

Global Health Governance

The Scholarly Journal For The New
Health Security Paradigm

Reform of the World Health Organization

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Tine Hanrieder and Adam Kamradt-Scott

Same, Same But Different:

Reforming the World Health Organization in an
Age of Public Scrutiny and Global Complexity

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Lawrence O. Gostin

GLOBAL HEALTH GOVERNANCE

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REFORM OF THE WORLD HEALTH ORGANIZATION

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Introduction

Same, Same But Different: Reforming the World Health Organization in an Age of Public Scrutiny and Global Complexity

Tine Hanrieder and Adam Kamradt-Scott

As the World Health Organization (WHO) enters its 70th year of existence, a new director-general assumes the helm of the intergovernmental organization for their next five-year term of office. The election process for the WHO's eighth director-general has been the single most competitive election in the organization's history, with an initial six candidates putting their names forward for the top job. In January 2017, the Executive Board eliminated three of the six candidates from the race,¹ and over the next four months the remaining candidates criss-crossed the globe to meet with world leaders and country representatives to secure their vote ahead of the 70th World Health Assembly in Geneva.

By all accounts, any organization's 70th anniversary should be a milestone marked by celebration and festivities. It arguably also should be a time for deep reflection on the institution's accomplishments; and it must be reasonably concluded the World Health Organization has had a number of them in its seven decades of operation. The eradication of smallpox, the birth of the Primary Health Care movement, the promotion of breastfeeding and advancing childhood vaccinations, and the adoption of the Framework Convention on Tobacco Control are just some of the organization's more prominent achievements. Its work in consistently setting global standards and benchmarks – an area where the organization has repeatedly demonstrated leadership, often despite staunch opposition – should be especially celebrated.

Even so, the WHO is once again in the midst of an extensive reform process instigated by its member states. This latest reform process represents a continuation of organizational restructuring and change that has been, quite literally, underway for decades now. In particular, appointments of new directors-general have time and again been accompanied by promises of all-out change and organizational renewal,² even though continuities abound. Commentators keep blaming the WHO's bureaucratic, fragmented, and sometimes inefficient methods of work, and they keep assuring that the world nevertheless needs the WHO as a legitimate standard setter and focal coordinator for global health.³ States and donors keep supporting the WHO rhetorically, but fail to commit to more sustainable funding of the organization. Non-governmental organizations (NGOs) keep pushing for more access and transparency at the WHO, but are faced with multiple barriers to access and a regime that does not differentiate between for-profit and not-for-profit civil society actors.

Still, these continuities can hardly detract from several substantive changes at the WHO – based on a mix of ongoing gradual transformations and more abrupt developments. The authors in this special forum discuss several of those developments and their implications. Some of the proposals for the ongoing reform effort can be implemented rapidly, while others will require a more methodical, sustained effort over time. What is clear, is the WHO's evolving authority in health security matters, its piecemeal engagement with the challenge of accountability, and the evolution of its formal decision-making procedures, are all areas of key importance.

Since the 2003 SARS pandemic and the 2005 reform of the International Health Regulations – which subjected the organization to ever closer public scrutiny – organizational change in the WHO has accelerated, especially with regards to its role in ensuring global public health security. Further calls for reform arose immediately following

the 2009 H1N1 influenza pandemic when the WHO was accused of having been improperly influenced into declaring a pandemic.⁴ Those calls then reached a crescendo, however, with the WHO's mishandling of the 2014 West African Ebola outbreak, with some commentators even calling for the organization's dissolution.⁵ Since that time, the WHO's work in disease outbreak control and health emergencies has assumed centre-stage, with member states agreeing in 2015 to one of the most substantial reforms in the organization's history – the establishment of the WHO's Health Emergency Programme which, when realised, will result in an entirely new workforce being deployed across all three levels of the institution, designed to assist countries respond more forcefully and appropriately to health crises.⁶

While these are important developments, Catherine Worsnop's contribution to this forum highlights that the WHO's emergency competencies may be a two-edged sword, alongside the security framing of health more generally. Worsnop points to the problem that during global health emergencies, many states disregard WHO recommendations and impose excessive measures. Her discussion reveals that the declaration of an emergency is not without its own risks and makes suggestions on how the WHO can adapt the way it handles these declarations so as to further discourage states from closing their borders to vulnerable countries. This contribution also shows how political science theories of institutional design can help us understand and address intricate cooperation problems during pandemic outbreaks.

Another site of continuous, albeit patchy reform efforts is the WHO's system of accountability. As Mark Eccleston-Turner and Scarlett McArdle submit in their analysis of accountability mechanisms at the WHO, measures taken by the organization to date do not fulfil some basic requirements such as independence and external oversight. Furthermore, WHO accountability is piecemeal at best, with policy-specific review mechanisms being the dominant method of work. The authors illustrate their claim with the post-Ebola action reviews and make a range of suggestions for how the WHO can establish a more coherent and powerful accountability regime.

In Julian Eckl's analysis, he focuses on the diplomatic practices at the World Health Assembly (WHA) and provides critical insight into the ambiguities of WHO reform and the ongoing quest for organizational efficiency. Combining ethnographic observation and archival research, Eckl shows how a quest for time efficiency and the proliferation of parallel meetings has turned the WHA, formally the WHO's highest and central decision-making body, into a highly complex and decentralized event. He claims that only some decisions are really taken at the WHA, with others moving to other, potentially more informal forums. His ethnographic account also illustrates the challenge that a WHA can pose to many smaller delegations.

Finally, Lawrence O. Gostin's commentary takes us on an expertly adroit tour of the profound challenges confronting the new director-general and the WHO more broadly. Gostin discusses not only the essential leadership qualities the new director-general requires to navigate the minefield of member state self-interest, he also surveys the vast array of agendas the organization has been tasked with executing in an operating environment characterized by a lack of confidence and unsustainable funding. Gostin notes the 'unvirtuous cycle' that now surrounds the WHO, and calls for a return to the principles the WHO was founded upon – international cooperation, global public goods, and a willingness to develop cross-border solutions.

These contributions underline that to understand and further the reform of the WHO, we need multi-disciplinary perspectives, reaching from political science to international law, ethnography and history. They also show that despite all seeming continuity and sclerosis, decision-making practices and the WHO's relationship to its environment are constantly evolving. More than ever, the WHO is called upon to legitimize (or de-legitimize) state behaviour through its public authority. But there are also new and fair demands for transparency and accountability that the organization needs to take seriously if it is to claim

its role as the universal health agency promoting a central health agenda for all states and all people. This unique legitimacy is its most precious asset when asking for dependable and sustainable support by its member states.

Tine Hanrieder specialises in the political sociology of global health and international relations theory. She directs the research project "Medical Internationalisms and the Making of Global Public Health (Dr.GLOBAL)" at the WZB Berlin Social Science Center. She has published on institutional change and normative dynamics in global (health) politics.

Adam Kamradt-Scott specialises in global health security and international relations. His research and teaching explores how governments and multilateral organisations cooperate and interact when adverse health events such as disease outbreaks, epidemics and pandemics occur, as well as how they respond to emerging health and security challenges.

¹ John Zarocostas, "Three candidates compete for WHO Director-General post", *Lancet*, 389 (2017): 490.

² Fiona Godlee, "Reform of the WHO depends on next week's vital budget debate", *BMJ*, 316 (1998): 1407.

³ Jeremy Youde, "Why proposed WHO reforms aren't enough to deal with the next pandemic", *The Washington Post*, May 26, 2015, accessed May 15, 2017.

https://www.washingtonpost.com/news/monkey-cage/wp/2015/05/26/why-proposed-who-reforms-arent-enough-to-deal-with-the-next-epidemic/?utm_term=.5909b8a33c4c; The PLOS Medicine Editors, "A Global Champion for Health—WHO's Next?", *PLoS Med* 13 (2016): e1002059. <https://doi.org/10.1371/journal.pmed.1002059>.

⁴ World Health Organization, "Statement by Dr Keiji Fukuda on behalf of WHO at the Council of Europe hearing on pandemic (H1N1) 2009", WHO, January 26, 2010, accessed May 15, 2017. http://www.who.int/csr/disease/swineflu/coe_hearing/en/

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Provoking Barriers: The 2014 Ebola Outbreak and Unintended Consequences of WHO's Power to Declare a Public Health Emergency

Catherine Z. Worsnop

One aim of the World Health Organization's (WHO) International Health Regulations (IHR) 2005 is to discourage the use of overly restrictive barriers because these measures incentivize outbreak concealment and undermine outbreak response efforts. Yet, during the 2009 H1N1 pandemic and the 2014 Ebola outbreak, close to 25% of states imposed trade and travel barriers in opposition to WHO recommendations. This article argues that WHO's declaration of a Public Health Emergency of International Concern (PHEIC)—in the absence of raising the costs of disregarding WHO recommendations—may actually exacerbate the long observed relationship between an outbreak being made public and governments' imposition of excessive measures. Original data from the 2014 Ebola outbreak supports this argument and illustrates that, paradoxically, the act of declaring a PHEIC, which is intended to alert and prepare the international community, actually provokes some states to overreact. As the revised IHR approach their 10-year anniversary and WHO elects its next director-general, this study points to the PHEIC declaration as an area of needed reform.

INTRODUCTION

The election of the next director-general of the World Health Organization (WHO) coincides with the 10-year anniversary of the revised International Health Regulations (IHR) entering into force. How have the regulations performed and what does the future hold for the only global agreement governing the international response to disease outbreaks?

The revised IHR, adopted by WHO member states in 2005, are meant to coordinate the global response to health emergencies and were initially heralded as “an historic development for international law and public health.”¹ Yet, the response to four declared public health emergencies of international concern (PHEIC)—the 2009 H1N1 pandemic, 2014 resurgence of Polio, 2014 Ebola crisis, and 2016 outbreak of Zika—reveal uneven success for the regulations.

Since their inception in 1951, the IHR (then called the International Sanitary Regulations, ISR) have had a dual goal of achieving “maximum security against the international spread of diseases with a minimum interference with world traffic.”² Yet, states have frequently interfered with trade and travel during outbreaks, imposing measures that are more restrictive than the IHR allowed. For example, in response to a 1965 outbreak of cholera in Iran, Afghanistan, Uzbekistan, and Iraq, 33 countries imposed overly restrictive measures ranging from requiring vaccination certificates to prohibiting importation of foodstuffs and barring entry to travelers from affected states.³ And, during outbreaks of plague in India and cholera in Peru in the 1990s, a number of states immediately imposed barriers against travel and goods from the two countries that were, again, more restrictive than the IHR allowed.⁴ Discouraging this behavior by states was a key motivation behind revising the IHR in 2005 and a number of changes were made to the regulations with this aim in mind.⁵

The use of overly restrictive trade and travel barriers during outbreaks undermines outbreak response in several ways: barriers disrupt international travel and trade, inhibit the free movement of people and resources from getting where they are needed during an

outbreak, and further weaken economies already struggling to deal with a public health emergency.⁶ Importantly, barriers also lead to a collective action problem that makes all states less secure from outbreaks in the long run. States that discover outbreaks have incentives to conceal them since other states cannot credibly commit to not impose excessive measures once an outbreak is made public. Not surprisingly, states will not rapidly and transparently report outbreaks if economic harm is their reward.⁷ This is problematic given that effective outbreak response relies on rapid and transparent outbreak reporting.

Since outbreaks are associated with many unavoidable costs including increased health care expenditures and lost productivity,⁸ limiting the unnecessary cost of other states' trade and travel barriers that do little to stop disease spread is critical. Yet, even after the revised IHR entered into force in 2007, many states continue to impose overly restrictive trade and travel barriers in response to global health emergencies. The H1N1 pandemic and the Ebola crisis suggest that a key aim of the revised IHR is not being met. In spite of changes made to the IHR in 2005 to discourage the use of overly restrictive travel and trade barriers during public health emergencies, during both outbreaks close to 25% of countries ignored WHO guidance and imposed measures that the organization said had little public health rationale.

During the first test of the IHR, the 2009 H1N1 outbreak, 47 states imposed trade or travel barriers against H1N1-affected states, even though WHO recommended against doing so.⁹ For its part, WHO did little to address this bad behavior. The 2014 Ebola crisis revealed a similar pattern. Over forty countries imposed travel restrictions against states with Ebola transmission, again ignoring WHO guidance that such measures would not be an effective strategy for fighting the outbreak.

Existing analysis of the use of barriers during H1N1 shows that domestic political incentives drove some states to ignore WHO guidance.¹⁰ But, the H1N1 pandemic also points to another dynamic: most states that imposed barriers did so soon after WHO declared H1N1 a public health emergency. A similar pattern emerged during the Ebola outbreak. Almost half of the states that imposed barriers did so within two weeks or so of WHO's declaration of a public health emergency. In the case of Ebola, this pattern of behavior is especially curious since the outbreak had reached crisis levels well before WHO's announcement and many public health experts argued at the time that the conditions for declaring a PHEIC had been met weeks before WHO did so.¹¹

Does WHO's declaration of a PHEIC, which is meant as a warning and call to action for the international community to effectively contain an outbreak, actually provoke trade and travel barriers? Several after-action reviews pointing to failures in the Ebola response have hinted at this possibility.¹² But, is WHO's declaration of a PHEIC really triggering the use of excessive measures by states? If so, what are the options for improvement as WHO heads into its next phase?

This article argues that WHO's declaration of a PHEIC can lead to this unintended outcome. The revised IHR have strengthened WHO's role as an information provider by allowing the organization to provide timely information about whether a global outbreak is occurring and how states can effectively respond. Indeed, many states do not impose trade and travel barriers once informed by WHO that such measures provide little protection and undermine outbreak preparedness and response. However, information provision alone is unlikely to effectively address the cooperation problem driving many governments' continued imposition of barriers. Though all states share an interest in limiting the use of excessive measures to improve outbreak response, when an outbreak actually occurs, conditions change for some governments that face shorter-term international and/or domestic political pressures to impose barriers. The IHR have done little to directly address these incentives. As such, in the absence of higher costs for disregarding WHO recommendations, a PHEIC declaration signaling that a serious outbreak is underway actually exacerbates the long observed relationship between outbreaks being made public and the imposition of barriers.

Analysis of original data from the 2014 Ebola outbreak supports this argument: only two states imposed barriers before WHO declared Ebola a PHEIC and the highest number of barriers were imposed in the first two weeks after the declaration, even accounting for the severity of the outbreak and the level of media attention on the outbreak. Paradoxically, the act of declaring a public health emergency, which is intended to facilitate effective outbreak response, may actually undermine that effort by provoking barriers.

The article proceeds as follows. The next section provides an overview of the purpose of the IHR and key changes made to the regulations in 2005. The third section explains the relationship between declaring a PHEIC and the imposition of barriers. The following section reviews the data, methodology, and results. The fifth section concludes with an evaluation of recent proposals for reform in the context of these findings.

THE IHR AND LIMITING EXCESSIVE MEASURES

The relationship, and tension, between disease outbreaks and the free movement of people and goods came to the fore nearly 100 years before WHO's 1948 founding. Several developments in the early 19th century including increased migration and expanded trade and shipping between Europe and Asia facilitated the spread of disease.¹³ The first of seven cholera pandemics of the late 19th century broke out in the 1820s, spreading from India to Europe. Yellow fever also spread across Africa and Latin America at this time. In response, a patchwork of quarantine regulations, including forced confinement, ship inspections, and bill of health requirements proliferated, hindering commerce and inconveniencing travelers. In spite of these restrictions, both diseases still spread widely.¹⁴

On this backdrop, 12 European states convened the first International Sanitary Conference in 1851 with the goal of harmonizing quarantine policies. The central aim of today's IHR can be traced back to this first conference. In spite of disagreements about how disease spread,¹⁵ all states at the conference wanted protection from disease with minimum interference in traffic and trade. State participants at the conference agreed that states should only impose *effective* public health measures at ports and avoid unnecessary interference with commerce; but because of different understandings of the science behind disease, they disagreed over the types of measures that would effectively prevent disease spread.¹⁶

When WHO member states adopted the International Sanitary Regulations a century later in 1951, providing protection from disease while maintaining the free flow of people and goods remained the central goal.¹⁷ As such, the regulations laid out "the maximum measures applicable to international traffic, which a State may require for the protection of its territory against the quarantinable diseases."¹⁸ And, states could submit disagreements over the application of the ISR to the director-general.¹⁹

Yet, as the above-described examples of cholera in 1965 and the 1990s outbreaks of plague and cholera illustrate, states frequently imposed trade and travel measures that were more restrictive than the regulations allowed.²⁰ In part due to the threat of economic harm, delayed outbreak reporting was also a persistent problem—one that the 2002 outbreak of Severe Acute Respiratory Syndrome (SARS) placed on the global stage. In recognition of the many issues caused by the imposition of overly restrictive trade and travel barriers, limiting their use by states was a key goal of revising the IHR in 2005.

Several changes were made to the IHR in 2005 to address this and other weaknesses in the regulations, which had come to be seen as "outdated and notoriously ineffective."²¹ The full scope of the revision has been discussed at length elsewhere.²² Five changes worth noting here include: 1) expanding the scope of the regulations to cover a broader range of health events referred to as Public Health Emergencies of International Concern (PHEIC); 2) giving WHO authority to declare when a PHEIC is underway; 3) allowing WHO to make non-binding recommendations about how states should respond to these events, including

limiting the use of “excessive measures” like trade and travel barriers deemed to not actually prevent disease spread in a given case; 4) allowing WHO to rely on non-state sources of information about potential outbreaks; and 5) giving WHO authority to publicize states’ failure to report potential public health emergencies or the imposition of excessive measures.

Taken together, these revisions aim to facilitate rapid response to global health emergencies while discouraging the use of excessive measures once an outbreak is reported. Yet, in spite of these changes, as the H1N1 and Ebola outbreaks demonstrate, many states continue to impose overly restrictive trade and travel barriers, often soon after WHO’s declaration of a PHEIC. What accounts for this observed pattern of behavior?

EXACERBATING THE RELATIONSHIP BETWEEN OUTBREAK REPORTING AND BARRIERS

The following discussion shows that the IHR have not been designed or implemented in a way that would address the cooperation problem motivating some states to impose excessive measures. As such, WHO’s expanded information provision role under the revised IHR can actually exacerbate the long observed connection between an outbreak being made public and the imposition of overly restrictive measures.

There are several potential explanations for why some countries follow WHO recommendations and others continue to impose excessive measures. Some states may refrain from imposing barriers for reasons that are unrelated to WHO’s recommendations—perhaps some states never consider imposing barriers regardless of their commitments to the IHR. Or, maybe governments see it as in their domestic or international interests to follow through with commitments to the IHR and abide by WHO guidelines. Another possibility is that states refrain from imposing barriers because WHO recommendations have provided them with needed information about which measures will (and will not) constitute an effective response to a given outbreak. For these states, WHO has solved a *coordination problem*. Coordination problems exist when all share a strong interest in collective action and have an overriding preference for a common end—in this case, effective outbreak response—but lack information about how to best work together to achieve that shared goal.²³

In the case of the IHR, since their founding in 1951 the regulations have always been designed to address such issues of information provision and coordination. Overcoming information deficits and coordination problems requires an organization with technical expertise to provide guidance, in this case, about what an effective response looks like. Until revision in 2005, the regulations specified the maximum measures that states should impose in response to diseases covered by the IHR. And, the 2005 revisions strengthened the regulations on this count by expanding the scope of the health events covered by the IHR, giving WHO authority to let states know when a “public health emergency of international concern” is occurring, and allowing the organization to make *real-time* recommendations about how states should (and should not) respond to these events.

These changes ensured that WHO could quickly provide relevant information to states about how they should respond to a range of pressing health threats as they evolve over time. Governments have clear reasons to follow WHO guidance during an outbreak because, as with all coordination problems, defection is self-defeating from the perspective of outbreak preparedness and response.²⁴ As described above, imposing overly restrictive trade and travel barriers makes all states less secure from outbreaks in several ways, most directly by disincentivizing rapid and transparent outbreak reporting by governments.

States cannot be expected to respond effectively to an outbreak if they do not know what constitutes an effective response. Though some states may still be uncertain about how to respond to outbreaks even with WHO recommendations, WHO’s expanded information provision role under the revised IHR has likely helped many governments that want to

cooperate adopt appropriate policy. Once provided with guidance from WHO, many countries follow it and do not impose excessive measures.

Yet, as recent outbreaks demonstrate, compliance is not universal; some countries disregard WHO recommendations. A central reason is that some governments face strong shorter-term domestic and/or international pressures to impose barriers that outweigh their interest in effective outbreak response.²⁵ Though in general all states are in favor of limiting the use of barriers to encourage early reporting and facilitate effective outbreak containment, when an outbreak occurs, conditions change for some states, leading them to forgo this longer-term collective good in favor of short-term incentives. This sort of situation represents a *cooperation problem* because states have time-inconsistent preferences that create incentives to engage in opportunistic behavior even after an agreement has been made.²⁶ Unlike the coordination problem described above, addressing these kinds of cooperation problems require more than just information provision.

