic sprawl. Over time this increases their dependence on funding while deflecting attention from the need to scrutinize the paucity of mission-centric outcomes.

It might make perfect sense in logic to attempt reform first before embracing a more wholesale agenda to replace the WHO. But logic does not always rule in world affairs. The current global flux created by the rise of anti-globalization sentiment and the corresponding crisis in multilateralism provides a confluence of circumstances for a transformative redesign of the architecture of global health governance. The "reform first" camp should be honest about the reality that the opportunity comes but rarely to go for meaningful and substantial organisational change. Taken at the flood, it could lead to better health outcomes. Allowed to recede, it will leave behind the detritus of failed efforts and lost hopes.

APPENDIX I: MEMBERS OF THE PANEL

DAVID BELL is a clinical and public health physician with a PhD in population health and background in internal medicine, modelling, and epidemiology of infectious disease. He has worked in global health and biotech for the past 25 years. Previously, he was Director of the Global Health Technologies at Intellectual Ventures Global Good Fund in the USA, Programme Head for Malaria and Acute Febrile Disease at FIND in Geneva, and was a Medical Officer and Scientist in infectious diseases at the World Health Organization. He currently consults in biotech and international public health and co-leads the REPPARE project on the evidence base behind the pandemic agenda at the University of Leeds.

RAMESH THAKUR is emeritus professor in the Crawford School of Public Policy, Australian National University, a former United Nations Assistant Secretary-General, and a Fellow of the Australian Institute of International Affairs. Born in India and educated in India and Canada, he has held full-time academic appointments in Fiji, New Zealand, Canada, and Australia and been a consultant to the Australian, New Zealand, and Norwegian governments and served on international advisory boards of policy-oriented research institutes in Africa, Asia, Europe, and North America. His books include *Global Governance and the UN* (Indiana University Press), *The Oxford Handbook of Modern Diplomacy* (Oxford University Press), *The United Nations, Peace and Security* (Cambridge University Press), and *The Nuclear Ban Treaty: A Transformational Reframing of the Global Nuclear Order* (Routledge). He has published opinion articles in the *Asian Wall Street Journal, Financial Times, International Herald Tribune*, and leading national newspapers.

ROGER BATE researches international health and development policy, with a special interest in medicines and nicotine products. He has a PhD in economics from Cambridge University and is currently a fellow at the International Center for Law and Economics and Brownstone Institute. His writings have appeared in, among others, the *New York Times, Lancet, Journal of Health Economics,* and the *British Medical Journal*. He has been an advisor to the South African Government. He has conducted research in India and numerous African countries on the public health consequences of the counterfeit and substandard medicine trade and published over two dozen peer-reviewed papers on the problem. He is the author or editor of 14 books and over 1,000 journal and newspaper articles. His broader interests include aid policy in the developing world and evaluating the performance and effectiveness of US Government and global agencies (especially the WHO and the World Bank).

GARRETT WALLACE BROWN is professor and Chair of Global Health Policy at the University of Leeds. He is Co-Lead of the Global Health Research Unit and WHO collaborator on evidence and analytics for health emergencies. His research focuses on global health governance, health financing, health system strengthening, health equity, and estimating the costs and funding feasibility of pandemic preparedness and response. He has over 25 years of research and policy experience, with over 100 published articles in global public health. He has worked with NGOs, governments in Africa, the UK Department of Health and Social Care, the UK Foreign Commonwealth and Development Office, the UK Cabinet Office, the WHO, the G7, and the G20.

HÉCTOR EDUARDO CARVALLO was born in Buenos Aires, Argentina, in 1957. He graduated from de Buenos Aires School of Medicine in 1983, and reached the degree of Adjunct Professor of Internal Medicine in the same School, in 2006. Dr. Carvallo has dedicated his professional life to teaching, assisting, and developing humanitarian projects, and has written widely on internal medicine, endocrinology, and antibiotics. He has participated as invited speaker in multiple international forums, and has received the City Keys from Sidney (NE)

and Seneca Falls (NY). He has also been awarded with a Proclamation from the New York Senate at Albany (NY).

THI THUY VAN DINH moved from Vietnam to study law in France, obtaining a PhD in law at the University of Limoges. Completing the United Nations National Competitive Examination in Legal Affairs, she joined the UN Secretariat to support the implementation of anti-corruption and human rights treaties in the United Nations Office on Drugs and Crime and the Office of the High Commissioner for Human Rights. Subsequently, at Intellectual Ventures Global Good Fund (USA), she managed multilateral organisation partnerships and led environmental health technology development efforts for low-resource settings. She currently advises on procedural and policy matters related to United Nations entities in general and the World Health Organization in particular.