For such states to follow WHO recommendations, they must anticipate costs for renegeing on their commitments to the IHR. In other words, to convince states that following WHO recommendations is in their interests, the cost benefit analysis must be shifted in favor of the collective good. This can be achieved in various ways through legalized agreements and institutions that have relatively high levels of delegation, precision, and obligation.²⁷ Violation can mean harm to a state's reputation in the international community, which can mean losing aid, trade, or security benefits, or a reduction in other states' willingness to cooperate with the violator in the future.²⁸ Violation can also harm leaders' domestic political standing, especially if the domestic population values the rule of law or if violation harms the interests of a domestic constituency.²⁹ These costs will be higher and more likely if the IO administering the agreement has the power to "name and shame" countries that do not adhere to the agreement (and exercises that power), or if there is a formal dispute resolution mechanism attached to the agreement, as is the case with the World Trade Organization. Of course, as the case of the IHR demonstrates, many cooperation problems persist in part because of states' unwillingness to bind themselves to a hard law agreement that might actually constrain their behavior.³⁰

As outlined in the previous section, the 2005 IHR revision did make it possible to raise the costs of disregarding commitments to the IHR by giving WHO the authority to monitor whether states followed its recommendations and to publicize which states imposed measures not called for by the organization. Publicizing bad behavior could raise the costs of not following WHO recommendations in several ways. First, it could threaten states with general harm to their international reputation. Second, it could legitimize bilateral punishment by states harmed by the excessive trade and travel barriers. Third, it could mobilize domestic groups that are harmed by barriers to pressure their governments to comply (such as pork importers during the H1N1 pandemic harmed by bans placed by their governments on pork imports from H1N1-affected states). However, WHO did not exercise its naming and shaming power during either the H1N1 pandemic or the Ebola outbreak, even though in both instances over 40 countries imposed measures not called for by the organization.³¹

WHO's hesitance to call states out for bad behavior is understandable given its continued reliance on member countries for financial support and cooperation.³² Still, failing to name and shame states for imposing excessive measures means that these states suffer few costs for doing so. There is also little evidence of bilateral punishment by countries themselves. For example, during the H1N1 pandemic, because it had one of the highest numbers of H1N1 cases, the US was the target of most pork import bans imposed by other countries. Though the US did warn countries to remove the bans, there is no evidence that the US followed through with any sort of punishment (though this warning alone may have been enough to convince some states to not impose barriers).³³ In short, states may have learned from the H1N1 experience that shirking commitments to the IHR comes with

few costs. As such, governments that face incentives to impose barriers have little reason not to do so.

While the IHR 2005 are, on the whole, more legalized than earlier versions of the regulations, portions of the IHR related to the imposition of excessive measures lack some of the aspects of hard law that might best address the cooperation problem at work.³⁴ Even though the IHR commits states to follow WHO recommendations unless they provide scientific justification for not doing so, the recommendations are not technically binding on states. Further, the IHR 2005 no longer include a dispute resolution mechanism for states to challenge measures imposed by others.³⁵

Of course, states often intentionally use soft law approaches to build in flexibility to institutional commitments. It is often more difficult to get states to sign on to a highly legalized agreement exactly because such an agreement might actually constrain state behavior. There is some evidence from state negotiations over the IHR that at least some states did not want to be bound without exception to follow WHO recommendations.³⁶ As such, building in flexibility to this part of the regulations may have been a rational decision by states to facilitate reaching an agreement that otherwise would not have been possible.

Yet, the soft law features of states' commitment to follow WHO recommendations, together with WHO's choice not to use its naming and shaming power—the key enforcement tool at its disposal—means that the incentives driving the cooperation problem in the first place persist. States still face few costs for disregarding WHO recommendations. In this context, other revisions made to the IHR in 2005 may have actually exacerbated the cooperation problem.

Specifically, the revised IHR give WHO authority to determine whether a disease event constitutes a PHEIC and then, if it does, to make an official declaration that such an event is occurring (see Article 12). This new authority was meant to address issues related to delayed outbreak reporting by governments and to ensure that the regulations would be flexible enough to apply to a broad array of health threats that will continue to change into the future. The declaration power was meant to serve as a signal to the international community and facilitate an effective response to outbreaks with potential for cross border or even global spread.

But, a declaration from WHO that a global health emergency is underway may also be sending a different sort of signal to some states—a signal to overreact. Given the long observed relationship between an outbreak being made public and the imposition of overly restrictive trade and travel barriers by countries, an authoritative declaration from WHO that a PHEIC is occurring—in the absence of raising the anticipated costs of imposing such measures—may actually exacerbate this relationship. With WHO's authority to declare a PHEIC, governments (and their constituents) are better able to distinguish between disease events. Perhaps this means that fewer states are imposing excessive measures during outbreaks not declared a PHEIC by WHO (one example is the lack of trade and travel barriers imposed against states with cases of Middle East Respiratory Syndrome, which has not been declared a PHEIC); but, declaring a PHEIC signals to states that a serious outbreak is occurring and thus may be provoking barriers during just those events that most require a coordinated international response.

In 2005, states may have strengthened the IHR when it comes to expanding WHO's role as an information provider. But, states also gave WHO the authority to send a strong signal that a serious outbreak is occurring *without* also increasing the anticipated costs for imposing overly restrictive trade and travel barriers, which exacerbates the cooperation problem. If this logic is actually operating, if WHO's declaration is provoking barriers, then we should see evidence of the following two observable implications:

Hypothesis 1. Most states should impose barriers after WHO declares a PHEIC, rather than before.

Hypothesis 2. The number of states imposing barriers should be highest soon after WHO's declaration.

Importantly, both of these observable implications should hold even when accounting for other factors that might explain the number of states imposing barriers over time, such as the severity of the outbreak itself or the level of media attention paid to the outbreak.

DATA AND METHODS

To evaluate the above hypotheses, I constructed an original dataset coding whether and when each WHO member state imposed trade or travel restrictions during the 2014 outbreak of Ebola. The Ebola outbreak is well-suited for this analysis because the disjuncture in timing between Guinea's report of the first cases in March 2014 and WHO's declaration of a PHEIC in August 2014 provides a good opportunity to examine the influence of the declaration independent of the severity of the outbreak.³⁷ The following briefly describes the three analyses I use to evaluate the argument laid out above.³⁸

Visualizing Barriers Over Time

I evaluate Hypothesis 1 by plotting barriers, Ebola cases and fatalities, media attention over time, the date of WHO's declaration that Ebola constituted a PHEIC (August 8, 2014), and several other events that could be related to when countries imposed barriers (see Figure 1 below).³⁹ I use newspaper sources and publicly available government documents to code whether and when each country imposed barriers during the outbreak.⁴⁰ When WHO declared Ebola a PHEIC, the IHR Emergency Committee recommended that "there should be no general ban on international travel or trade."⁴¹ WHO did not recommend that states adopt *any* border measures; as such, states that imposed measures like visa restrictions, flight cancellations, or requirements that travelers have a medical certificate proving that they are Ebola-free, are coded as having imposed excessive barriers. I find that 44 states imposed barriers and 150 states did not (see Table 1).⁴² I then total the number of states with barriers in place on each day of the outbreak, beginning the day the first cases were reported (March 23, 2014) and lasting through the day after the fourth meeting of the IHR Emergency Committee (January 21, 2015).⁴³

The Number of States Imposing Barriers over Time

Next, to evaluate Hypothesis 2, I examine variation in the number of states imposing barriers each day of the outbreak (see Tables 2 and 3). If WHO's announcement sparked the imposition of barriers, we should observe that more states imposed barriers soon after the announcement than at other times, even controlling for other factors. The dependent variable in this analysis is a count of the number of states that *newly* imposed barriers each day of the outbreak;⁴⁴ as such, an event count procedure is appropriate.⁴⁵ To examine whether the two weeks following WHO's declaration saw higher numbers of barriers than other weeks during outbreak (either before or after WHO's declaration), the key explanatory variables are binary variables for 1) the first week after the declaration, 2) the second week after, and 3) the first two weeks after. To account for other factors that may have led many states to impose barriers during these time periods, I include the extent of global media coverage of the outbreak and the number of Ebola cases and fatalities each day.⁴⁶

Table 1. States that imposed excessive measures during the 2014 Ebola outbreak (March 23, 2014 - January 21, 2015)

Antigua and Barbuda	Maldives
Australia	Mauritania
Bahrain	Mauritius
Belize	Namibia
Botswana	Nauru
Cameroon	Nepal
Canada	Panama
Cape Verde	Qatar
Chad	Rwanda
Colombia	Saint Kitts and Nevis
Cote d'Ivoire	Saint Lucia
Dominican Republic	Saint Vincent and the Grenadines
Equatorial Guinea	Sao Tome and Principe
Gabon	Saudi Arabia
Gambia	Senegal
Guinea-Bissau	Seychelles
Guyana	South Africa
Haiti	South Sudan
India	Sri Lanka
Indonesia	Suriname
Jamaica	Trinidad and Tobago
Kenya	Zambia

The Potential Role of Domestic Characteristics

Another important alternative explanation is that heightened fears of disease spread among powerful states, many of which are WHO's biggest donors, may have influenced the timing of WHO's declaration. This increased threat perception could explain why WHO made the declaration *and* why so many countries imposed barriers in the two weeks following the recommendation, which would suggest that the observed relationship between the PHEIC declaration and barriers is spurious. If this were true, then we might expect higher income countries to be particularly likely to impose barriers in the weeks following the declaration. To assess this possibility, I construct a binary dependent variable coded "1" if a state imposed barriers in the two weeks following WHO's declaration and "0" if the country either imposed barriers at another time or never imposed barriers. Using logistic regression, I examine whether either GDP or GDP per capita is associated with state behavior.⁴⁷ I also include several other factors that existing research suggests might influence variation in behavior across countries: total health spending, the level of democracy, whether the state imposed barriers during H1N1, and whether the country is located in the UN Africa region (all for 2013, the year before the Ebola outbreak began).⁴⁸ I first examine variation across

all 194 states, but since “0” includes states that never imposed barriers, I repeat the analysis after subsetting the data to just the 44 countries that imposed barriers (see Table 4).

ANALYSIS AND RESULTS

The Vast Majority of States Imposed Barriers After WHO's Declaration

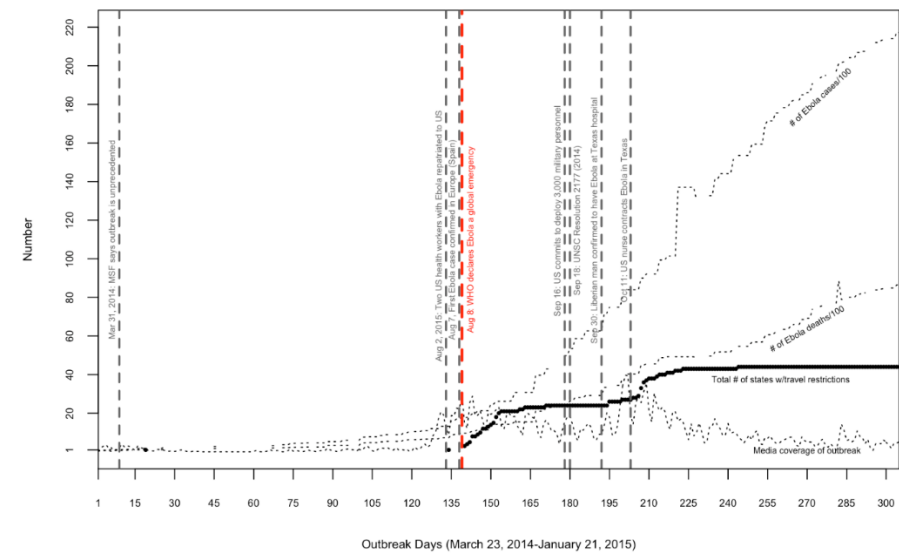
Figure 1 plots the number of Ebola cases and fatalities, media coverage, and the cumulative number of countries with barriers in place each day of the outbreak, along with the date of WHO's declaration that Ebola constituted a PHEIC (August 8, 2014) and several other events that could be relevant to when countries imposed barriers:

- March 31, 2014: Doctors Without Borders/Médecins Sans Frontières (MSF) warned of an “unprecedented epidemic.”⁴⁹
- August 2, 2014: Two US health workers with Ebola repatriated from Liberia.⁵⁰
- August 7, 2014: First Ebola case confirmed in continental Europe (Spain).⁵¹
- September 16, 2014: United States commits to deploy 3,000 military personnel.⁵²
- September 18, 2014: United Nations Security Council (UNSC) calls the outbreak “a threat to international peace and security.”⁵³
- September 30, 2014: Liberian man confirmed to have Ebola at a Texas hospital.⁵⁴
- October 11, 2014: First documented case of local transmission of Ebola in the US.⁵⁵

The figure illustrates several key points. First, as expected, the vast majority of states imposed barriers after WHO's August 8 declaration that Ebola constituted a PHEIC. Only two states imposed barriers before the declaration—Bahrain on August 4 and Gambia on April 10. In Gambia's case, the April 10 order to airlines to cancel flights from Guinea, Liberia, and Sierra Leone was removed on May 14. Then, after the PHEIC was underway, on September 3, the Gambian government banned entry of travelers coming from Ebola-affected countries.⁵⁶ The 42 other countries that imposed barriers began doing so on August 9, the day after WHO's PHEIC declaration. And, almost half of the countries that ended up imposing barriers did so in the two weeks following the declaration. More compelling is that the imposition of barriers does not appear to track with the severity of the outbreak. For one thing, many public health experts, including MSF as early as March 31, 2014, argued that the outbreak had reached crisis levels weeks, if not months, before WHO's declaration.⁵⁷ Moreover, the figure shows that about 90 days after WHO's declaration, no additional countries imposed barriers in spite of the outbreak's growing severity (measured in cases and fatalities).

Further, the figure suggests that several other events that might have increased perceptions of a growing threat of global spread, especially among high-income countries, do not account for why most countries began imposing barriers on August 9. The repatriation of US health workers from Liberia occurred on August 2, and yet most countries only began imposing barriers the day after WHO's declaration on August 9. The first case was confirmed in continental Europe on August 7; even though that is only the day before WHO's declaration, the meetings at WHO to make the declaration were already underway on August 6, before the case was confirmed in Spain.⁵⁸ The US commitment to deploy 3,000 military personnel on September 16 and the September 18 statement by the UNSC occurred during a lull in the imposition of barriers. And, the confirmation at a Texas hospital that a Liberian man indeed had Ebola occurred on September 30 with the first local transmission of the disease to one of his nurses on October 11, after most states that would eventually impose barriers had already done so.

Figure 1. Mapping the Ebola outbreak



However, there looks to be a second wave of states imposing barriers during the week of October 12, over two months after WHO’s declaration. This second wave still does not seem to track with outbreak severity. It does begin right after local transmission in the US and seems to correspond with an uptick in media coverage of the outbreak as well. This second wave suggests that, even if WHO’s declaration is one event that leads states to impose barriers, not surprisingly, it may not be the *only* event that could prompt this behavior. For example, other events like local transmission in the US, the introduction of screening for Ebola at US airports (which also began October 11), and increased media coverage of these events could heighten threat perception among certain countries and lead more states to impose barriers. However, Figure 1 suggests that the PHEIC declaration may be one of the events provoking barriers. Further, whatever the initial impetus, the IHR are clearly not playing the desired role of discouraging states from imposing barriers.

This descriptive data provides initial support to the argument that WHO’s declaration prompted some states to impose barriers. Of course, this figure alone cannot tell us that the likelihood of imposing barriers was not related to the severity of the outbreak or to the extent of media coverage. And, the figure alone cannot show that heightened fear of disease spread among high-income states did not influence both WHO’s declaration *and* the imposition of barriers that followed. As such, the next two subsections provide additional evidence.

More States Imposed Barriers in the Weeks Following the Declaration, Even Controlling for Outbreak Severity and Media Attention

Table 2 displays the results of six negative binomial models where the dependent variable is the number of states that begin imposing barriers each day of the outbreak. Model 1 examines whether more states imposed barriers in the first week after WHO’s declaration than at other times; Model 2 examines whether more states imposed barriers in the second week after WHO’s declaration; and, Model 3 examines whether more states imposed barriers in the first two weeks after WHO’s declaration. All three models control for the

number of Ebola fatalities. Models 4-6 include the number of Ebola cases in place of fatalities.⁵⁹

Together, Models 1-6 show that the two weeks after WHO's declaration are associated with a higher number of countries imposing barriers than other times during the outbreak, either before or after the declaration. Holding the number of Ebola cases constant, the two weeks after the declaration are associated with 1.29 more countries imposing barriers per day than other times during the outbreak (based on Model 6, $p < .05$). Importantly, neither the number of Ebola cases, nor the number of fatalities is significantly associated with the number of countries imposing barriers each day (it is worth noting that there is also no bivariate relationship between either the number of cases or fatalities and the number of states imposing barriers each day).

Table 2. Negative binomial models explaining the number of states imposing excessive measures each day of the outbreak (March 23, 2014-January 21, 2015)

	(1)	(2)	(3)	(4)	(5)	(6)
Deaths	0.001 (0.01)	0.002 (0.01)	0.01 (0.01)			
Cases				-0.002 (0.003)	-0.002 (0.003)	0.001 (0.003)
Week One	2.01** (0.69)			1.88** (0.69)		
Week Two		2.29*** (0.61)			2.19*** (0.60)	
Week One or Two			2.59*** (0.41)			2.44*** (0.40)
Observations	235	235	235	235	235	235

Note: · $p < 0.1$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$
Standard errors in parentheses

What about the role of media coverage? Models 7-12 in Table 3 are the models from Table 2, this time controlling for media coverage (and employing a Poisson model). Not surprisingly, more media coverage is significantly associated with the number of barriers imposed each day. However, even controlling for media coverage, the two weeks after WHO's declaration are associated with a higher number of countries imposing barriers than other times. Outbreak severity is still not positively associated with barriers. It is worth noting that controlling for media coverage actually poses a hard test for the argument presented here. Media coverage could be operating through several different channels. Possibilities include increasing fear among populations that then pressure governments to act, or directly heightening fear among policymakers. Alternatively, the extent of media coverage could be a reflection of some other process. One likely possibility is that media coverage is a mechanism through which the PHEIC declaration influences the number of countries imposing barriers. Thus, that the two weeks following the PHEIC are still

significantly associated with the number of countries imposing barriers per day, independent of media coverage, provides compelling evidence that the PHEIC may have been a trigger.

Table 3. Poisson models explaining the number of states imposing excessive measures each day of the outbreak (March 23, 2014-January 21, 2015), controlling for media coverage.

	(7)	(8)	(9)	(10)	(11)	(12)
Deaths	-0.01 (0.01)	-0.01 (0.01)	0.01 (0.01)			
Cases				-0.005 (0.004)	-0.004 (0.004)	0.0002 (0.004)
Week One	0.88* (0.44)			0.83* (0.43)		
Week Two		1.51*** (0.39)			1.46*** (0.39)	
Week One or Two			1.72*** (0.40)			1.59*** (0.37)
Media Coverage	0.12*** (0.02)	0.12*** (0.02)	0.11*** (0.02)	0.12*** (0.01)	0.12*** (0.02)	0.12*** (0.02)
Observations	235	235	235	235	235	235
<i>Note:</i> · p<0.1; *p<0.05; **p<0.01; ***p<0.001 Standard errors in parentheses						

These results illustrate that the time period immediately following WHO’s declaration is significantly associated with a higher number of countries imposing barriers, even controlling for outbreak severity and media coverage. However, we might still wonder whether some other country-specific factors explain whether states imposed barriers during this two-week period. In particular, if high-income countries are more likely to impose barriers during the two weeks following WHO’s declaration, then the relationship we see between the declaration and the number of barriers may be spurious and could instead be driven by increased fear of disease spread among high-income countries. This increased fear may be unrelated to the PHEIC declaration, or, as suggested above, could have played a role in WHO declaring a PHEIC to begin with.

Country Characteristics Played a Limited Role

Table 4 presents the results from two logit models, where the dependent variable is whether each state imposed barriers during the two weeks after WHO’s declaration. Model 13 includes all 194 states in the analysis. Model 14 includes just states that ended up imposing barriers. Both models show that domestic factors are not associated with whether states imposed barriers in the two weeks after the WHO declaration. Perhaps most importantly, higher income is not associated with behavior. This null finding casts doubt on the possibility that strong states became worried about disease spread at the beginning of August and that this explains both WHO’s declaration *and* subsequent state imposition of

barriers. Even if high-income member states influenced the timing of WHO's declaration, this did not lead those same countries to impose excessive measures. These results add support to the contention that WHO's declaration sparked the imposition of barriers by some states. The only factor significantly associated with imposing barriers in the first two weeks is whether a state is located in the UN Africa region. Further exploration is needed into *why* countries within Africa were more likely than those in other regions to impose barriers. The point here is that the PHEIC declaration may have convinced those states in Africa considering a travel ban to go ahead and impose one.

Table 4. Logit models explaining whether states imposed excessive measures in the two weeks following WHO's declaration

	(13)	(14)
ln(GDP per capita)	0.21 (0.32)	−0.76 (0.50)
ln(GDP)	0.003 (0.22)	0.62 (0.47)
Democracy	0.10 (0.07)	0.06 (0.13)
Health Spending (% GDP)	−0.07 (0.14)	0.29 (0.34)
Africa Region	4.24*** (1.09)	5.45** (2.04)
H1N1 Barriers	1.34 (0.87)	2.71 (1.79)
Observations	151	34
<i>Note:</i> · p<0.1; *p<0.05; **p<0.01; ***p<0.001 Standard errors in parentheses		

DISCUSSION

The empirical analysis provides support for the argument presented here—that WHO's declaration of a PHEIC can provoke the imposition of excessive barriers. However, there are likely multiple events that could similarly “trigger” barriers, as well as several potential mechanisms through which the PHEIC declaration could be influencing state behavior. I address both of these points in what follows.⁶⁰

First, WHO's declaration of a PHEIC is likely not the *only* event that could lead states to start imposing barriers. Before WHO gained the PHEIC declaration power in 2005, states imposed barriers in response to outbreaks—that behavior was one reason for the 2005 revision. During the 2014 Ebola outbreak, factors other than the PHEIC declaration led Bahrain and Gambia to impose excessive measures since both did so before the declaration was made. Further, as suggested above, the second wave of states imposing barriers beginning the week of October 12 (see Figure 1) may have been a reaction to the first case of local transmission in the US and the introduction of increased screening at US airports.

Nonetheless, the analysis presented in the previous section suggests that in the case of the 2014 Ebola outbreak, the PHEIC declaration played a major role in motivating many states to start imposing barriers around August 9. To further demonstrate the unique nature of the two weeks following the PHEIC declaration, as a robustness check I examine whether any of the other 43 weeks of the outbreak period are significantly associated with the number of states imposing barriers. Only one other week was associated with an increase in the number of states imposing barriers—not surprisingly, it was the week of October 12 just mentioned above. The evidence suggests that the PHEIC declaration provoked barriers during the Ebola outbreak, even though it may not be the *only* event that could do so.

The second point worth noting here is that this analysis does not isolate the precise mechanism driving the relationship between the PHEIC declaration and states' imposition of barriers. There are several possibilities. Is the declaration influencing state behavior through its effect on media coverage of the outbreak, which in turn heightens levels of fear among populations or policymakers? And, is fear increasing among governments, populations, or both? Further, is the declaration operating through its influence on governments' domestic political calculations or through international pressures?

The focus of this article is not on *which* states end up imposing barriers. Existing research on the H1N1 outbreak shows that governments that anticipate harmful domestic political backlash for not “doing something” in the face of an outbreak were more likely than others to impose barriers, suggesting that the PHEIC declaration may be operating through domestic channels.⁶¹ However, it could also be that the PHEIC declaration led a few “first mover” states to impose barriers and then through a process of policy diffusion led other peer states to impose barriers as well. There is limited evidence of this in the case of the H1N1 outbreak, but there is some evidence of regional effects in the case of Ebola.⁶² The argument in this article is that the PHEIC declaration can help to explain *when* many states will begin imposing barriers—this point is compatible with several potential explanations for *which* states those will be.

Perhaps the most important potential alternative explanation to the one presented here is that other co-occurring events with the August 8 PHEIC declaration might have led so many states to impose barriers around that time. I have tried to account for some of the most significant of these possibilities—outbreak severity and media coverage—by controlling for them in the analysis. I also address the possibility that powerful states both led WHO to make the declaration when it did and also then were the ones to impose barriers soon afterwards by showing that high income-countries were not more likely than others to impose barriers in the two weeks following the PHEIC declaration. Future work should enrich the analysis presented here by focusing on in-depth qualitative research into government decision-making during this period to hone in on the particular mechanisms at work.

CONCLUSION AND OPTIONS FOR REFORM

States' imposition of overly restrictive trade and travel barriers is a longstanding issue dating back to the International Sanitary Conventions of the 1800s and most recently put on display during the 2014 Ebola outbreak. The three part analysis presented in this article provides compelling evidence that WHO's declaration of a PHEIC can provoke trade and travel barriers. Drawing on theories of institutional design, I argue that this is because the IHR have not sufficiently raised the costs of imposing excessive measures to address the cooperation problem driving the behavior of some states. These costs remain low due to both states' unwillingness to design more effective IHR when it comes to excessive measures and WHO's own reluctance to exercise the naming and shaming power it does have (though, as noted, there are some very good reasons for this from WHO's perspective). As a result, WHO's authority to declare a PHEIC enables it to send a very clear signal that a serious

outbreak is underway while the costs states face for imposing measures that are more restrictive than WHO recommends remain low. As a result, WHO's expanded role under the revised IHR to notify states when a global health emergency is underway serves as a signal to some states to overreact.

Analysis of data from the 2014 Ebola outbreak supports this argument. Only two states imposed barriers before WHO's declaration. Further, more states imposed barriers during the first two weeks after the declaration than at any other time, even controlling for media coverage and outbreak severity. Importantly, outbreak severity is not significantly associated with the number of countries imposing barriers. Further, whether countries imposed barriers in the first two weeks was not driven by country-level characteristics that might have also caused WHO to make the declaration. The Ebola case suggests that a PHEIC declaration could have a similar effect during future outbreaks. If WHO is to successfully coordinate the international response to global health emergencies, it must be able to notify states about these events to spark an effective response while preventing overreaction; the findings presented here suggest that the IHR have not yet addressed this challenge.

In spite of this unintended relationship between declaring a PHEIC and barriers, it is worth noting that the IHR may have positively influenced the behavior of some states. As described above, the revised IHR are designed provide faster and better information to states about a wider range of health threats. States are now better informed than they used to be about when a serious outbreak with potential for cross-border spread is occurring and how they should respond. While there are likely a variety of reasons why some states follow WHO recommendations, this improved information might have convinced some states that they should not impose barriers because they realize doing so is self-defeating from the perspective of outbreak preparedness and response. Though over 40 countries imposed excessive barriers during both H1N1 and Ebola, this represents a minority of states; most states followed WHO guidelines.

So, WHO's declaration only provoked *some* countries to impose barriers. And, the argument presented above suggests that many states are imposing barriers for a particular reason—because they have time-inconsistent preferences driven by domestic or international pressures. Some states will continue to disregard WHO recommendations as long as the benefits of imposing overly restrictive trade and travel barriers outweigh the costs of doing so. As such, this cost-benefit analysis must be shifted in favor of following WHO recommendations.

As we look ahead to the election of the next director-general of WHO, what are the options for more effectively addressing the cooperation problem? In the wake of H1N1 and Ebola, many recommendations have been made for reforming WHO's role in outbreak response and several focus on the issue of excessive measures.⁶³ These include further empowering the WHO Secretariat to “request justification of these measures under the Regulations,” “examine options for sanctions for inappropriate and unjustified actions under the Regulations,”⁶⁴ and calling on WHO to “confront governments that implement trade and travel restrictions without scientific justification.”⁶⁵ Another suggestion is to “consider the possibility of an intermediate level [declaration] that would alert and engage the wider international community at an earlier stage” before a PHEIC is underway.⁶⁶

As others have pointed out, implementation of most of the recommendations made in the aftermath of Ebola is unlikely.⁶⁷ As noted above, during negotiations over revising the IHR, states were not willing to give “more teeth” to the commitment to follow WHO recommendations during outbreaks; there is little evidence that this has changed. And, WHO is not likely to start naming and shaming states without a change in the structural conditions that make the organization wary of criticizing its member states. In light of the findings presented here, the suggestion of an “intermediate” level alert that would signal an outbreak less serious than a PHEIC is not likely to stop states from overreacting. Any sort of declaration coming from WHO about a potentially serious outbreak may provoke some

states to impose barriers. And, even if this intermediate announcement did not provoke as many states to impose barriers as a PHEIC declaration, any time a PHEIC was declared—which, again, is when a coordinated international response is most needed—states would be likely to impose barriers in response.

Any reform that does not raise the costs of imposing excessive measures relative to the benefits is not likely to change state behavior on this count. And, these costs are likely to remain low as long as states are not invested in raising them. However, there are two ways that WHO itself might be able to shift this cost benefit analysis.

Raising the costs of imposing barriers is not the only way to shift states' cost benefit analysis. The other strategy would be to reduce the benefits of imposing barriers. A central benefit to governments is that barriers can provide them with political cover. If the outbreak ends up crossing the border and causing damage, the government is at least able to point to having tried to stop outbreak spread by imposing trade or travel barriers. But, this is only politically beneficial to governments if they think that the public believes that barriers protect from spread. As such, WHO could work to better communicate to populations during outbreaks, and at other times, that trade and travel barriers are not actually effective at stopping disease spread. Research shows that the public updates its perceptions about disease when exposed to new information; perhaps this applies to perceptions about which measures should be used to try to stop disease spread as well.⁶⁸

Given that most other proposals are unlikely to be implemented in the near future, promoting learning, though it is not a quick fix, could be particularly promising in the case of the IHR because it actually builds on WHO's role as an information provider. WHO already has the authority to provide information about what constitutes an effective response to a given outbreak. It needs to do a better job of showing populations, not just governments and leaders, that trade and travel barriers are not effective at stopping spread.

More consequential, however, would be the election of a director-general willing to hold states accountable. As many have pointed out, if WHO would only exercise its power to name and shame, the costs of imposing excessive barriers would increase. This is a tall (and unlikely) order, but the election of a director-general with political experience and pre-existing relationships with member state governments—which is what set Dr. Gro Harlem Brundtland apart and may have allowed her to criticize states at times—might make this possible. However, Dr. Brundtland is an exception among WHO directors-general and there are reasons why member states tend not to elect those that might be more willing to call them out for bad behavior.⁶⁹ However, whoever fills the director-general role next has the potential to shape the future of the IHR and WHO's role in outbreak response.⁷⁰ If the costs of imposing excessive measures do not increase relative to the benefits, then WHO's power to declare a PHEIC will continue to provoke barriers and actually undermine outbreak response.

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- ¹⁵Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900* (Cambridge, U.K.: Cambridge University Press, 2000), 39; Francesco Carelli, "Miasmatists and Health Reforms," *London Journal of Primary Care* 4, no. 2 (2012): 148–49.
- ¹⁶World Health Organization, *The First Ten Years of the World Health Organization*; see also Richard Cooper, "International Cooperation in Public Health as a Prologue to Macroeconomic Cooperation," in *Can Nations Agree?: Issues in International Economic Cooperation* (Washington, DC: Brookings Institution Press, 1989).
- ¹⁷World Health Organization, *International Sanitary Regulations* (Geneva, Switzerland, 1951).
- ¹⁸*Ibid.*, Article 23.
- ¹⁹This provision was only ever used one time when Turkey charged Bulgaria and Romania with unnecessarily restricting Turkish goods during a cholera outbreak in 1970. Turkey referred the case to the director-general, and it was resolved by the Committee on International Surveillance of Communicable Diseases (formally the Committee on International Quarantine). See, World Health Organization, "The Sixteenth Report of the Committee on International Surveillance of

- Communicable Diseases," 1971, 30, WHO /IQ/70.152. Though the provision was only formally used once, WHO was often informally involved in settling disputes. See, World Health Organization, "Official Records of the World Health Organization, No. 9: Report of the Interim Commission to the First World Health Assembly, Part 1: Activities" (Geneva, Switzerland, 1948), 36.
- ²⁰ World Health Organization, "The Fourteenth Report of the Committee on International Quarantine, Volume II: Special Review of the International Sanitary Regulations," 1967, 6, WHO/IQ/67.147; World Health Organization, "Official Records of the World Health Organization, No. 172: The Work of WHO 1968" (Geneva, Switzerland, 1969), 9.
- ²¹ Barbara von Tigerstrom, "The Revised International Health Regulations and Restraint of National Health Measures," *Health Law Journal* 13 (2005): 35.
- ²² See, for example, Fidler and Gostin, "The New International Health Regulations."
- ²³ Thomas C. Schelling, *The Strategy of Conflict* (Cambridge, MA: Harvard University Press, 1960); Kenneth W. Abbott and Duncan Snidal, "Hard and Soft Law in International Governance," *International Organization* 54, no. 3 (2000): 421–456.
- ²⁴ Abbott and Snidal, "Hard and Soft Law in International Governance," 429.
- ²⁵ Worsnop, "Domestic Politics and the WHO's International Health Regulations."
- ²⁶ Kenneth W. Abbott and Duncan Snidal, "Why States Act Through Formal International Organizations," *Journal of Conflict Resolution* 42, no. 1 (1998): 3–32; Kenneth W. Abbott and Duncan Snidal, "Hard and Soft Law in International Governance," *International Organization* 54, no. 3 (2000): 421–456.
- ²⁷ Legalization has three components: delegation, precision, and obligation. The degree of delegation is the extent to which neutral third parties (either the institution itself or other actors) have been granted authority to create, interpret, implement, and/or enforce rules. Precision refers to whether institutional rules clearly and unambiguously lay out what is expected of states (or other actors) in a given circumstance, so narrowing "the scope for reasonable interpretation." Obligation refers to the extent to which states are bound by commitments to institutional rules. See Kenneth W. Abbott et al., "The Concept of Legalization," *International Organization* 54, no. 3 (2000): 412; See also Judith L. Goldstein and Lisa L. Martin, "Legalization, Trade Liberalization, and Domestic Politics: A Cautionary Note," *International Organization* 54, no. 3 (2000): 603.
- ²⁸ Robert Keohane, *After Hegemony: Cooperation and Discord in the World Political Economy* (Princeton: Princeton University Press, 1984); Beth A. Simmons and Zachary Elkins, "The Globalization of Liberalization: Policy Diffusion in the International Political Economy," *American Political Science Review* 98 (2004): 171–190.
- ²⁹ Judith Kelley, "Who Keeps International Commitments and Why? The International Criminal Court and Bilateral Nonsurrender Agreements," *American Political Science Review* 101, no. 3 (2007): 573–589; Xinyuan Dai, "The Conditional Nature of Democratic Compliance," *Journal of Conflict Resolution* 50, no. 5 (2006): 690–713; Xinyuan Dai, "Why Comply? The Domestic Constituency Mechanism," *International Organization* 59, no. 2 (2005): 363–398.
- ³⁰ Abbott and Snidal, "Hard and Soft Law in International Governance," 434; See also, Jana Von Stein, "Do Treaties Constrain or Screen? Selection Bias and Treaty Compliance," *American Political Science Review* 99, no. 4 (2005): 611–22.
- ³¹ Worsnop, "Domestic Politics and the WHO's International Health Regulations"; Kamradt-Scott, "WHO's to Blame?," 411.
- ³² Kamradt-Scott, "WHO's to Blame?"
- ³³ See, for example, US Department of State, "Demarche Request: Urge Posts to Remove Trade Bans on Pork due to H1N1 Fears" (WikiLeaks. WikiLeaks cable: 09STATE44254_a, April 30, 2009), https://search.wikileaks.org/plusd/cables/09STATE44254_a.html.
- ³⁴ Abbott and Snidal, "Hard and Soft Law in International Governance," 429.
- ³⁵ Catherine Z. Worsnop, "The Politics of Outbreak Response: The Causes and Consequences of Revising the WHO's International Health Regulations" (Ph.D. dissertation, Brandeis University, 2016).
- ³⁶ Sara E. Davies, Adam Kamradt-Scott, and Simon Rushton, *Disease Diplomacy: International Norms and Global Health* (Baltimore: Johns Hopkins University Press, 2015); Adam Kamradt-Scott, *Managing Global Health Security: The World Health Organization and Disease Outbreak Control* (New York: Palgrave Macmillan, 2015).
- ³⁷ In contrast, this would be harder to do with the case of the 2009 H1N1 pandemic since WHO declared that outbreak a PHEIC very soon after the first cases were reported.

³⁸ A full discussion of data and methods, including descriptive statistics and robustness checks, is in the appendix, which is available upon request from the author.

³⁹ Case and fatality data from HealthMap, "2014 Ebola Outbreaks," 2016, <https://www.healthmap.org/ebola/>; to capture the level of media coverage on the outbreak, I include the number of articles with headlines including the term "Ebola" published in major world publications (newspapers, magazines, and trade publications) according to LexisNexis Academic. The number of articles is not a perfect measure of media attention. We might, for example, also be interested in the substance of media coverage. However, the substance of media coverage likely varies across countries. Because the analysis is looking at the total number of countries that impose barriers each day, rather than variation across countries, the media coverage variable needs to be a system level variable that is constant across countries. The number of articles gets at the overall level of media attention. Variation in the substance of media coverage across countries could certainly be important to look at in further research on which countries end up imposing barriers. Others have used publications as a measure of media attention and their work also highlights that substance likely varies across countries. See, Tara Kirk Sell et al., "Media Messages and Perception of Risk for Ebola Virus Infection, United States," *Emerging Infectious Diseases* 23, no. 1 (2017): 108; Corey H Basch, Charles E Basch, and Irwin Redlener, "Coverage of the Ebola Virus Disease Epidemic in Three Widely Circulated United States Newspapers: Implications for Preparedness and Prevention," *Health Promotion Perspectives* 4, no. 2 (December 30, 2014): 247–51, doi:10.5681/hpp.2014.032; Sam Smith and Stella Smith, "Media Coverage of the Ebola Virus Disease in Four Widely Circulated Nigerian Newspapers: Lessons from Nigeria," *Health Promotion Perspectives* 6, no. 2 (June 11, 2016): 92–95, doi:10.15171/hpp.2016.16.

⁴⁰ WHO has stated that 47 states imposed excessive barriers during Ebola. See, World Health Organization, "2014 Ebola Virus Disease Outbreak: Current Context and Challenges; Stopping the Epidemic; and Preparedness in Non-Affected Countries and Regions: Report by the Secretariat," May 15, 2015, Document Number: A68/24. But, according to personal email correspondence with the Director of the Secretariat for the Review of the International Health Regulations (IHR), the organization is not planning to make that list public.

⁴¹ World Health Organization, "Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa," August 8, 2014, <http://who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.

⁴² Other research counts over 50 states that imposed barriers. See, Wendy Rhymer and Rick Speare, "Countries' Response to WHO's Travel Recommendations during the 2013–2016 Ebola Outbreak," *Bulletin of the World Health Organization* 95, no. 1 (January 1, 2017): 10–17, doi:10.2471/BLT.16.171579. Differences in coding are explained by a different observation period as well as the fact that I do not include cases of only mandatory quarantine.

⁴³ World Health Organization, "Statement on the 4th Meeting of the IHR Emergency Committee Regarding the 2014 Ebola Outbreak in West Africa," *WHO*, January 21, 2015, <http://www.who.int/mediacentre/news/statements/2015/ebola-4th-ihc-meeting/en/>.

⁴⁴ I use the same observation period as above: the day WHO reported the first cases—March 23, 2014—and lasting 305 days through the day after the fourth meeting of the IHR Emergency Committee on Ebola—January 21, 2015. Findings are robust to different length observation periods.

⁴⁵ I use a negative binomial model where the data is overdispersed, and otherwise a Poisson model. See, Michael Smithson and Edgar C. Merkle, *Generalized Linear Models for Categorical and Continuous Limited Dependent Variables* (CRC Press, 2013); J. Scott Long, *Regression Models for Categorical and Limited Dependent Variables* (SAGE, 1997).

⁴⁶ These independent variables are not lagged in the analysis presented in the paper, but as a robustness check I lag cases, deaths, and media coverage by one day and the results are unchanged.

⁴⁷ This could have been done with a duration model, but logistic regression gets at what I am interested in more directly—variation in whether countries imposed barriers in the first two weeks—rather than which types of countries imposed barriers more quickly than others as in a duration model.

⁴⁸ To measure democracy, I use the Polity score from Monty G. Marshall, Keith Jaggers, and Ted Robert Gurr, *Polity IV Project: Political Regime Characteristics and Transitions, 1800–2012* (Center for Systemic Peace, 2014), <http://www.systemicpeace.org/inscr/p4manualv2012.pdf>; GDP, GDP per capita, and health spending data come from World Bank, "World Development Indicators," 2016, <http://data.worldbank.org/data-catalog/world-development-indicator>.

⁴⁹ "Guinea: Mobilisation against an Unprecedented Ebola Epidemic," *Médecins Sans Frontières (MSF) International*, accessed December 14, 2016, <http://www.msf.org/en/article/guinea-mobilisation-against-unprecedented-ebola-epidemic>.

⁵⁰ "How Many Ebola Patients Have Been Treated Outside of Africa?," *The New York Times*, July 31, 2014, <http://www.nytimes.com/interactive/2014/07/31/world/africa/ebola-virus-outbreak-qa.html>.