HARRIET GREEN holds an MA with Distinction in Political Theory and a PhD. Her research in Global Distributive Justice and Health focused on unpacking the United Nations' Sustainable Development Goal 3.8 of Universal Health Coverage (UHC), assessing what UHC ought to deliver as a driver of global health development. Harriet has worked with the World Health Organization as a policy consultant and reviewer, culminating in a report which critically evaluated the existing Action Review processes. She has published on global development and health.

WELLINGTON OYIBO is a Tropical Diseases Specialist, Professor, and consultant Medical Parasitologist at the College of Medicine, University of Lagos, Idi-Araba, Lagos, Nigeria. With over two and a half decades of experience working in the space of tropical diseases and over 120 papers published in peer-reviewed journals, Wellington continues to contribute to tropical diseases research and scholarship. He is Director of the Centre for Transdisciplinary Research in Malaria and Neglected Tropical Diseases (CENTRAL-NTDs) and a Bioethics Fellow of the NIH-sponsored South Africa Research Ethics Initiative (SARETI).

REGINALD M.J. ODUOR is Associate Professor of Philosophy at the University of Nairobi, with more than 36 years of university teaching experience. He holds a Ph.D. in Political Philosophy from the University of Nairobi, and has written widely on the need for context-sensitive models of democracy for African states. He has also written feature articles and opinion pieces on Covid-19 vaccine mandates, the growing centralisation and corporatisation of medical care, the WHO Pandemic Agreement, and amendments to the WHO's International Health Regulations. He has also spoken in several webinars and press conferences on the emerging global public health architecture, with an emphasis on the need to uphold medical ethics and public health ethics grounded in human rights. He is Co-Chair of the Pan-African Epidemic and Pandemic Working Group. He was the first person with total visual disability to be appointed to a substantive teaching position in a public university in Kenya. He is also Co-Founder and former Chair of the Nairobi-based Society of Professionals with Visual Disabilities (SOPVID).

ELISABETH PAUL holds a PhD in Management Sciences from the University of Liège (2006), with a thesis on the application of incentive theory to the improvement of public resource management in developing countries. She combines an academic and field career, with about a hundred technical support, evaluation, and research missions to her credit, mainly in West Africa. She is currently Associate Professor at the School of Public Health of the Université Libre de Bruxelles (ULB), and the Director of the Research Center on "Health Policies and Systems – International Health." She teaches various courses related to health policies (planning and evaluation), health financing, and health systems (performance) analysis. She is also an independent consultant, and a former member of the Technical Review Panel of the Global Fund and of the Independent Review Committee of Gavi, the Vaccine Alliance. Her areas of expertise are global health systems and policies, development aid effectiveness, performance-based financing, international aid, and public finance management.

APPENDIX II: FOUNDATIONS OF THE RIGHT TO HEALTH

The United Nations Charter (1945)[275]

Article 13.1: The General Assembly shall initiate studies and make recommendations for the purpose of:

> (b): promoting international co-operation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 55: With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

> (b): solutions of international economic, social, health, and related problems; and international cultural and educational cooperation.

Article 62.1: The Economic and Social Council may make or initiate studies and reports with respect to international economic, social, cultural, educational, health, and related matters and may make recommendations

275 https://www.un.org/en/about-us/un-charter/full-text

with respect to any such matters to the General Assembly to the Members of the United Nations, and to the specialized agencies concerned.

Health Sovereignty
Article 2

> 1. The Organization is based on the principle of the sovereign equality of all its Members.
>
> 7.Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state.

The Universal Declaration of Human Rights (1948)[276]
Article 25.1: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The WHO Constitution (1948)
Preamble
The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

276 https://www.un.org/en/about-us/universal-declaration-of-human-rights

The International Covenant on Economic, Social and Cultural Rights (1966)[277]

Article 7: The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

(b) Safe and healthy working conditions

Article 10.3: The employment of children and young people in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law.

Article 12:
1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b. The improvement of all aspects of environmental and industrial hygiene;
c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

277 https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)[278]

Article 10(h): States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women, access to specific educational information to help to ensure the health and well-being of families.

11.1(f): The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

12.1: States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

14.2(b): States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas…and, in particular, shall ensure to such women the right to have access to adequate health care facilities, including information, counselling and services in family planning.

The Convention on the Rights of the Child (1989)[279]

Article 24.1: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

278 https://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

279 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

Article 24.2: States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c. To combat disease and malnutrition, including within the framework of primary health care;
d. To ensure appropriate pre-natal and post-natal health care for mothers;
e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition;
f. To develop preventive health care, guidance for parents and family planning education and services;

32.1: States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development

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