⁵¹ *Ibid.*

⁵² White House Office of the Press Secretary, "Fact Sheet: U.S. Response to the Ebola Epidemic in West Africa," *Whitehouse.gov*, September 16, 2014, <https://obamawhitehouse.archives.gov/the-press-office/2014/09/16/fact-sheet-us-response-ebola-epidemic-west-africa>.

⁵³ United Nations Security Council, "Resolution 2177 (2014)," accessed March 15, 2017, [https://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177%20\(2014\)](https://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177%20(2014)).

⁵⁴ "How Many Ebola Patients Have Been Treated Outside of Africa?"

⁵⁵ *Ibid.*

⁵⁶ US Department of State, "Security Message for U.S. Citizens: Banjul (Gambia), Entry Restrictions for The Gambia due to Ebola Virus Disease," September 5, 2014, <https://www.osac.gov/pages/ContentReportDetails.aspx?cid=16271>.

⁵⁷ Siedner and Kraemer, "The Global Response to the Ebola Fever Epidemic"; See also Daniel G. Bausch and Lara Schwarz, "Outbreak of Ebola Virus Disease in Guinea: Where Ecology Meets Economy," *PLOS Neglected Tropical Diseases* 8, no. 7 (July 31, 2014): e3056, doi:10.1371/journal.pntd.0003056.

⁵⁸ World Health Organization, "Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa."

⁵⁹ Note that I use listwise deletion for all regression analyses included in the main text, but as a robustness check I redo the analysis using multiple imputation to account for missingness. See Gary King et al., "Analyzing Incomplete Political Science Data: An Alternative Algorithm for Multiple Imputation," *American Political Science Review* 95, no. 1 (2001): 49–70.

⁶⁰ The author thanks the editors and two anonymous reviewers for helping to clarify these points.

⁶¹ Worsnop, "Domestic Politics and the WHO's International Health Regulations."

⁶² See Table 4 and also Worsnop, "The Politics of Outbreak Response," chap. 6.

⁶³ Suerie Moon et al., "Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola," *The Lancet* 386, no. 10009 (November 2015): 2204–21; World Health Organization, "Report of the Ebola Interim Assessment Panel"; World Health Organization, "Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009" (Geneva: World Health Organization, May 5, 2011), http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1.

⁶⁴ World Health Organization, "Report of the Ebola Interim Assessment Panel," 12.

⁶⁵ Moon et al., "Will Ebola Change the Game?," 1.

⁶⁶ World Health Organization, "Report of the Ebola Interim Assessment Panel," 6.

⁶⁷ Kamradt-Scott, "WHO's to Blame?," 411.

⁶⁸ Milan Brahmbhatt and Arindam Dutta, "On SARS Type Economic Effects during Infectious Disease Outbreaks," Policy Research Working Paper (Washington, DC: World Bank, 2008), <https://openknowledge.worldbank.com/handle/10986/6440>.

⁶⁹ Yanzhong Huang and Gabriella Meltzer, "Who Have Been the Best WHO Director-Generals?," *Council on Foreign Relations - The Internationalist*, November 25, 2016, <http://blogs.cfr.org/patrick/2016/11/25/who-have-been-the-best-who-director-generals/>.

⁷⁰ Others have pointed to how consequential Dr. Brundtland was for the IHR, see Adam Kamradt-Scott, "The WHO Secretariat, Norm Entrepreneurship and Global Disease Control," *Journal of International Organization Studies* 1, no. 1 (2010): 72–89.

Accountability, International Law, and the World Health Organization: A Need for Reform?

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INTRODUCTION

Recently the World Health Organization (henceforward WHO) has received significant criticism for its choice of action, as well as on occasion its inaction, with much of this criticism focusing on the role the Organization plays in coordinating the global response to potential pandemics.¹ While the merits of these criticisms are not the focus of this paper, the WHO's action, or delayed action in responding to global health emergencies raises a number of questions about its accountability for its actions. To that end, this paper examines accountability through the lens of the WHO's management of the recent Public Health Emergency of International Concern (PHEIC) regarding the outbreak of Ebola in West Africa. In doing so we consider the actions, or inactions, of the WHO during this outbreak along with the internal and external accountability mechanisms that the WHO currently employs in order to ensure oversight of its actions.

This paper argues that the Ebola pandemic has highlighted one of the major flaws in WHO governance: the lack of appropriate accountability mechanisms to address wrongful acts or omissions by the Organization when they occur. This paper also argues that the recent criticism regarding how the WHO has responded to and managed global health emergencies is exacerbated by the defects in the accountability mechanisms employed by the WHO. It further argues that the Guiding Principles which are set at the core of the WHO Accountability Framework are too limited in their remit, and the manner in which the Principles are implemented and operationalized by the WHO are also far too limited. In addition, while there has been some consideration of accountability in general terms by the WHO, with the creation of an explicit Accountability Framework, there remains a number of issues that limit the ability of the WHO to be effectively held to account. This paper concludes that the WHO needs to further develop its accountability mechanisms to strengthen the concept of accountability under the next Director-General, and suggest ways in which this could be achieved.

It is important to note at this stage that our focus in this paper is on WHO accountability as we consider the WHO to be an autonomous actor, beyond its Member States.² This concept of accountability requires the WHO to account to both its Member States and to the broader international community, and both aspects will be contemplated within this paper. Member State accountability may continue to arise but considerations of that are beyond the remit of this paper.

THE CONCEPT OF ACCOUNTABILITY

Accountability has a broad range of meanings, criteria and standards, and has recently expanded beyond its initial usage in the context of audits and accounts.³ It is now generally understood as the need to answer for action, or a failure to act, by an authority of some sort.⁴ Liberal democratic systems have long held concepts of accountability as fundamental to the exercise of power,⁵ and as the international system has evolved, greater discussions on the concept of accountability within the international legal system have emerged.⁶ The importance of accountability was seen with the International Law Association (ILA) undertaking a project on accountability where it determined that "as a matter of principle, [it] is linked to the authority and power of an [Organization]. Power entails accountability

that is the duty to account for its exercise",⁷ or for the purpose of this discussion, its lack of exercise.

At the most basic level accountability has developed to mean 'answerability' for actions, ensuring a check on power, and is seen as an important part of the identity of international institutions.⁸ However, whilst 'accountability' appears to be a straightforward concept, ensuring accountability is actually a multilayered, and multidimensional pursuit. To that end, numerous criteria for accountability can be identified, including: it is external; it involves social interaction and exchange; it implies rights of authority in that those calling for an account are asserting rights of superior authority over those who are accountable; including the rights to demand answers and to draw consequences of varying magnitude.⁹ To summarise, accountability provides 'internal and external scrutiny and monitoring irrespective of potential and subsequent liability and/or responsibility.'¹⁰ These ideas of accountability can also be found in the law of international organizations. One of the few definitive statements seeking to clarify the broad concept of accountability in respect of international organizations can be found in the International Law Association's report on accountability of international institutions from 2004. The report defined accountability as having three levels:

[First level] the extent to which international organizations, in the fulfillment of their functions as established in their constituent instruments, are and should be subject to, or should exercise, forms of internal and external scrutiny and monitoring, irrespective of potential and subsequent liability and/or responsibility;

[Second level] tortious liability for injurious consequences arising out of acts or omissions not involving a breach of any rule of international and/or institutional law (e.g. environmental damage as a result of lawful nuclear or space activities);

[Third level] responsibility arising out of acts or omissions which do constitute a breach of a rule of international and/or institutional law (e.g. violations of human rights, or humanitarian law, breach of contract, gross negligence, or as far as institutional law is concerned acts of organs which are *ultra vires* or violate the law of employment relations).¹¹

This paper is primarily concerned with the first two levels of this definition, as the third is related to the law of responsibility, and responsibility must be delimited from accountability with only the latter being the focus here. Responsibility is well understood in respect of international law - it is the legal consequences arising from non-compliance with an international legal obligation. Included within responsibility would be any legal sanctions or impositions of costs arising from such non-compliance. Whereas consequences arising from accountability are quite different - here we are referring to "an acceptable outcome arrived at through a procedure instigated by an aggrieved party and is intended to include....other means of redress which might be more appropriate to the circumstances of the case e.g. prospective changes of policy or practice by the [organization]."¹²

Returning to the ILAs definition of accountability the first level of the definition can be understood as having three main components: the concept of scrutiny, both internal and external; subsequent monitoring of actions; and, imposition of consequences. The first critique to consider in relation to accountability and the WHO is that there does not exist any external body ensuring oversight. While this is perhaps the ideal when considering the above conceptions of accountability, it is entirely absent here. A potentially more positive aspect, however, is that there is recognition by the Organization of the need to include accountability within its institutional framework, with the development of a standalone Accountability Framework. This may be an internal mechanism, but the recognition of the

need for this should be given some credence. In spite of this positive recognition, however, the particular approach taken towards accountability by the WHO is a difficult one that does not completely correlate with the generally accepted approach of accountability by international organizations, which is intended to have answerability at its core. Not only that, but the initial focus entirely bypasses the concept of *institutional* accountability. As part of the Framework, the WHO states that accountability is the:

obligation of every member of the Organization to be answerable for his/her actions and decisions, and to accept responsibility for them. Accountability includes achieving objectives and results in response to mandates and in accordance to the General Programme of Work and Programme Budget, fair and accurate reporting on programme performance, stewardship of funds, and all aspects of performance in accordance with regulations, rules and standards, to its stakeholders in a timely and transparent manner.¹³

This shows a limited approach to accountability; its initial focus is upon staff members being accountable to the organization. This is a rather precise focus of accountability. Furthermore, as we outline below, other specific accountability mechanisms within the WHO focus upon Member States reporting to the organization. The focus appears to be not accountability *of* the organization but accountability *to* the organization.

By not addressing institutional accountability, this approach effectively weakens any further attempts at ensuring the accountability of WHO as a multilateral institution, let alone an autonomously acting organization. Through this the WHO is effectively placing itself as an organization that *holds to account*, rather than being one that is *held to account*. This State-centric approach to accountability is most likely borne out of the fact that international organizations are traditionally seen as mere collections of states, as opposed to an autonomously acting organization in and of themselves. However, this is not reflective of the organization that the WHO has evolved into; it has developed to exist in a fashion that is distinct and autonomous of its members. As stated above, we are examining accountability of the WHO as an autonomous actor in its own right, rather than through the lens of its Member States, as the WHO can be said to be in possession of legal personality and existing in a manner that is 'more than the sum of its parts.'¹⁴ While there is no explicit recognition of legal personality on the part of the WHO, its ability to conclude international agreements, pass distinct legal acts as well as its institutional framework including distinct legal actors are such powers that could only be explained by the WHO possessing legal personality and a degree of autonomy apart from its member States.¹⁵

Even when considering the approach the WHO takes to accountability in light of the institution itself, there are substantial limitations in the interpretation of accountability. Answerability as a central idea of accountability is addressed within this definition, but it is interesting that this concept continues to be explicitly addressed to the members of the organization, rather than on the organization itself. When considering the WHO and organizational accountability, the focus is a much more particular one that considers aspects such as general reporting on performance, and following preset rules and objectives. Such an approach can be conceived of in terms of good governance and the internal workings of the institution. However, these general concepts of accountability, while positive, are far too broad, and not reflective of what accountability has come to mean more recently; there is a lack of focused and precise mechanisms and no concept of consequence for actions. This can be seen when considering the Guiding Principles that the WHO developed to underpin accountability within the organization:

- a) *Mutual accountability and clarity of organizational responsibility*
- b) *Alignment of strategic direction and results with accountability*

- c) *Individual and collective commitment*
- d) *Highest standards of personal integrity*
- e) *Transparency*
- f) *Balanced expectations and capacity*
- g) *Continuous monitoring and learning*⁶

While the existence of the Framework is positive and the inclusion of a set of principles, such as these, shows a willingness to engage with accountability, even at an institutional level, these principles only serve to demonstrate the WHO's limited approach. In particular, the key concepts of accountability, which were outlined above, are all missing from the Guiding Principles. It is bizarre that the Guiding Principles for Accountability of a complex, multi-layered institution, such as the WHO, does not include answerability, external scrutiny, or consequences for actions. The focus is instead on much more internal institutional concepts of strategic direction, integrity, and continuous monitoring and learning. As a result, the manner in which the WHO interprets and engages with organizational accountability is particularly limited, and fails to reflect the broader principles associated with accountability at the international level. This limited approach means that there are minimal, or no, consequences for the WHO in respect of its actions or inactions. This can be seen most prominently when looking at the manner in which the Guiding Principles are operationalized, which has mainly been through *internal* scrutiny mechanisms, as opposed to the external mechanisms typically associated with accountability. Moreover, the internal mechanisms are largely approached in specific, quite limited scenarios.

There are, for example, accountability frameworks addressing different policy areas, such as the Global Strategy on Women's and Children's Health.¹⁷ In this regard the WHO has created the Commission on Information and Accountability for Women's and Children's Health (Accountability Commission) to examine the most effective ways of reporting, oversight and accountability in the areas of women's and children's health.¹⁸ One of the Commission's recommendations was the creation of an independent Expert Review Group (iERG), which was established in September 2011. The iERG provides an annual report on progress, results and resources on the recommendations of the Accountability Commission.¹⁹ This is an interesting development, it shows recognition by the WHO of the need to integrate accountability into areas of policy, and have it as an integral part of any action that they take.

This recognition is limited, however. When considering the particular reports of the iERG, it is clear that they have a very precise remit in relation to this particular policy area. The focus of the group is one of assessing compliance and implementation of strategy and recommendations, as well as identifying good practice and obstacles to delivery of targets, to improve transparency and to make recommendations. This remit is one that is particular to Women's and Children's Health, and the iERG cannot examine accountability in respect of any other operational remit. Despite this, through both the iERG and other policy-specific accountability mechanisms, such the Global Vaccine Action Plan,²⁰ we again see the WHO's state-centric approach to accountability with WHO acting as an entity that holds others to account, as opposed to one which is held to account by others. To move from a scenario whereby the WHO holds others to account, to one where the Organization itself is held to account by external agencies will require a radical shift in focus at the Organization. The new Director-General has a prime opportunity to begin this shift.

There do also exist some limited mechanisms that apply in a more overarching fashion at the WHO. For example, the Office of Internal Audit and Oversight (IAO), which focuses on internal audit, inspection, monitoring and evaluation of finances. While this shows a degree of integrated accountability, as all systems, processes, operations, functions and activities within the Organization are subject to IAO's review, evaluation, and oversight, the

remit of this body is very narrow - focusing solely on auditing and finance management. There is also the Office of Compliance, Risk Management and Ethics (CRE) which has a rather vague objective of "the pursuit of excellence at all levels of the WHO in an effective, efficient, transparent and accountable way".²¹ While at first glance this may appear to be an overarching, holistic approach to accountability, in reality the role of the CRE is limited to financial, procurement and business strategy.²² The WHO has also showed some approach towards external accountability with its External Auditor and Independent Expert Advisory Oversight Committee (EAIOC). These bodies are, again, however, largely focused on financial management.

While it is positive that the WHO has incorporated concepts of accountability within its structures, both through the overarching Accountability Framework, and through more specific mechanisms, there remain a number of difficulties with the approach taken. The most substantial of these is the limited focus that the overarching approach and concept of accountability has at the WHO, as well as the very limited approach of the specific mechanisms that exist to ensure the accountability of the organization. As noted above, the WHO has chosen to operationalize 'accountability' through a range of specific internal measures addressing specific areas, such as women's and children's health or financial management. While developing some sort of internal mechanism is positive, this does not allow for a comprehensive approach to accountability, which would include the accountability of the organization as a whole with a focus on answerability, external scrutiny, and, consequences for actions. Instead, the WHO has focused on having reporting measures in place for Member States or particular areas of policy under the guise of 'accountability', without ever truly engaging with organizational accountability.

It would appear that the interpretation of accountability taken by the WHO is one that considers low-level implementation of policies, rather than the actions of the WHO as an institution. Indeed, in respect of accountability the WHO approach is often directed towards human resources, financial control and compliance in country offices. In some instances the WHO does include wider accountability mechanisms to critique their own work, but only in respect of specific policy areas that have those accountability mechanisms built into them. This is despite the fact that the WHO Accountability Framework states that "[a]ccountability has always been embedded in the structure of WHO and its operational policies and procedures.delegated responsibility, authority and accountability exist in a decentralized environment at all levels of the Organization".²³

We contend that the WHO is substantially lacking an approach to accountability which is embedded in its structure, policies and produces, meaning that it fails to engage with the overall concept of accountability in a meaningful way. Within the WHO there is a continual attempt to push accountability mechanisms downwards, on to the Member States, or those charged by the Organization with delivering on a specific policy, and a lack of consideration of the concept of accountability at the organization level. In order for accountability to truly be considered an embedded principle as the Accountability Framework claims, it needs to be established within the institution as a whole. To this end, it has been noted that "a culture of accountability as a fundamental pillar of accountability" is currently missing from the frameworks of the WHO, as well as other UN bodies.²⁴ The Joint Inspection Unit of the United Nations System commented that

A culture of accountability is nascent in most United Nations system organizations and needs further efforts to reach maturity. Consistent application of discipline and awards are needed in addition to training and ownership; the United Nations system lacks a comprehensive system of motivation and sanctions. The system of sanctions is stronger than the system of motivation, awards and rewards. There is a need to develop a stronger system to ensure personal accountability. However the Inspector concluded that the culture will only reach full maturity when

*the senior managers set the tone at the top, bolstered with examples for all to see of holding themselves accountable.*²⁵

It is clear that the approach taken to accountability at the WHO is not sufficient to provide proper 'forms of internal and external scrutiny and monitoring, irrespective of potential and subsequent liability and/or responsibility' in line with the definition of accountability provided by the International Law Association. We therefore argue that it is pursuant upon the new Director-General to fundamentally reform the approach taken to accountability at the WHO, and the mechanisms which it uses to ensure accountability - in order to better align the WHO's Accountability Framework with established principles of accountability for international organizations. The pressing need for this reform is well demonstrated by a consideration of accountability in respect of the WHO's management of the recent Ebola outbreak in West Africa.

THE WHO, EBOLA AND A LACK OF ACCOUNTABILITY: GAPS IN THE FRAMEWORK?

The recent Ebola epidemic in West Africa began in Guinea during December 2013²⁶, and the WHO was officially notified of the outbreak on March 23, 2014.²⁷ The WHO did not declare the outbreak to be a 'public health emergency of international concern' (PHEIC) until August 8th that year²⁸; by which time there were 1,779 confirmed and suspected cases of Ebola, nearly a thousand of which were confirmed or suspected to have resulted in death.²⁹ This delay between the WHO being made aware of the epidemic and declaring it a PHEIC has been the subject of considerable criticism in the literature,³⁰ as well as in the Report of the Ebola Interim Assessment Panel commissioned by the WHO which stated that that 'significant and unjustifiable delays occurred in the declaration of a Public Health Emergency of International Concern'³¹ (PHEIC) by WHO.³² A number of accountability issues arise from the WHO and the Ebola outbreak, but the delay and inaction of the Director-General is one of the most considerable. In spite of the Director-General possessing expansive powers in respect of a PHEIC, this is an area within the WHO where there exists a gaping hole in accountability terms.

The Director-General is a substantial figure within the WHO, having responsibility as the head of the Secretariat, the technical and administrative organ of the WHO. As part of this the DG is the 'chief technical and administrative officer, [responsible for] the appointment of Secretariat staff, drafting of the programme budget'.³³ The DG has a crucial role to play in agenda setting for the work undertaken by the WHO, reporting to the Health Assembly on the technical, administrative and financial implications of all agenda items submitted to the Assembly prior to consideration. No proposal can be considered by the Assembly without a report from the DG except for cases of urgency.³⁴ As head of the Secretariat, accountability is particularly relevant to the DG, as RES/64/259, as adopted by the UN General Assembly noted "Accountability is the obligation of the Secretariat and its staff members to be answerable for all decisions made and actions taken by them, and to be responsible for honouring their commitments, without qualification or exception."³⁵ Despite this, it is concerning that, despite the significant power which the DG holds, there appear to be very few accountability mechanisms overseeing the work of the DG. While there is an 'accountability report' of the first term of Dr. Margaret Chan in her role as DG, this appears to have been drafted by the office of the DG, for the 2012 DG election, and does not appear to have been considered by any other body in the WHO for critique.³⁶ More concerning, is the fact despite the DG being a crucial figure in pandemic management, there are very few obligations upon the DG to account for their actions.

The role of the DG in the declaration of a PHEIC is one of the areas where the pressing need to reform the limited approach taken to accountability at the WHO can most readily be seen. The International Health Regulations (2005) provide that the Director-General has

the power to establish an Emergency Committee to advise the Director-General in determining whether a particular event constitutes a PHEIC, and also to advise on any recommendations to address the PHEIC.³⁷ Specifically, the Emergency Committee is to 'provide [the Director-General with] its views on'

- a) whether an event constitutes a public health emergency of international concern; b) the termination of a public health emergency of international concern; and c) the proposed issuance, modification, extension or termination of temporary recommendations.

Given that the DG has a significant role to play in the declaration and management of a PHEIC it is all the more concerning that there is a substantial lack of oversight of how the DG uses their powers; greater power ought to equate to greater accountability. This lack of oversight and accountability becomes particularly apparent when one considers that the DG is the sole entity that can convene and instruct an Emergency Committee, which is crucial to a PHEIC being declared. The potential for failings on the part of the DG, and therefore the need for accountability in this area, was especially pronounced during the Ebola outbreak. The late creation of the Committee by the DG led to the late declaration of the PHEIC in relation to Ebola, and these errors and delays should have precipitated some form of accountability for action. There ought to be an obligation to account for all actions within an institution and, furthermore, this obligation ought to be heightened when considering the poor exercise of authority. This is not presently the case - the DG appears to be fairly free to act with little oversight as to their actions.

Not only do concerns arise in general terms with the DG and their expansive authority, but the Ebola crisis gives further cause for concern in the inability of the WHO to engage and live up to its own Guiding Principles on accountability. There are, therefore, not only a lack of mechanisms, but the only concrete aspects that could be relied upon here in the Guiding Principles, are simply not followed.

The WHO's actions in relation to the Ebola outbreak show, most notably, a lack of '*mutual accountability and clarity of organizational responsibility*'. This principle is elaborated upon in the Accountability Framework as being 'individual Members, as well as other contributing partners, have distinct responsibilities for delivering on their respective obligations'³⁸. If we take the power of the DG to convene an Emergency Committee and declare a PHEIC as being a power that comes with a corresponding obligation or responsibility to convene an Emergency Committee and declare a PHEIC when it appears correct to do so, then clearly this Principle was not followed during the most recent Ebola outbreak. Internal emails and documents show that the WHO were well aware of the severity of the outbreak in West Africa, but resisted convening an Emergency Committee, which begins the process of declaring a PHEIC, for two months.³⁹

To that end, such inaction also calls into question the extent to which there was an '*Alignment of strategic direction and results with accountability*' which is elaborated upon as being the 'Strategic direction and priorities of the Organization are understood and managers are accountable for aligning the strategic direction and objectives, expected results and activities set for their areas of responsibility'. With the objective of the Organization being 'the attainment by all peoples of the highest possible level of health.'⁴⁰ It is difficult to align the actions of the WHO in intentionally delaying declaring Ebola a PHEIC in West Africa with this objective.

There was also a lack of *transparency* in the decision making process relating to the decision to declare Ebola a PHEIC, or not. This is evident by the fact that there was a significant disparity between the internal and external discussions about Ebola around June 2014. Internally senior staff at the WHO spoke of: the reported cases being "the tip of the iceberg"; the virus spread being worse than the data implied; unanswered pleas for support

from WHO staff on the ground in West Africa; and, the fact that internal discussions about convening an Emergency Committee was dismissed as “a hostile act”.⁴¹ In contrast, in external discussions with the media the WHO stated that: “WHO and partners are providing the necessary technical support to the Ministries of Health to stop community and health facility transmission of the virus”; “WHO does not recommend any travel or trade restrictions be applied to Guinea, Liberia, or Sierra Leone based on the current information available for this event”.⁴² The external communication from the WHO implied that the outbreak was under control, when internally it was quite clear that this was not the case.

Despite the fact that the WHO appears to have failed to meet the standards it set in the Accountability Framework in respect of accountability during the Ebola outbreak, very little consideration was given to accountability in the Report of the Ebola Interim Assessment Panel, which was commissioned by the WHO. The report is critical of the role of the WHO during the Ebola outbreak, as well as directly criticizing specific members of the Secretariat, including the DG for their role in delaying the declaration of a PHEIC

The declaration of a PHEIC can lead to disagreements with national governments, and the Panel notes that independent and courageous decision-making by the Director-General and the WHO Secretariat is necessary with respect to such a declaration. This was absent in the early months of the Ebola crisis.⁴³

The Report also notes that “[d]elivering an effective emergency response in countries requires significantly strengthened administrative and managerial structures. There must be transparency, accountability, and monitoring, especially for financial resources”.⁴⁴ A new WHO Centre for Health Emergency Preparedness and Response and the establishment of an independent Board to oversee the work of this new Centre is also proposed in the report.⁴⁵ While it is disappointing to again see such a narrow approach to accountability being taken by the WHO, the creation of such a Centre and Board would be a positive step in terms of accountability of the WHO during a public health emergency. It is therefore concerning to see that this proposition was not addressed in the WHO Secretariat’s response to the Report of the Ebola Interim Assessment Panel.⁴⁶ Instead, in the WHO Secretariat response report the Secretariat notes that they intend to ‘Improved functioning, transparency, effectiveness and efficiency of the International Health Regulations’ in order to ‘facilitate rapid and transparent decision-making and action, and a staffing and financing plan’⁴⁷ during major outbreaks and emergencies, but no further details regarding how this would be achieved are provided.

Despite the considerable criticism of both the work of the DG and the wider WHO in respect of Ebola, both of these internal reports from the WHO fail to adequately take accountability into consideration, and how it ought to be improved at the organizational level. This is particularly disappointing because weak accountability mechanisms lay at the heart of the weak response to Ebola – a point noted by the report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola.⁴⁸ The Harvard-LSHTM report is much clearer on the accountability failings at the WHO, and provides more robust recommendations for addressing these failings through an independent Accountability Commission for Disease Outbreak Prevention and Response in order to ‘institutionalise accountability’.⁴⁹ It is worth noting that the Harvard-LSHTM report recommends that the UN Secretary-General should create an Accountability Commission, which would report to the World Health Assembly and the Security Council’s Global Health Committee.⁵⁰

This is a laudable aim; the existence of an independent external body to ensure the scrutiny and oversight of numerous agencies of the UN would achieve a strong concept of accountability within the UN system, and would strengthen the external accountability mechanisms of the WHO which we highlighted as a weakness above. Had this been in place when the Ebola outbreak happened, it could be envisaged that more robust and honest reporting would have been ensured. Not only this, but with the prospect of such open reporting to an external body, it is not a great leap to consider that this may have internally

exerted some pressure in ensuring speedier action on the part of the WHO DG. This is the very core of accountability; ensuring the answerability of actions and, from this, seeking to better improve policy and action in light of these answers. The proposition of an independent external body is the pinnacle that would achieve this.

This is a proposition not without problems, however. While it appears to address accountability in a much more substantive manner than either of the two WHO commissioned reports, it does so specifically through the creation of an Accountability Commission with a limited remit – one specifically limited to disease outbreak and response. The WHO needs to adopt a much more holistic approach to accountability across the Organization in respect of all of its operations and actions, not merely the ones where accountability has been found to be most lacking, most recently. Moreover, the provision of an external body to which the WHO could be accountable would be the ideal scenario and would enable complete oversight. When considering the practicality of it, however, it is difficult to envisage how this proposal would be workable within the international system. There are financial difficulties and strains generally within the UN system, and so it is difficult to envisage where the funds would come from to create and operate a system such as this. In light of this the following section on reforms will propose pragmatic solutions. These are solutions which are substantially limited and do not follow the ‘ideal’ solution outlined above. They do, however, offer the first steps which could be taken by the WHO, on the path to the ideal.

REFORM OF ACCOUNTABILITY AT THE WHO

The next WHO Director-General should take two key approaches to strengthening accountability. The first is to return to the WHO’s Accountability Framework and to develop and strengthen the guiding principles contained within it. The second approach that needs to be addressed is to develop a far more comprehensive approach to accountability that develops mechanisms of accountability that address the institution as a whole, as well as mechanisms that address accountability of the DG, and Secretariat.

The difficulty with accountability and the WHO is one of a lack of comprehensive accountability; the WHO has recognised the need to engage with accountability within its institutional framework, which is positive. Its existence as one of only seven institutions within the United Nations framework as having a standalone accountability framework is encouraging. This needs to be returned to, however, and further work is required to rectify the limited approach to accountability currently taken within the Organization. The WHO needs to further develop its mechanisms to strengthen the concept of accountability under the next Director-General. The accountability gaps at the WHO, which were highlighted by the Organization response to Ebola should serve as a strong impetus for the next Director-General to reform accountability.

The question of how to approach the reform of accountability mechanisms within the WHO is far from straightforward. Despite the fact that this paper expressed some concerns as to the limited scope of the ‘Accountability Commission’, as developed by the Harvard-LSHTM Independent Panel on the Global Response to Ebola⁵¹, and the financial barriers to its implementation, it is nonetheless a good starting point to build from. It could perhaps be envisaged that a smaller scale version of such a body could be feasible. Rather than a permanently standing body with a very broad remit, an accountability body akin to the Emergency Committees set up for consideration of a PHEIC may be a more feasible option. This would enable external oversight and would ensure a degree of answerability from the Director-General and Secretariat, specifically in relation to their actions, or lack thereof during a PHEICs. However, such a mechanism in and of itself is open to the same criticism that this paper has target towards the WHO, in that it is limited to a particular mechanism

in a particular policy space; therefore it needs to be combined with a more holistic approach to accountability throughout the organization.

To this end, the existing Accountability Framework gives a basis from which to begin reform, but it does require development. There needs to be first and foremost a greater consideration of how these Principles, and the Accountability Framework more broadly, are operationalised within the WHO. An initial starting point would be to address the WHO's definition of accountability and the Guiding Principles it uses to clarify and operationalise the definition. The WHO needs to have more of an explicit recognition of the concept of answerability on the part of the institution. It shows some recognition of this in relation to Member States but the WHO's basic definition of accountability needs to be more explicit in the concept of the institution answering for its actions, as a standalone entity, rather than as the conduit through which its Member States act. This idea then needs to be manifested more explicitly in the Guiding Principles. When considering the issues surrounding Ebola, however, one of the difficulties was a failure to follow the Guiding Principles. Consequently, although these are important aspects to ensure reform, without considering the implementation mechanisms, any reform of Guiding Principles would simply be acknowledging the concept of accountability without engaging in any meaningful change.

While reform of the accountability system would be of great benefit to the WHO and the international system as a whole, this should be done in combination with development of the international law of responsibility to enable greater redress for wrongful acts when they occur. The law of responsibility begins to ensure legal consequences for breaches of international legal principles; when there is an internationally wrongful act, for which responsibility is incurred, there will be an obligation to make reparation.⁵² The law of responsibility therefore enables a legal form of accountability and legal action to be brought against a responsible actor.⁵³ As Hafner stated: "accountability seems to reflect primarily the need to attribute certain activities under international law to such actors as a precondition for imposing on them responsibility under international law."⁵⁴

As such, these two areas are intrinsically linked. Any reform of accountability must exist alongside developments in the law of responsibility to better address the actions of institutional frameworks. Responsibility has expanded beyond its origins as a law of state responsibility with the drafting of the Articles on the Responsibility of International Organizations (ARIO)⁵⁵. With the origins of these principles being so substantially in the area of state responsibility, there remain substantially limited in their potential application. While a detailed consideration of responsibility is beyond the scope of the current paper, the need for further work in this area ought to be borne in mind alongside reform of accountability; they are separate but intrinsically linked areas of law.

CONCLUSION

The WHO has shown, in a number of ways, a recognition of the importance of accountability. Its development of an Accountability Framework really ought not to be underplayed. Its existence shows an important recognition that accountability needs to be incorporated within the WHO's structures. In spite of this recognition, however, the WHO has created a substantially limited approach.

The delay and errors that became apparent with the Ebola outbreak only served to further expose the weaknesses in the WHO's approach to accountability, both internally in respect of its senior decisions makers, and externally as an organization. In spite of substantial issues in the way in which this pandemic was managed by the WHO as a whole, and the Director-General more specifically, there was no real capacity for the institution or the DG to be held to account for their failings. Given the substantial consequences that arose from the errors here, this is highly questionable.

It is imperative that the next Director-General revisits accountability as part of their tenure. A more comprehensive approach to accountability is needed, one that is based upon fully developed principles of accountability that address the concept of answerability at their core. The General Principles need substantial attention in order to address the issue of accountability. Not only do the Principles need attention, but there needs to be recognition of the need for a comprehensive approach to accountability mechanisms with the institution as a whole and also with the DG specifically. The existing approach of the WHO to develop specific mechanisms has resulted in mechanisms that exist in silos and that do not fully engage with the concept of institutional accountability as a whole. The development of accountability as a more comprehensive principle that sits at the core of the WHO, will allow the institution to develop a greater degree of integrity at the international level.

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¹ Lawrence O. Gostin and Eric Friedman, "Ebola: A Crisis in Global Health Leadership," *The Lancet* 384(2014): 1323-1325; Lawrence O. Gostin, "The Future of the World Health Organization: Lessons Learned from Ebola," *Milbank Quarterly* 93(2015): 475-479; Mark Siedner, Lawrence O. Gostin, Hilarie H. Cranmer, et al., "Strengthening the Detection of and Early Response to Public Health Emergencies: Lessons from the West African Ebola Epidemic," *PLOS Medicine* 12(2015) e1001804 <https://doi.org/10.1371/journal.pmed.1001804>; Alexander S. Kekulé, "Learning from Ebola Virus: How to Prevent Future Epidemics", *Viruses*, 7(2015): 3789-3797.

² See "The Concept of Accountability" for more details.

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Successful Governance Reform and Its Consequences: How the Historical Drive for Shorter Meetings and More Time Efficiency Reverberates in Contemporary World Health Assemblies

Julian Eckl

The paper argues the working methods of the World Health Assembly (WHA) have been a recurrent object of reform discussions and that the vision that WHAs should become shorter has been a constant driver for them. It shows also how the vision of shorter WHAs was turned into reality and to what extent the consequences of these past reforms still reverberate today. With a view to the current debates, the paper suggests contemporary WHAs cannot be understood without considering past practices, and that some present problems are the (un)intended consequence of previous reforms. The paper concludes that reform is an inherent element of WHO governance: this kind of “self-reflection” will continue to be a time-consuming assignment for decision-makers also after the seventieth anniversary of the organization.

INTRODUCTION

While the World Health Organization (WHO), its reform, and its place in global health governance enjoy intensive attention in scholarly debates,¹ the present article takes the experiences of practitioners including their continuous reform discussions as a point of departure and analyses the history of WHO-governance reform in this light. Such an inductive approach that starts with the lived realities of practitioners is common among ethnographers regardless of their specific disciplinary background.²

The article complements research that emphasises the value of disentangling apparently monolithic international organizations in order to explain specific outcomes. At the same time, its starting point differs from most other research since the disentangling is largely a consequence of methodology and was not primarily motivated by specific WHO-related expectations. In particular, the article starts neither from concerns over WHO fragmentation (as a consequence of regionalization and donor influence), nor from the principal-agent relationship between member states and WHO, nor from the structural conflicts among member states.³ Rather, it starts from ethnographic and ethnomethodological concerns with “lived order” and “political work” that foreground the fact that also prestigious work is earthly quotidian work where people have to overcome practical challenges and tend to achieve this in a systematic manner.⁴ In line with this reasoning, the article focuses on a specific aspect of WHO work, namely the multilateral governing of the WHO whose key site (or workplace) is presumably the World Health Assembly (WHA, or Assembly). The underlying analysis began with a visit to this central site but it led subsequently to an interest in the historical dimension of present practices and in the relationship of the WHA to other sites of WHO governance.

The role of the WHA as well as suggestions for its reform have been considered in the literature before, but the WHA's changing temporal organization and the consequences of these reforms have so far not been systematically analysed.⁵ The project from which the article emerged has a background in political science and its beginnings date back to 2010. Starting from the discussions on competing fora and overlapping competencies, the project was set up as a political ethnography in the course of which sites of global health governance are visited in order to study the way in which the practitioners themselves try to come to terms with the fragmented nature of the global health governance architecture.⁶ While this

underlying question plays an important sensitizing role, the project follows an open research design – as suggested by ethnographers and by proponents of grounded theory – that allows the researcher to investigate further those issues that emerge “on the way” rather than sticking to predefined questions that were derived from the existing scholarly literature.⁷ By the same token, the sites to be studied are selected incrementally – following a logic of holistic reconstruction and a logic of empirical comparison.⁸ For the purpose of the article, the project period from 2014 onwards is particularly relevant since the analysis of WHO-related sites started then.

As a consequence of the flexibility that open research designs allow for, it is common for the research process and focus to change in ethnographic studies. Following this and other traditions in ethnographic writing, the article will begin with a description of my first visit to a WHA and how this drew my attention to the issue of WHO reform, or, more specifically, WHA reform. The interest in reform, in turn, raised the question of how reform efforts previously emerged and correspondingly, the article then considers the history of WHA reform. The particular focus of the historical analysis will be on how temporal factors influenced – and importantly still influence – practitioner behaviour. The article then concludes with revisiting the contemporary concerns around WHO reform in light of the historical analysis, and considers some of the implications that arise.

From a methodological point of view, the article begins with material generated via participant observation before undertaking an analysis of historical documents, and then returns to insights gained from participant observation. In this way, the article illustrates the seamless complementarity of these two methods: participant observation generated questions that were then addressed through document analysis, and subsequently (re)embedded the findings from participant observation. The complementarity of these two methods is not particularly surprising from the perspective of disciplines that have long relied on ethnography, but scholars of political science and international relations might find this illustration useful since it emphasises that ethnography should not be reduced to participant observation.⁹ While each step in the research process leads to several follow-up questions, the article as a whole addresses the following closely interrelated questions: What characterises the temporal organisation of the WHA, how did it develop historically, and what consequences follow from it under contemporary conditions?¹⁰ The analysis will show that in spite of an increasing number of WHO member states and WHA agenda items, the WHAs have become progressively shorter. It will also reconstruct through which reforms this was made possible and what other consequences these reforms had. For example, it will conclude that the growing complexity and multi-sited nature of the WHA poses a challenge to in-depth discussions and blurs the roles and responsibilities of the delegates. The partial outsourcing of decisions to other formal bodies such as the Executive Board (EB) or to informal meetings has greatly transformed the role of the WHA within the WHO. Through an ethnographic focus on organizational practices, scholars can capture such subtle transformations and the contradictory and unintended outcomes of organizational reform.

FIRST IMPRESSIONS

The WHA is the WHO's supreme decision-making body and it was therefore an instinctive location to start an analysis of WHO-related sites of global health governance.¹¹ In preparing for my first visit to a WHA in 2014, I consulted the preliminary issue the *World Health Assembly Journal* in order to develop a sense of how the WHA was going to be organized on a day-to-day basis.¹² The information contained in the document was concise and straight forward but in the section 'Date, location and working hours' I was surprised to read that the working hours of the WHA were from 09:00 to 12:00 and from 14:30 to 17:30. Somewhat puzzled, I wondered whether six hours per day were really a sufficient amount of daily working hours and what happened outside of them. After all, how would people spend

their time during a lunch break that lasted for two and a half hours?

While the opening sections of the *Journal* had created the impression that the WHA was a leisurely environment, it did not take long to appreciate that the Assembly was much more complicated. Going through the subsequent section 'Tentative programme of work of the Health Assembly' it became clear that even during the official working hours there were parallel and overlapping meetings. For example, Committee A seemed to begin its work while the plenary meeting was still underway. Moreover, not all meetings would run the entire allocated time, and some meetings seemed to be prioritized since no other meetings were scheduled in parallel. My initial impression of the WHA was further undermined when I considered the sections 'Technical briefings' and 'Other meetings' where two things became clear. First, there had actually been preparatory meetings in the days leading up to the WHA and, second, there was going to be a multitude of meetings before 9:00, during the lunch break, and after 17:30. But this was just the beginning.

As I realized when actually attending the WHA, the *Journal* covered only those meetings that had been planned beforehand, that took place in the *Palais des nations* (or at WHO headquarters), and that were somewhat formalized. It did not cover the multitude of additional parallel meetings as well as side-events outside of the *Palais*. Moreover, the official working hours could be formally expanded by setting up evening sessions and also drafting meetings or other gatherings could run late into the night. Finally, on top of all this there would be countless informal meetings and conversations in the hallways, cafés, and restaurants. In short, even the complex account in the rear sections of the *Journal* provided only a partial overview of proceedings.

While I had for a moment feared that the WHA might consist of long breaks and uneventful sequences, it turned out to be a busy and bustling site where it was entirely possible to miss a key event by being at the wrong place at the wrong time. Instead of having to find activities to occupy my time over lunch, I found it increasingly difficult to eat at all. These time pressures only worsened the longer I attended the WHA, as I learned about more and more of the parallel processes. Towards the end of the WHA and even more so at the next WHA in 2015, I struggled to access formal meetings as there were either overlaps with side-events or I found myself remaining in hallways and social areas to talk with individual participants. These experiences revealed the WHA to be not just one, but multiple sites of governance.

In stark contrast to the usual bustle, the WHA concurrently gave the impression of a void ritual. While such moments were not limited to plenary meetings, it was in the Assembly Hall in particular where this emerged. First, while on the first day of the WHA and during some specific agenda items on subsequent days the Assembly Hall might be filled with delegates and spectators, for the majority of the time the room was less than half full. Moreover, a significant proportion of the work in the Assembly Hall appeared to have been pre-approved, as though decisions had been taken elsewhere previously. But even when an exchange of views was foreseen, there was still no real interaction or discussion. Rather, it was an endless array of speeches that had been written beforehand and read out by delegates who came to the rostrum one after the other. In such moments, the comment of an interlocutor who had claimed that the Assembly Hall was referred to as "the cage" by some delegates gained some plausibility. In other words, there were phases during which the setting was stilted and time seemed to stand still.

The fragmented nature of the WHA, the time pressure that the parallel processes put on delegations and on individual delegates as well as (their contrast to) the WHA's ritualized aspects are among the reasons for which there is also a constant debate among the practitioners on the need to reform the WHA in particular and the WHO in general. Actually, I found it striking to see how many of the participants engaged in discussions on the structure rather than on the content of the policy-making process. While the criticism of the participants varied strongly, for example, in its radicalness or in the degree to which

they considered the WHO as capable of reform, it became difficult to imagine that one could attend a WHA without facing some version of internal criticism. From this perspective, the most recent WHO reform process that emerged a few years ago had to be seen as a catalyst rather than the sole reason for such discussions.¹³

Through conversations with delegates as well as based on my own experiences at the WHA, I started to develop an interest in the question of how the relationship between the seemingly constant debates about reform and the present state of affairs had developed historically. There were two considerations in particular that arose my interest. First, it would have been strange if previous generations of participants had not reflected on their work in a similar manner since some of the enabling factors for such reflections had not changed. For example, the professional diplomats among the participants had also previously been assigned to Geneva for a time-limited period, which implied that, like now, there would have been a constant influx of novices who would not necessarily take everything for granted and would have to go through the same learning process I had experienced. Second, it occurred to me that some of my interlocutors expressed opinions that the governance processes could be improved along one specific dimension, namely, time efficiency. This one-dimensional take on the issue interpreted reform as a case of optimization where (political) trade-offs and unintended consequences are not necessarily considered. If past reforms had followed a similar line of thought, it appeared quite likely that some of the present problems with the WHA could be the (un)intended consequences of previous reforms.

LOOKING INTO THE PAST

These considerations made it apparent the synchronic account that was based on participant observation should be complemented with a diachronic element that needed a research design of its own while the field research could be continued (i.e. additional sites such as meetings of the Executive Board [EB], but also later WHAs were, visited). With a view to the newly added historical dimension, the following question had to be addressed in a first step: How should the past reforms be identified, and more specifically, how should the documents be identified that contain information on the substantive content of these past reforms as well as on the accompanying discussions? The sampling strategy that was eventually chosen could be called diachronic snowballing since it took changes to the rules of procedure of the WHA as a starting point for the identification of reform debates.

The idea behind this strategy was that, even though reform discussions will usually be broader than the eventual changes, some traces of previous discussions should still be found in amendments to the WHA rules of procedure. Once these had been identified via specific WHA resolutions, it should be possible to identify the WHA's at which reform discussions had occurred. Moreover, the additional resolutions, background documents (including EB documents), and discussions offered the prospect to cross-reference failed reform attempts. This sampling strategy seemed to be particularly apt for an ethnographic study of past reforms since it would be possible to identify changes in formal rules (i.e. amendments to the rules of procedure), and allow to understand past practices as described in resolutions, background documents, and accompanying discussions. This method of diachronic snowballing proved productive and I successfully located multiple documents.¹⁴

Facing this rich corpus of text, I narrowed the focus of my analysis to the temporal considerations that prompted this study: time and timing, which also included discussions surrounding time efficiency. From here, resolutions were given first priority while background documents such as verbatim and summary records were selectively consulted when other documents did not provide enough detail to understand the changes which had been made or the rationales behind them. Finally, falsificatory reading, which encourages the analyst to continuously search for evidence that refutes rather than confirms the

interpretation of a text, was applied when analysing the documents, thereby avoiding premature interpretations.

The rules of procedure as they can be found in the 48th edition of the *Handbook of Basic Documents* (2014) served as the starting point for the diachronic snowballing described above. While this sampling strategy worked as envisioned, a small adjustment was required due to the fact that WHA8 (1955) made such extensive amendments to the rules of procedure that eventually a completely new text was adopted and only the amendments to the WHA8 text are documented in contemporary editions of the *Handbook of Basic Documents*. As a result, the sampling strategy was adjusted to accommodate the fact that the pre-WHA8 text of the rules of procedure and any associated amendments had to be reconstructed from historical editions of the *Handbook of Basic Documents*.¹⁵

Following this new strategy, 42 resolutions were identified on the basis they amended either the rules of procedure that had been adopted at WHA1 (1948) or the revised rules of procedure adopted by WHA8. These 42 resolutions were passed at 32 different WHAs and there are only two phases during which no changes to the rules of procedure were made for more than three years in a row: 1989 to 1994 and 1998 to 2003. This shows that even if one relies on the very narrow indicator of “resolutions passed that changed the rules of procedure”, governance reform has been a constant feature of WHA history.¹⁶ At times this was also noted by the participants themselves and, for example, in 1979 the EB considered “that the method of work of the Health Assembly need not be reviewed every year, and that it would be desirable to have such a review undertaken only in the light of experienced [sic] gained over a period of several years”.¹⁷

TIME AND TIMING: FINDINGS FROM THE HISTORICAL DOCUMENTS

Drawing on the identified documents, time and timing emerged as a recurrent theme in the historical reform discussions. The duration and frequency of WHAs proved to be of particular concern. Somewhat confusingly, however, a number of the statements on the issue proved contradictory. On the one hand, some documents argued that measures should be taken to prevent the WHAs from becoming longer. These contrasted with other documents that argued the WHAs should be shortened. Reading these contradictory concerns, it became clear that a meaningful analysis of time and timing could not be conducted without understanding how the duration of the WHAs developed historically. Such knowledge would be particularly relevant in order to judge whether the goals of the reforms were achieved, namely whether member states had succeeded in reducing, maintaining, or extending the duration of WHAs.

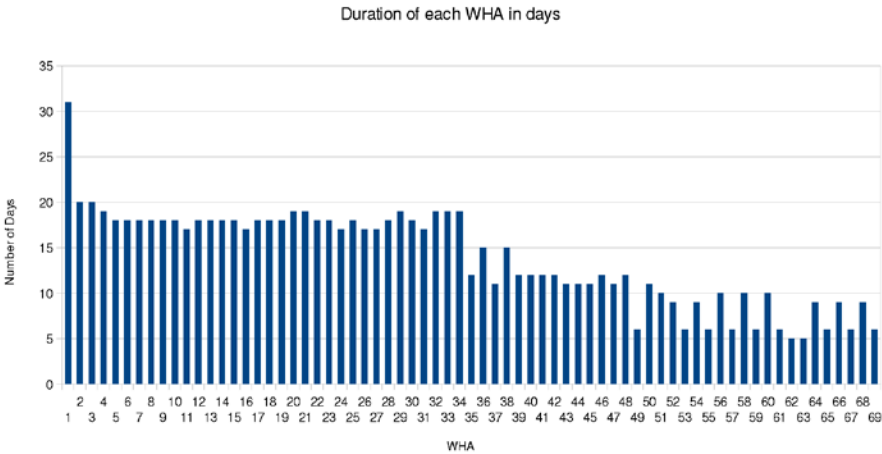
How much time does it take to govern?

From here, I consulted the official records of all past WHAs paying particular attention to the duration of each WHA (in days from the opening to the closure). These results are summarised in Figure 1.

As this data clearly shows, the WHAs' duration has been progressively reduced even though there were also long periods during which their length was kept relatively constant or varied only marginally. In other words, the past vision that future WHAs should be shorter has clearly influenced behaviour. When it comes to time and timing as an object of reform, the questions that arise include: when did this vision emerge, did it undergo changes, and through which more specific reforms did it become a reality? In the following, I present the most relevant time-and-timing-related reforms as they have been extracted from the sample. While chronology will be the main ordering principle, the reconstruction of the main themes will sometimes make it necessary to depart from a strict chronology. There are six main themes that emerged from the material and will be discussed in the

following: the general vision (or grand strategy), the speaking time and the duration of interventions, the introduction of a biennial rhythm, the political will to fix and limit the duration of WHAs, the general scheduling of meetings that included discussions on the desirability of parallel meetings in particular, and, finally, the role of the technical discussions that became eventually technical briefings.

Figure 1. Duration of each WHA in days



Source: (WHO's WHA documents; graph: author)

How can governance be made more time-efficient?

The amount of time spent at WHAs was identified as a concern early in the history of the WHO and there are two visions, or grand strategies, that emerged for dealing with the time problem. While it was not the first occasion at which they were discussed, the two alternatives were explicitly outlined at EB11 (1953). The goal of the first strategy was to reduce the *duration of individual WHAs*,¹⁸ whereas the second proposal was to lessen their *frequency* by changing to *biennial WHAs*.¹⁹ No amendments were approved at WHA6 (1953) which followed EB11, but member states did request “the Director-General to continue to prepare and organize the sessions of the Health Assembly with a view to limiting their duration to a reasonable minimum compatible with the agenda of the session”²⁰ and postponed the discussions on the frequency of WHAs.²¹ WHA11 (1958) and WHA12 (1959) revisited the proposals again and concluded that biennial WHAs were not feasible. A reduction of the duration, however, was considered more feasible even though it was also acknowledged that the increasing number of WHO members – largely as a consequence of decolonization – would make this challenging.²²

The reduction of the length of WHAs as the preferred alternative remained on the agenda of WHA13 (1960) and WHA14 (1961) but did not lead to major changes.²³ This was despite the fact that fear over increased membership leading to protracted WHAs was repeatedly discussed. In the following year, WHA15 (1962) effected an amendment to the rules of procedure and introduced the possibility the President of the WHA would limit the speaking time or close the list of speakers.²⁴ This specific proposal was further clarified at WHA20 (1967) that recommended to limit speaking time for general discussions in the plenary to ten minutes; in the same resolution, member states decided that “delegates wishing to do so may submit prepared statements, preferably of not more than twenty

typewritten pages, double-spaced, for inclusion *in extenso* in the verbatim records of the plenary meetings”.²⁵ WHA23 (1970) appealed to limit speakers’ length of time to make interventions in the main committees,²⁶ a point that was reiterated again a couple of years later at the WHA25 (1972).²⁷ The arrangements for the plenary meetings, however, remained in place until WHA50 (1997) when the speaking time was reduced to five minutes and the length of written statements to 600 words.²⁸ This is still common practice today and resolution WHA50.18 continues to be quoted when the President of the WHA explains how the general discussion in the plenary (usually Item 3 on the agenda) will be conducted. In the main committees, the current practice is to limit speaking time to three minutes.²⁹

Around the same time at which the first arrangements on speaking time emerged, another novel proposal began to be discussed, namely, a biennial programme and budget. While this idea had been first tabled at WHA22 (1969) it was not enacted (on a trial basis) until WHA25 (1972) with the intended purpose of improving the efficiency of the WHA.³⁰ In particular, by distinguishing between WHAs that would undertake “a full review of the proposed programme budget for the following biennium” and alternative meetings that would only conduct “a brief review of the changes in the programme budget for the second year of the biennium”,³¹ the general distinction between budget and non-budget WHAs emerged – a practice that is still retained. Following a trial period, the biennial rhythm was introduced in earnest for the 1980-1981 biennium (i.e. for WHA33 and WHA34).³² Once introduced, WHA33 (1980) revived the former proposal of biennial WHAs and recommended the necessary changes to the WHO’s Constitution.³³ While this recommendation was not implemented,³⁴ it reinforced the idea that less time was needed in non-budget years, which led eventually to a difference in duration between budget and non-budget WHAs.

The difference in duration was, however, not merely the consequence of a division of labour between budget and non-budget WHAs. It was just as much the consequence of the political will to fix and limit the duration of WHAs. As discussed above, debates regarding the preferred length of WHAs had arisen early in the history of the WHO. It was, however, only at WHA30 (1977) that an important change in practice emerged. Until then, it had been common practice that the EB determined the starting date of each WHA, while the closing date was set in the course of the WHA. Following a recommendation by the General Committee, WHA30 requested the EB “to fix also the duration of each session”.³⁵ This innovation allowed EB63 (1979) to specify that WHAs should normally not last longer than three weeks.³⁶ The aforementioned WHA33 (1980) that recommended the introduction of biennial WHAs also expressed the belief that while waiting for the necessary constitutional changes, non-budget WHAs should be limited to no more than two weeks.³⁷ While rejecting the idea of biennial WHAs, WHA34 (1981) specified the two-week limit for non-budget years should be introduced from 1982 onwards (also on a trial basis).³⁸ Finally, WHA36 (1983) confirmed the decision and set a maximum duration for budget years by stating that, in odd-numbered years, WHAs should be limited “to as near to two weeks as is consistent with the efficient and effective conduct of business”.³⁹

As can be seen from Figure 1, in the two biennia following the introduction of the biennial planning rhythm (i.e. WHA35 [1982] to WHA38 [1985]), the new rhythm had an initial, albeit temporary impact on WHA duration. This impact then dissipated for almost a full decade before returning in the 1992-1993 biennium (WHA45 and WHA46). Since that time, the trend whereby WHA duration fluctuates between two and three-weeks length, depending on whether it is a budget planning year, has been evident.

The biennial rhythm strategy, the limitation of speaking time, and the political will to limit the duration of WHAs were accompanied by several additional changes that are important for understanding the continuous reduction of time allocation for WHAs. Two additional changes are especially notable. The first was the introduction of parallel meetings – a practice which is now common. The utilization of parallel meetings and the manner in

which they were conducted initially proved so controversial that there was a period whereby the decision to allow them was temporarily reversed. The initial step was taken by WHA28 (1975) that de-prioritised the plenary meetings thereby permitting the main committees to work in parallel.⁴⁰ WHA32 (1979) by contrast decided that “neither main committee of the Health Assembly shall meet during plenary meetings of the Health Assembly” and discontinued the practice.⁴¹

The decision was based on a recommendation of EB63 (1979) that considered a report by the director-general on this matter. In the report, the director-general outlined supportive and critical perspectives on parallel meetings, but the report seemingly concluded to be in favour of them. In particular, the observation “that this procedure had the effect of leaving the Assembly Hall almost empty, since most delegations did not have sufficient members to attend two meetings held simultaneously” was put in perspective by stating that “it is possible that as in earlier years, when no committees met during the general discussion in plenary, this impression may sometimes be conveyed by the large size of the hall”.⁴²

While WHA32 (1979) had agreed with the critics of parallel meetings described in the director-general’s report, the decision to discontinue parallel meetings was short-lived. WHA35 (1982) reintroduced parallel meetings and went beyond even previous provisions by allowing the plenary and one of the main committees to work in parallel to the technical meetings.⁴³ While WHA35 had introduced these changes on a trial basis and had applied them immediately to its own proceedings, WHA36 (1983) made the changes permanent.⁴⁴ WHA36 (1984) linked these changes explicitly to the political will to limit the duration of the WHA and the graph in Figure 1 highlights that, starting with WHA35 when the changes were introduced on a trial basis, these efforts were also met with success.

The second notable change was the move away from technical discussions over multiple days to technical briefings during lunch breaks as they are common now. This change in practice was initiated at WHA44 (1991) when it was decided to conduct technical discussions only in even-numbered years.⁴⁵ WHA48 (1995) went one step further deciding that, “from [WHA49] in May 1996, and on a trial basis, Technical Discussions will be replaced by a limited number of well-organized technical briefings and by informal forums for dialogue”.⁴⁶ While the decision led to a phase during which different kinds of formats were tested, the abandonment of the technical discussions was still a major change. The magnitude of this shift can be illustrated by recapitulating the technical discussions during WHA8 (1955) that were particularly elaborate (and even a continuation of the technical discussions from the preceding WHA7 [1954]).⁴⁷ WHA8 took place in Mexico City and the topic of the technical discussions was “public-health problems in rural areas”. The technical discussions started with two days (Saturday and Sunday) of *field trips* to rural areas in Mexico, continued with half a day of discussion during the week that followed and were concluded during a final session of one and a half hours on the subsequent Saturday. Overall, the time spent on the technical discussion at WHA8 was reported as the equivalent of two working days and there were no parallel meetings during these discussions. While the field trips as such seem to have been rather unusual, it was common for decades that the technical discussions would last for the equivalent of around two working days and there were repeatedly comments suggesting that even more time would have been needed.⁴⁸ In any event, the shift by WHA48 from technical discussions to technical meetings over lunch has certainly contributed to shortening WHA duration.

As noted above, these changes in WHA practice reveal the working methods of the WHA have been under continuous reform. For the purpose of this article, the analysis of these reforms focused on time and timing, which proved to be a recurrent theme. In light of the contradictory predictions about the future duration of WHAs, it was initially unclear how the duration of the WHAs had evolved over time, but as Figure 1 shows, there was actually a long-term trend towards ever shorter WHAs. Figure 1 further reveals that, over

the years, the biennial rhythm that was introduced in earnest for the 1980-1981 biennium (WHA33 and WHA34) increasingly determined WHA duration. The progressive reduction of WHA duration was not an accidental outcome, but reflected a conscious (collective) decision of member states. While it is rather obvious that the self-set goals were reached, we can now turn to the question of what further consequences the changes had and how they reverberate in contemporary WHAs.

This involves another round of combining methods; so far, document analysis has added historical depth to the initial participant observation described at the beginning of the article; in the following, the discussion of the (un)intended consequences of past reforms will build on these insights while being enriched with relevant insights from participant observation that, as mentioned earlier, continued in parallel to the historical research and is still on-going. Most importantly for the present purpose, I have not only revisited the WHA in subsequent years but have also observed the proceedings of the other key decision-making bodies (or sites) in the WHO's annual policy cycle, i.e. meetings of the EB, meetings of the EB's Programme, Budget, and Administration Committee (PBAC), and meetings of Regional Committees (RCs).⁴⁹

RETURNING TO THE PRESENT

When WHA participants read through the preliminary issue of the *World Health Assembly Journal*, they interpret an artefact that indirectly documents decades of reform. For example, the fact that (the latest possible) end date of the WHA has been set before the WHA has even started was once a novelty; similarly, the way in which plenary meetings and meetings of the main committees are scheduled, alongside the rule that no more than two of these meetings should take place simultaneously, are the consequence of efforts to use time efficiently while trying to limit the amount of parallel processes; furthermore, the technical briefings over lunch reflect more recent reforms to the WHA.

There are, however, also various other artefacts and practices that one inevitably comes across when attending a WHA and that appear in a new light when placed in broader historical context. For example, both plenary meetings and the meetings of the main committees are governed by a 'traffic light' system. At the beginning of a speaker's intervention the light is green before eventually turning yellow and then red when the speaking time is over. While it is not common to interrupt speakers, once an overlong intervention has been concluded, the Chair will often comment on the fact that the traffic light had already turned red. As strange as this system might appear to outside observers, and as restricting as the time limit might be for individual participants, from a historical perspective it is a wonderful illustration of the time pressure under which the WHA operates.⁵⁰

If one considers how successfully the WHA has been shortened in spite of the fact that ever more states have joined the organisation and even though the number of agenda items has substantially increased, it is striking that the desire for an abbreviated WHA still remains. It is not uncommon, for instance, to find delegates and observers who argue that the WHA is too long and that it has to become more efficient. There are two considerations in particular that help to make sense of this striking observation.

First, (time-)efficiency is an open-ended project since it sets a relative goal and does not contain a self-evident cut-off point at which the envisioned goal has been reached.⁵¹ By the same token, after each round of reform, increased efficiency can be pursued anew. Second, this self-perpetuating logic of 'increasing efficiency' is also propelled by paradoxical effects of the continuous reform efforts. Such effects are particularly obvious in the case of plenary meetings that run in parallel to other meetings, are attended by few participants, and are effectively devoid of any genuine debate. The outcome is a combination of measures to guarantee time efficiency has created practices that are not just highly scripted but also

lacking the attention of a broader audience. A lack in audience, in turn, will inevitably be seen as a lack of relevance, thereby reinforcing the impression of ritualized proceedings. The end result is paradoxical situation whereby reform, in the pursuit of efficiency, has turned some activities into 'mere rituals' which, in turn, has led to further discussions about the need for greater efficiency or abandoning these activities altogether.⁵²

In addition, past reforms have led to further (presumably) unintended consequences for WHA proceedings. As predicted and outlined in the historical records, delegations struggle with the parallel processes and with the crowded WHA programme that, at times, stretches beyond the official working hours. This understandably adversely affects small delegations in particular, and undermines the principle of member state equality. Yet, when viewed collectively the effect on all delegations has been to negate traditional boundaries between delegates, alternates, and advisers as envisioned in the WHO Constitution and in the rules of procedure. For individual delegations it is often more important to be constantly represented in meetings rather than having a particular person in a specific formal role present.⁵³ This tendency to treat all members of a delegation as interchangeable in order to participate in parallel processes does, however, not always overlap with the participants' own perspective and there are regularly moments at which they consider themselves to be at the wrong place at the wrong time or at which they wonder why another country sent an inexperienced intern to a discussion they view as crucial.

Another issue that affects all delegations – and by default the WHA – is the tension between an enabling environment for serious discussions and the constant pressure to move forward on the agenda. While lengthy discussions are generally feared by WHA participants, discussion and debate is understandably important for achieving consensus and improving the quality of an outcome. If, however, the evaluation of WHA proceedings focuses primarily on time efficiency there is the danger of marginalizing the value of discussion; the shift from technical discussions to technical briefings could be interpreted as one illustration of this phenomenon. While it can be appreciated that longer discussions do not automatically guarantee better debate or consensus, a focus on efficiency invites more attention being allocated to temporal considerations than quality. As illustrated by Figure 1, the fact that WHA duration has been reduced might be interpreted by some as having enhanced the efficiency of the annual meetings. It does not, however, automatically follow that the quality of discussions – or their outcome – has been enhanced by these reforms, as this is ultimately subject to divergent frames of reference and competing political perspectives.

Indeed, the amount of time available for discussion can be an important prerequisite for reaching consensus, which has become the WHA's preferred mode of decision-making. From this perspective, lengthy discussions are not necessarily the consequence of poor organization but can be a sign of genuine disagreement over competing ideas, values and/or methods. If there is no time to reach a genuine consensus, a decision may still be taken but might lead to a less than ideal outcome. Alternatively, the required time might be gained by setting up a drafting group which will add to the aforementioned challenge of parallel processes, or the issue might be postponed to a later WHA – and in extreme cases – to a completely different decision-making body resulting in an 'outsourcing' of discussions.

It is within this context that the EB has become to some extent a 'mini-WHA' in that even member states that are not among the EB's 34 elected members attend its meetings and participate in the discussions. Similarly, while the Programme, Budget and Administration Committee is officially a committee of the EB, it has not only become a key preparatory meeting for the EB in January but also for the WHA in May. Moreover, like the EB, the PBAC is not only attended by its 14 elected members but also by other member states. In both cases, the rising number of member states who attend are evidence of the increasing significance attributed to these bodies as sites of governance. Moreover, while a discussion of specific agenda items by the EB and/or by PBAC does not formally preclude discussions at the subsequent WHA, there is nevertheless a preference to not 're-open' the

debate in order to save time.

From this perspective, it is reasonable to conclude that while both increased WHO membership and agenda items did not prevent reducing the WHA's duration, time pressure has necessitated shifting some of the discussions that would otherwise be had in the WHA to other WHO sites of governance. Further, in spite of the expanding numbers of member states who attend the EB and PBAC, it is still often the case that fewer member states are represented at these meetings when compared to the WHA where all 194 member states hold a seat. In other words, while legitimate concerns were previously raised about increasing WHO membership and WHA duration, the 'solution' to the problem seems to have been to move discussions to bodies with a smaller, less representative membership base.

The rising relevance of the EB and the PBAC, as well as the number of associated WHO intergovernmental meetings, highlights the temporal constraints that have been increasingly placed on the WHA. Yet, the trend described above of moving to alternative sites of governance is, in fact, even more complex and ambiguous. For example, the importance of the WHA as a forum for discussion and debate appears to largely depend on the specific agenda item. While some issues seem to have been effectively settled before the WHA, others are allocated time for discussion.⁵⁴ Moreover, there has been a discernible trend whereby the number of registered participants is increasing over time. If this phenomenon is taken as an indicator of relevance, then the WHA is growing in importance as a site of governance. At the same time, these numbers have to be treated with care since the WHA, as described above, comprises several parallel processes and some participants may be highly selective in which meetings they decide to attend.

Having said this, the ambiguity of the WHA can also be interpreted as the consequence of an on-going struggle over time as a source of power. Specifically, representative bodies need to be able to control their proceedings and manage their time effectively, as it ensures a measure of independency and can assist in meeting internal standards of inclusiveness and quality.⁵⁵ Conversely, representational bodies are also dependent on their operating environment to provide them with the necessary resources to conduct their work, but this environment can be prone to change. For example, a view may develop amongst the members of a representational body that much less response time is needed or that competing institutions will fulfil the tasks even better. Against this background, it could be argued that the WHA has been able to retain its unique position in the WHO's annual policy cycle even though some discussions have moved to other WHO meetings.

At the same time, shifting the level of analysis offers yet another interpretation on the utility of the reforms described above. If the WHO is viewed in its entirety as the decision-making body, it could be argued the internal reforms such as permitting some discussions to be held outside the WHA have allowed the organization to take on more contemporary challenges – issues that the WHA would not otherwise have the capacity to deal with. In other words, in spite of the much-quoted fragmented nature of global health governance and the WHO in particular, the WHA – in teamwork with other WHO bodies – has been able to defend its role, ensure its continued relevance, and structure the global annual health-policy cycle. Indeed, this is arguably evidenced by the fact that other global health meetings are still organized around the WHA and by the aforementioned continuous increase in participants.⁵⁶ This success comes however at the price of a relative loss of significance within WHO, the 'cost' of including parallel processes as well as other measures to increase efficiency, and at the risk of continuous criticism concerning its efficiency.

Lastly, there are also significant implications for inclusiveness and transparency when important discussions occur outside of the WHA. As noted above, the PBAC and EB are traditionally attended by less member states than the WHA. Importantly, however, there is also a distinction in the types of member states attending these meetings: elected members that participate with certain privileges including the right to vote, and all other member

states. For non-governmental organizations (NGOs) in official relations with the WHO it also makes a difference where discussions take place: while they are permitted to participate in the WHA and EB meetings in reading statements, they are not permitted to attend PBAC meetings and some other WHO intergovernmental meetings. This situation is similar for members of the general public in that while the WHA and EB are accessible and now webcast, PBAC meetings are closed and webcasting practices have varied. The lack of transparency is even more severe in the case of intergovernmental meetings, which are neither open to the public nor webcast.

Moreover, there is a negative correlation between the importance of discussions and their preservation in the WHO's official records. The most comprehensively documented aspect of WHO's annual policy cycle are the ritualized plenary meetings in the Assembly Hall whereby verbatim records preserve member states' interventions. Since WHA64 (2011) the WHO secretariat has also sought to make these interventions available as audio files. By contrast, the proceedings of the main committees and the EB are documented as summary records while the PBAC produces only a condensed report of its meeting. Intergovernmental meetings usually generate an outcome document while the discussions that were held to arrive at that consensus are not captured. In other words, there is a great variation in the degree to which the official records are rich in detail or a mere summary of key points. Finally, in the case of all of the other parallel processes at the WHA, the situation is even worse for a retrospective analyst since even the ones mentioned in the *Journal* will usually not be documented systematically, if at all.

As may be appreciated, therefore, the implications arising from the overwhelming focus on time efficiency undermine the concept and practice of legitimate governance. This can even lead to situations in which one reform effort undermines another. Webcasting of governance meetings, for instance, was introduced only recently, but since this practice applies to some meetings while excluding others, the ever increasing relevance of non-webcast meetings undermines the organization's overall reputation as a site of transparent governance.⁵⁷ While the present article – with its focus on practical challenges that WHA participants face collectively – leans towards interpreting such contradictory outcomes as the unintended consequences of one-sided reform efforts, it could be argued they reflect the structural conflicts and power relations among member states. From a structural perspective, there is a reasonable chance that the undermining of inclusiveness and transparency is not a coincidence but the consequence of the ever-present tendency towards informal governance that privileges structurally powerful states.⁵⁸ Regardless of whether these changes were brought about intentionally or not, the negative consequences on inclusiveness and transparency as well as the aforementioned challenges they pose for less resourceful delegations in particular are significant in any event.

CONCLUSION: LOOKING AHEAD

One consequence of the various reform efforts described above is that the lived experience of participants attending a WHA will vary considerably. Depending on which of the multiple parallel meetings participants attend, and depending on what particular aspect of the WHO's work a participant is interested in, a WHA can appear as either a highly satisfactory and dynamic event, or as an arduous ritual with a lot of scope for further shortening. In the latter case, many participants would probably consider the plenary meetings as the most obvious feature of the WHA for further reform. Yet conversely, the pervasive ambiguity of the WHA can conceivably be best illustrated by the role of the technical briefings – if the topic is of particular interest, the technical briefing can be an exciting experience. Where participants attend out of duty though it is entirely possible the presentations appear as dull and overlong. This multiplicity of perspectives and experiences has two implications that point into two different directions regarding future reform discussions.

Firstly, it raises the question of whose WHA matters and what kind of participants should find it appealing. In slightly simplistic terms, the WHA could either be seen as a forum that attracts people with a keen substantive interest in specific issues of global health by offering them an environment in which they can contribute to discussions and engage in mutual learning (not only in the course of technical briefings but also during meetings of the main committees), or it could be seen as a forum in which generalists efficiently take decisions and pass resolutions. Delegations try to bridge these two worlds by including people from different ministries and with different backgrounds but they can still not evade this tension and I have often been struck by the divergent perspectives on WHA priorities – even within delegations. Taking these divergent perspectives into account and considering that the supporters of efficiency in particular have been listened to for decades, it seems important that assessments of the WHA also consider the requirements of (public health) experts and the functions of the WHA beyond taking decisions and passing resolutions in the narrow sense of these terms.

While such a reluctance to try to optimize the WHA along one dimension stands in contrast to calls for a further increase in time efficiency, the second aspect that has to be discussed in this context points into the opposite direction. Indeed, it seems quite likely that the multiplicity of perspectives will reinforce the aforementioned self-perpetuation of the 'efficiency project' thereby keeping time and timing as well as WHA governance high on the agenda well into the future, even though this part of WHO reform has arguably been much more successful in reaching its objectives than others.⁵⁹ The lived reality of governing the WHO is something that all WHA participants can relate to; the multiple dimensions of the WHA, the fact that the search for consensus can quickly become time consuming, and the consideration that 'delays' in consensus-seeking will usually be interpreted as being caused by others, make it very likely that *all* participants will at one moment or another have had a somewhat frustrating experience with the WHA. From this perspective, it looks likely that the notion of accelerating the process will, also in the future, appeal to most participants; although the underlying sense of redundancy will probably have emerged at different occasions and for divergent reasons.

This suggests that, in the case of WHA governance reform, the participants do not need any scholarly encouragement for reform at all; quite to the contrary, it might sometimes be helpful to remind them of the consequences of past reforms and of the typical drivers for reform. A key problem might actually be that the participants think too much about the question of how to improve the WHA further and thereby lose sight of the multitude of other, more substantive challenges that the WHO faces in its daily work but which are often beyond the personal (and procedural) experiences of WHA participants. The crux of the matter is that WHA reform has certainly led to time efficiency but constant reform and continuous reform discussion cost also time and energy. Moreover, their (un)intended consequences create new challenges.

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¹ See Kelley Lee, *The World Health Organization (WHO)* (London: Routledge, 2009); Kelley Lee, Sue Collinson, Gill Walt and Lucy Gilson, "Who should be doing what in international health: A confusion of mandates in the United Nations?", *British Medical Journal (BMJ)* 312, no. 7026 (1996): 302-307; Devi Sridhar and Lawrence O. Gostin, "World Health Organization: Past, present and future", *Public Health* 128, no. 2 (2014): 117-118; D.J. Hunter, T. Schrecker and R. Alderslade, "Governance for health in a changing world: Special issue", *Public Health* 129, no. 7 (2015): 831-832.

² See Giampietro Gobo, *Doing Ethnography* (London: Sage, 2008) and Robert M. Emerson, Rachel I. Fretz and Linda L. Shaw, *Writing Ethnographic Fieldnotes, Second Edition* (Chicago: University of Chicago Press, 2011).

³ See Nitsan Chorev, *The World Health Organization between North and South* (Ithaca: Cornell University Press, 2012), Erin R. Graham, "International organizations as collective agents: Fragmentation and the limits of principal control at the World Health Organization", *European Journal of International Relations* 20, no. 2 (2014): 366-390, Tine Hanrieder, *International Organization in Time: Fragmentation and Reform* (Oxford: Oxford University Press, 2015).

⁴ Jörg Bergmann, "Studies of work", in *Handbuch Berufsbildungsforschung*, edited by Felix Rauner (Bielefeld: W. Bertelsmann, 2006), 639-646, Melvin Pollner and Robert M. Emerson, "Ethnomethodology and ethnography", in *Handbook of Ethnography*, edited by Paul Atkinson, Amanda Coffey, Sara Delamont, John Lofland and Lyn Lofland (London: Sage, 2001), 118-13, and Kendra Coulter and William R. Schumann eds., *Governing Cultures: Anthropological Perspectives on Political Labor, Power, and Government* (Basingstoke: Palgrave, 2012).

⁵ Ilona Kickbusch and Mathias Bonk, "Making the World Health Assembly fit for the 21st century", *BMJ* 348, no. 7964 (2014): g4265, Ilona Kickbusch, Wolfgang Hein and Gaudenz Silberschmidt, "Addressing global health governance challenges through a new mechanism: The proposal for a Committee C of the World Health Assembly", *Journal of Law, Medicine, and Ethics* 38, no. 3 (2010): 550-563.

⁶ On the notion of political ethnography as a specific case of ethnography, see Edward Schatz ed., *Political Ethnography: What Immersion Contributes to the Study of Power* (Chicago: University of Chicago Press, 2009) and Dvora Yanow, "What's political about political ethnography? Abducting our way toward reason and meaning", *Qualitative & Multi-Method Research* 7, no. 2 (2009): 33-37.

⁷ See Gobo, 2008, Emerson, Fretz and Shaw, 2011, as well as Kathy Charmaz and Richard G. Mitchell, "Grounded theory in ethnography", in *Handbook of Ethnography*, edited by Paul Atkinson, Amanda Coffey, Sara Delamont, John Lofland and Lyn Lofland (London: Sage, 2001), 160-174. For a defence of open research designs see Herbert Blumer, "What is wrong with social theory?", *American Sociological Review* 19, no. 1 (1954): 3-10.

⁸ "Holism" is a classic ethnographic concern and "comparison" is a classic analytic strategy across the social sciences. While the first logic encourages the researcher to study as many sites as possible in order to give an encompassing account of global health governance, the second logic encourages the researcher to think about these sites in comparative terms and to select them along the lines of maximal and minimal contrast in order to identify the dimensions of the phenomena studied as well as variation therein.

⁹ Even though the discussion on the potential contribution of ethnography to the study of international relations is not new, it has become particularly visible in the last decade or so. For some elder texts and studies, see for example, Michael N. Barnett, "The UN Security Council, indifference, and genocide in Rwanda", *Cultural Anthropology* 12, no. 4 (1997): 551-578, Carol Cohn, "Sex and death in the rational world of defense intellectuals", *Signs: Journal of Women in Culture and Society* 12, no. 4 (1987): 687-718, and Hugh Gusterson, "The virtual nuclear weapons laboratory in the New World Order", *American Ethnologist* 28, no. 2 (2001): 417-437; for more recent contributions, see, for example, Morgan Brigg and Roland Bleiker, "Expanding ethnographic insights into global politics", *International Political Sociology* 2, no. 1 (2008): 89-90, Julian Eckl, "Responsible scholarship after leaving the veranda: normative issues faced by field researchers – and armchair scientists", *International Political Sociology* 2, no. 3 (2008): 185-203, Patrick Thaddeus Jackson, "Can ethnographic techniques tell us distinctive things about world politics?", *International Political Sociology* 2, no. 1 (2008): 91-93, Jon Harald Sande Lie, "Challenging anthropology: anthropological reflections on the ethnographic turn in International Relations", *Millennium: Journal of International Studies* 41, no. 2 (2013): 201-220, Iver B. Neumann, *At Home with the Diplomats: Inside a European Foreign Ministry*, (Ithaca: Cornell University Press, 2012), Schatz, 2009, Niels Nagelhus Schia, "Being part of the parade – 'going native' in the United Nations Security Council",

PoLAR: Political and Legal Anthropology Review 36, no. 1 (2013): 138-156, Finn Stepputat and Jessica Larsen, "Global political ethnography: a methodological approach to studying global policy regimes", *DIIS Working Paper* (Kopenhagen: DIIS, 2015), http://pure.diis.dk/ws/files/71410/wp2015_01.pdf, and Yanow, 2009. In spite of the increasing interest, ethnographic research has not reached the scholarly mainstream in international relations while other disciplines have relied on it for decades.

¹⁰ I would like to thank the anonymous reviewers and the guest editors for their helpful comments. I am also grateful for comments that I received on two presentations that prepared the ground for the present article: first at "MAGic2015: Anthropology and Global Health: Interrogating Theory, Policy and Practice" in Brighton, United Kingdom, on 10 September 2015, and then at the annual convention of the International Studies Association (ISA) in Atlanta, Georgia, USA, on 17 March 2016.

¹¹ While I had first tried to register as an academic observer and then attempted to register as a journalist, I was finally told that you could simply try to get one of a limited number of public badges. In other words, attending the WHA turned out to be less bureaucratic than I had assumed but only for those people who know how to get in while I had spent weeks trying various other ways, sending emails that were never answered, and calling people who never picked up the phone.

¹² On the eve of WHA67, the preliminary issue was available at the following URL: http://apps.who.int/gb/e/e_wha67.html. Presently, only the issues 1 through 6 can be downloaded while the preliminary one has disappeared. For the complementing *Guide for delegates to the World Health Assembly*, see A67/DIV./2, which is still available at the URL.

¹³ See WHA64.2 in particular, which is *inter alia* available at http://www.who.int/about/who_reform/documents/en/ that contains a compilation of documents related to the most recent reform process.

¹⁴ In addition to the documents identified in this manner, I have also found documents by coincidence. Flipping through the pages of past WHA's it proved impossible to find only the documents that one had been looking for. Quite to the contrary, there were always headings and passages that for one reason or another caught my spontaneous attention and proved eventually to contain some information that spoke to my research interest. For example, the duration of speaking time was a recurrent issue in the debates even when the substantive content of the debates was on a different issue. While these additional finds were obviously accidental, they reinforced the impression that WHA rules and practices have been a recurrent point of debate indeed.

¹⁵ The resolutions and other governance documents quoted in the following can be found in the *Official Records* series for the time period 1948 to 1978. After the discontinuation of the *Official Records* series, governance documents were published in separate volumes that are labelled according to the following pattern [Number of WHA]/[Year of WHA]/REC/[Number of record for the specific WHA] in the case of WHAs and analogous in the case of EBs. The resolutions are usually contained in the first number of these records. For example, the resolutions for WHA42 that took place in 1989 are contained in WHA42/1989/REC/1. Both the *Official Records* series and the subsequent official records are continuously digitalized and will eventually all become available at <http://apps.who.int/iris/>. For official records from the last decade, see also <http://apps.who.int/gb/or/>.

¹⁶ In the historical documents, the terminology would usually be something like "improving the methods of work" rather than "governance reform".

¹⁷ EB63.R33.

¹⁸ See, in particular, EB11.R68; for earlier ideas in this regard, see also WHA5.49.

¹⁹ See, in particular, EB11.R69; for an earlier formulation, see also WHA3.96.

²⁰ WHA6.58.

²¹ See WHA6.57.

²² While WHA11 focused on the frequency of WHAs (WHA11.25), WHA12 mentions both alternatives in one resolution and opts for shorter meetings (WHA12.38).

²³ See WHA13.40 and WHA14.51.

²⁴ See WHA15.50.

²⁵ WHA20.2.

²⁶ See WHA23.1 that repeated an appeal of the preceding EB (EB43.R45).

²⁷ See WHA25.33.

²⁸ See WHA50.18.

²⁹ The last two claims are based on my observations at WHA67 (2014) and WHA68 (2015). WHA69 (2016), which I watched via webcast, followed the practice as well but, at least in Committee A, the

speaking time was even reduced to two minutes for the final two days of the meeting. (The proposal was made by the Chair at the end of an evening session at around 8:55 pm and when no one opposed to it, the decision was met with applause.)

³⁰ See WHA22.53 and WHA25.24.

³¹ WHA28.69.

³² See, in particular, WHA30.20 and WHA 30.22.

³³ See WHA33.19.

³⁴ See WHA34.28.

³⁵ WHA30([decision] xvi).

³⁶ See EB63.R33.

³⁷ See WHA33.19.

³⁸ See WHA34.29.

³⁹ WHA36.16.

⁴⁰ See WHA28.69.

⁴¹ WHA32.36

⁴² EB63/17

⁴³ See WHA35.1.

⁴⁴ See WHA36.16.

⁴⁵ See WHA44.30.

⁴⁶ See WHA48.17.

⁴⁷ See *Official Records of the World Health Organization* 63.

⁴⁸ In 1952, for example, the Director-General reported the following information on the technical discussions at WHA5 to the EB: "The technical discussions covered two and a half days, in addition to an evening meeting, and it would appear to be the general opinion of the members taking part in the group discussions that insufficient time was allotted to them. The addition of at least another half day would have been desirable" (EB10/20).

⁴⁹ In the case of WHAs, EBs, and RCs, I have so far attended at least two meetings each in person and watched additional ones via webcast; however, meetings of PBAC could only be observed online since access is particularly restricted. For an article that emerged from the same phase of the project but focuses on malaria policy and goes beyond WHO-related sites that are discussed here, see Julian Eckl, "The social lives of global policies against malaria: Conceptual considerations, past experiences, and current issues", *Medical Anthropology* 36, online first (2017): <http://dx.doi.org/10.1080/01459740.2017.1315667>.

⁵⁰ Drawing on what I could see via webcast, WHA69 (2016) seems to have introduced a small change in the case of plenary meetings where the old traffic lights have been substituted with a countdown clock. Interestingly enough however, the clock still relies on the on the old colour scheme but adds blue to it: there is a blue ring around the clock when it has been reset (or stopped) and the ring turns green once the clock has been started; later the ring turns yellow and at the very end red.

⁵¹ While formulations such as "efficiency" or "more efficient" are common in the documents, I have also come across terms like "streamlining", "rationalizing", and, simply, "improving".

⁵² Obviously human behaviour is inherently ritualized but there is a tendency to recognize rituals as rituals when they do not "work properly".

⁵³ This point has been further elaborated in: Julian Eckl, "Doing being a delegate in multi- and polyateral fora in the field of global health", paper presented at the annual convention of the International Studies Association (ISA) in Atlanta, Georgia, USA, 16 March 2016.

⁵⁴ Moreover, there was also an important change into the opposite direction: The WHA has gained importance through the new election process for the Director-General since the WHA will be able to elect one of three candidates short-listed by the EB rather than following the previous practice of formally appointing the single candidate nominated by the EB.

⁵⁵ See Werner J. Patzelt and Stephan Dreischer eds., *Parlamente und ihre Zeit: Zeitstrukturen als Machtpotentiale [Parliaments and Their Time: Time Structures as Power Potentials]* (Baden-Baden: Nomos, 2009).

⁵⁶ Actually, already in the late 1970s complaints about the competition between meetings were expressed. For example, WHA32.26 contains the following two preambular paragraphs: "Considering the increase in meetings on health matters organized at both the regional and international levels at which countries are required to be represented; Bearing in mind the consequent heavy demands on human and financial resources required for attending such meetings which may create problems, particularly for developing countries;"

⁵⁷ For the decision to introduce webcasting in the case of the WHA, see WHA67.2.

⁵⁸ See, in particular, Randall W. Stone, *Controlling Institutions: International Organizations and the Global Economy* (Cambridge: Cambridge University Press, 2011).

⁵⁹ For the particularly divergent case of efforts to centralize WHO that could not even prevent the further decentralization of the organization, see Hanrieder 2015.

The World Health Organization's Historic Moment of Peril and Promise: Reimagining a Global Health Agency Fit for Purpose in the 21st Century*

Lawrence O. Gostin

The United Nations created the World Health Organization (WHO) as its first specialized agency in 1948. This was a time of enormous promise for the world, coming as it did after the horrors of World War II. What is striking about the post-war consensus is that the United Nations envisaged health and human rights as two great, intertwined social movements. At its birth, the United Nations adopted a “trilogy” of landmark documents. The UN Charter expressed a vision of international peace, security, and human rights deeply influenced by the great humanitarian, Eleanor Roosevelt. The Universal Declaration of Human Rights became the bedrock of modern human rights law. The WHO Constitution proclaimed a fundamental right to “the highest attainable standard of health,” granting the Organization virtually unique normative authority.

The WHO was supposed to be the vanguard of the right to health. Yet despite notable achievements, the Organization has been reticent to venture into norm-development, and rarely invokes the right to health. As the World Health Assembly elects its eighth Director-General, the Organization faces a crisis of confidence as never before.

In the wake of its deeply ineffective Ebola response, four global commissions – the United Nations, WHO, National Academy of Sciences, and Harvard/London School of Hygiene and Tropical Medicine – all questioned the Organization's capacity to respond to global health emergencies. Those commissions spurred major internal reforms, such as the new WHO Health Emergencies Program designed to make the agency fully operational in responding to health crises. (The Center, and the WHO Emergency Contingency Fund are themselves considerably underfunded). Yet, the most fundamental organizational deficits remain: unsustainable funding, dysfunctional regional relationships, weak governance, and an uneasy relationship with the private sector. Most importantly, WHO has failed to garner political support in major capital cities throughout the world, and failed to inspire grassroots advocacy for its mission.

Deepening the Organization's tribulations are growing political movements tied to ethnocentric, fervently nationalist populism, notably among its historically most generous funders in Europe and the United States. This form of populism has an ideology – and a set of policies – wholly inconsistent with WHO's mission, purpose, and activities. The movement's central premise of “country first” eschews WHO's core values of international cooperation, mutual solidarity, re-distributional health equity, transnational norms, and robust international institutions. For example, President Trump's budget – and expressed views – devalues and defunds humanitarian assistance, the UN and its specialized agencies, global health diplomacy, and health research. Even at the best of times, WHO has struggled to gain legitimacy and modern relevance, but now it faces political headwinds that have no precedent in its nearly 70 year history.

* This article is closely based on the following two sources: Lawrence O. Gostin & Eric A. Friedman, “Reimagining WHO: Leadership and Action for a New Director-General”, *Lancet*, 389 (2017): 755–59, [http://dx.doi.org/10.1016/S0140-6736\(17\)30203-9](http://dx.doi.org/10.1016/S0140-6736(17)30203-9); and Lawrence O. Gostin & Eric A. Friedman, “Global Health: A Pivotal Moment Of Opportunity and Peril”, *Health Affairs*, 36 (2017): 159-165, doi:10.1377/hlthaff.2016.1492.

While WHO faces a crisis of confidence, the new Director-General will have a unique opportunity to advance the agency's mission and become the 21st century global health organization envisaged by its creators. The Director-General comes to the Organization at the cusp of major health challenges, but also unprecedented high-level political engagement.

The West African Ebola epidemic itself pushed the health agenda to the United Nations, with the Security Council unanimously adopting a resolution, which for the first time deemed a health crisis a threat to international peace and security.¹ The Secretary-General established a UN Mission for Ebola Emergency Response (UNMEER) on 19 September 2014, the first-ever UN emergency health mission. Responding to discrete threats to global health security, the UN General Assembly hosted a high-level summit on antimicrobial resistance (AMR). UN Organs also tackled a broader health agenda beyond emergency preparedness and response, including the Secretary-General's high-level panel on access to medicines² and the General Assembly's political declaration on noncommunicable diseases.

Beyond the United Nations, political leaders have begun to urge global action on health, much as they did during the height of the AIDS pandemic. The 2016 G7 offered a "Vision for Global Health" comprising emergency preparedness, universal health coverage (UHC), and a "one-health" strategy to combat AMR.³ During its G7 Presidency, Germany launched a research initiative to develop vaccines for tropical diseases. Chancellor Angela Merkel's leadership of the 2017 G20 summit placed universal health coverage high on the agenda, to achieve "the extremely ambitious goal of giving every person in the world, whatever their age, an entitlement to health care."⁴

Traditional security concerns such as war, terrorism, mass migration, and natural disasters have enormous consequences for health and development. Yet alongside these threats, the international community has a unique opportunity to reduce poverty and disease through the UN Sustainable Development Goals (SDGs), which encompasses UHC with its twin mandates of universality and leaving no one behind.

These seismic events come at a pivotal moment, with the election of UN Secretary-General António Guterres and re-election of World Bank President Jim Kim. If these and other world leaders work in concert with WHO to advance the global health agenda, the results could be transformative. Will it be possible to merge WHO's technical competence, the UN's political clout, and the Bank's economic muscle? All these institutions confront shared challenges—mandates exceeding their resources, harnessing multi-stakeholder engagement, and commanding the international community's confidence.

The new WHO Director-General can succeed only by reimagining the Organization as a well-funded, agile, and accountable organization that commands the respect of governments and the public, while galvanizing civil society to advocate for WHO in the halls of power. What AIDS taught us, is that social mobilization is the best, perhaps only way, to achieve fundamental health reform, grounded in justice. While nongovernmental organizations routinely lobby for funding for the Global Fund for AIDS, Tuberculosis and Malaria, and even GAVI—the Vaccine Alliance, they barely lift a finger for WHO. The reasons will become apparent when I discuss the broad exclusion of civil society from WHO governance and the Organization's skittishness in the field of human rights. How, then, could the new Director-General reimagine WHO? It is best to answer this vital question by demonstrating innovative strategies to overcome the agency's chronic weaknesses, which have been so resistant to change. At the same time, WHO's effective functioning relies on member state political and financial support, but governments do not act as stakeholders. Let's start with WHO's most glaring problem, the utter absence of a model for sustainable funding.

SUSTAINABLE FINANCING, WITH WHO'S BUDGET UNDER ITS CONTROL

The WHO Secretariat is caught in a dysfunctional cycle: member states' loss of trust impedes sustainable financing, while underperformance due to a paucity of resources reinforces that erosion of confidence. The undeniable truth is that existing resources are wholly incommensurate with WHO's worldwide mandate. WHO's current (2016/17) budget is \$4.340 billion, while its proposed 2018/19 budget is \$4.422 billion—less than the operating costs of a large United States hospital, and not even one-third the US Centers for Disease Control and Prevention's. Even this bare-bones budget fails to reflect the agency's fiscal weakness. A single issue – the polio eradication campaign – takes up nearly one-quarter of its annual budget.

At WHO's October 2016 financing dialogue, the Director-General reported a \$500 million deficit. Despite novel circulating viruses, the health emergencies program was facing the largest shortfall within the agency, along with NCDs.⁵ Beyond WHO's own funding, global health funding deficits remain daunting, including a US\$7 billion annual funding gap in the AIDS response.⁶ Even if WHO were to push hard for increased voluntary donations, it would be competing in a crowded landscape of health and humanitarian organizations—public, private, as well as public/private partnerships. There simply isn't the global health funding worldwide to solve the Organization's financial woes.

Sustainable funding commensurate with its global mission is vital for WHO's future. But there is another problem of equal concern. The Director-General has little control over his or her own budget, due to the increasing propensity for member states and other funders to earmark their contributions. Only 22% of its 2016/17 budget came from assessed contributions, that is mandatory membership dues states owe to the Organization.⁷ This ties the agency's hands

The problem of low funding, tied to donor's pet projects has been stubbornly resistant to change. The next Director-General's first act should be to host a sustainable financing dialogue with the Executive Board, finance ministers, and a broad array of stakeholders including civil society. The output should be a blue print for getting to sustainable core funding over a five year period.

The blueprint should certainly identify political pathways for higher mandatory assessments. Member states, however, have rejected this idea for decades. In 2016, Margaret Chan's proposed 10% increase in assessed dues fell flat.⁸ In response to this modest budget request, India – an economically powerful middle-income country – inexplicably asserted that a US\$342,000 increase in its WHO assessed contributions could be unaffordable.⁹ The new Director-General will have to fulfill bold promises while facing a frosty reception for a robust financing model.

Recognizing the political headwinds, the next Director-General – supported by the political muscle of a high-level financing dialogue – must identify alternative pathways to financial sustainability. First, the Director-General should forcefully advocate for a voluntary financing pool without earmarks to re-establish some budgetary control—bearing in mind the crowded institutional landscape just discussed. Second, the next Director-General should cultivate increased funding from non-traditional sources, such as the BRICS and oil-rich Gulf states. Third, the next Director-General should devise and implement innovative financing sources. Models include the UNITAID levy on airline tickets.¹⁰ The next Director-General should convene a high-level commission of health, finance, and development ministers on innovative financing strategies,^{11,12} using both state sources (e.g., sugary beverage, tobacco or alcohol taxes, with a small portion directed to WHO) and non-state sources, like the airline levy and/or a financial transactions levy.

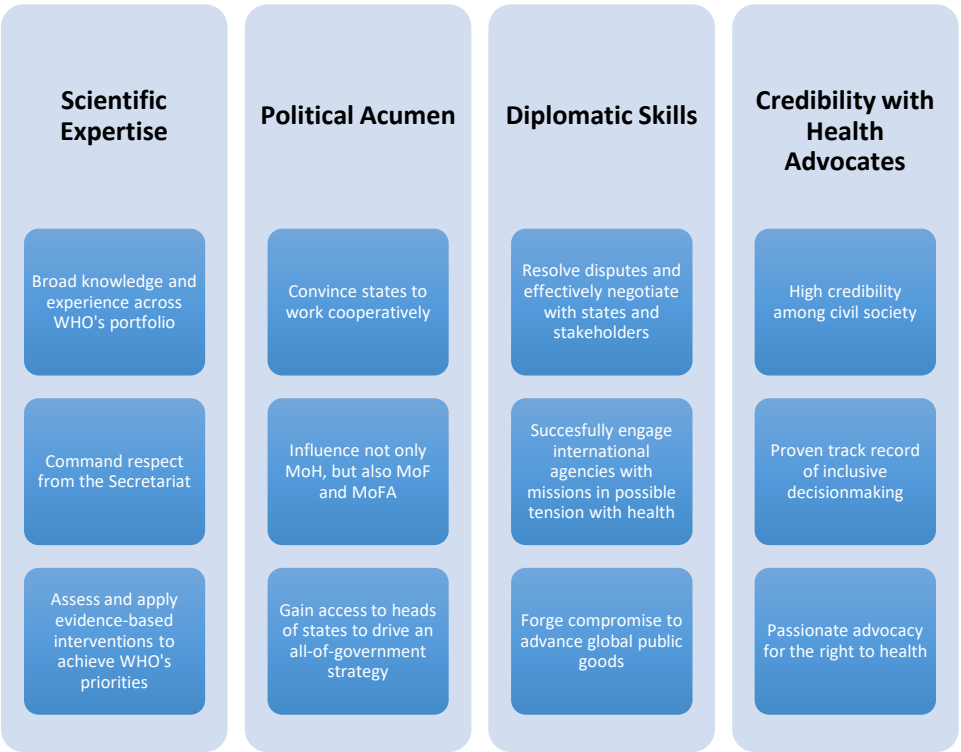
MEMBER STATES ACTING AS STAKEHOLDERS

WHO draws its legitimacy from its member states, but member states are resistant to fully funding the Organization's activities because they lack trust in its competence. Member states also want to keep tight reigns on the way WHO uses funds, preferring to direct favored projects through earmarked funding. At the same time, WHO needs member states' political support, which also is hedged with concerns about the agency's ability to meet its objectives in a cost-effective manner. All in all, WHO is caught in a cycle of dysfunction. It needs a leader widely respected in the halls of government power, and a leader who can restore confidence in the agency. Thus, WHO's member state governance remains a blessing and a curse. It is the Organization's greatest strength because it creates an aura of a global democratic institution. But it is also the Organization's greatest weakness because its key governance machinery is not fully behind the idea of empowering the agency and helping to assure its success.

ESSENTIAL LEADERSHIP CHARACTERISTICS

The new Director-General must be willing to make a clean break from the *status quo*, open to dramatic reforms and ready to innovate, even in the face of internal and member state resistance. This requires at least four essential leadership skills (Figure 1):

Figure 1: WHO Director-General essential leadership skills



Human resources and scientific expertise. The WHO has gained a reputation as a world-class technical agency that sets international health standards. The Director-General must demonstrate broad scientific knowledge and experience across the Organization's portfolio. He or she must command respect from the Secretariat as well as public health professionals and policymakers. The Director-General should be able to assess and apply evidence-based interventions to achieve WHO priorities. But the new Director-General's biggest challenge will be to recruit and retain world-class staff with exceptional competence and judgment. This requires a human resources ethos that rewards high functioning, sanctions poor performance, and ultimately sheds professionals who are unable to demonstrate the level of effectiveness demanded by member states and civil society. That will be require a new rigor on the part of the Director General to make the hard decisions the Organization badly requires.

Political acumen. Perhaps the Director-General's greatest leadership challenge is persuading governments to act as stakeholders invested in the Organization's success. The new Director-General will have to convince governments to work cooperatively, adhere to WHO norms, and back the Organization operationally and financially. The Organization's influence must extend beyond health ministries, which constitute its core constituency. The new Director-General must also have the political stature to influence ministries of finance and foreign affairs, which make decisions regarding health financing and international agreements. Ultimately, the Director-General will have to gain access to heads of state, which can drive an all-of-government strategy for advancing health and make health a top governmental priority.

Diplomatic skills. Related to political acumen, is the ability to resolve disputes and effectively negotiate with states and stakeholders. A 21st century WHO has to navigate among sovereign governments with sharply divergent national interests. Whether the issue is intellectual property, falsified medicines or virus sharing, low- and high-income states often clash. The Director-General must have the diplomatic skills to secure compromises, while achieving public goods that only cooperative action can bring. It simply isn't good enough for the Director-General to be a global health servant, doing the bidding of 194 member states. She or he must have a clear vision and strategy, using diplomacy to move states toward more cooperative solutions. The Director-General will need to similarly engage other international agencies, which may have interests and priorities in tension with public health, such as the World Trade Organization and UN Office of Drugs and Crime.

Credibility with health advocates. The AIDS pandemic taught us that social mobilization is a crucial element to raise awareness and mobilize resources. Modern global health organizations such as UNAIDS and the Global Fund have actively engaged civil society, even incorporating community leaders into their governance. Yet, public health advocates have less buy-in and lower awareness of WHO's value, and many feel excluded, perennially dampening WHO's budget prospects. The new D-G must have high credibility among civil society based on a proven track record of inclusive participatory decision-making and passionate advocacy for the right to health. The Director-General must form and implement a policy of full civil society participation in governance decisions (see below).

ACTION AGENDA

The new Director-General should set an action agenda, with clear benchmarks, ongoing monitoring, and rigorous evaluation of progress (Table 2). Funded pathways for achieving each priority should become clear in the new Administration's first 100 days.

Table 2: An action agenda for the new WHO Director-General: facing the challenges

AGENDA ITEM	OBSTACLES	DIRECTOR-GENERAL ACTIONS
Global Health Security	Lack of state trust due to weak performance in the Ebola outbreak	Effectively implement internal reforms, including on accountability and transparency
		Build capacities needed for success of new health emergencies programme
	Long-term inability to effectively mobilize resources	With World Bank and IMF, make investment case at highest political levels
		Find new funding sources, including innovative financing
	State sovereignty and low IHR compliance	Use evaluation tools to assess countries’ preparation and capacities
		Publicly name states failing to comply with IHR or WHO recommendations
		Link countries to sources of technical and financial support for building core capacities
		Work with World Bank and IMF to incentivize countries to build core capacities
Anti-Microbial Resistance (AMR)	Wide funding gap to spur R&D incentives	Incremental USD\$1 billion per annum increase in R&D financing
	Multiple sectors coordination	Cooperative action with international organizations including the Food and Agriculture Organization and the World Organisation for Animal Health
Universal Health Coverage (UHC)	Patent laws pose barriers to affordable drugs	Advocate for UN high-level panel on affordable medicines recommendations
	Countries fail to prioritize needs of and access for marginalized people	Become a global advocate for rights and equity, including calling for the Framework Convention on Global Health
		Promote national health equity strategies
		Incorporate R2H norms, including participation, equity, and accountability into technical guidance

Universal Health Coverage (UHC) cont.	Weak and underfunded national health systems	Advocate for UHC investments at highest political levels
		Promote innovative financing models
		Implement <i>Workforce 2030</i> strategy and high-level task for on health employment
		Mobilize state and stakeholder buy-in; influence domestic spending and international assistance toward UHC
Non-Communicable Diseases (NCDs)	Rapid growth of NCDs, especially in lower-income countries	Include high-cost/high-value NCDs drugs in WHO essential medicines list, ensuring their affordability
		International norms and national regulations to prevent NCDs as core health system function
		Strengthen accountability and technical assistance for FCTC implementation
	Entrenched corporate interests	Support state action by building evidence, sharing lessons, and strengthening norms
		Ensure strict adherence to protections against conflict of interest
		Employ mix of strategies to help governments: advocate for regulations, expose industry tactics, and provide legal/political support
Climate Change	Health is low priority in national adaptation strategies	Build evidence on health effects of climate change and strategies to mitigate them
		Develop technical guidance on mitigating health effects of climate change
	Health sector contributions to climate change	Set targets, develop and promote guidance on reducing health sector carbon emissions
	Indoor and outdoor air pollution among leading causes of death	Promote right to health impact assessments
		Advocate for clean cooking technology
		Forge closer links with environmental sector and advocates

Global health security

If for no reason other than WHO's weak response to Ebola, global health security promises to top the next Director-General's agenda.¹³ The Organization formed a health emergencies programme recommended by the post-Ebola commissions.¹⁴ Partnering with the Global Health Security Agenda, WHO also established a Joint External Evaluation to assess whether states have met core health system capacities in the International Health Regulations (IHR).¹⁵ Yet, the emergency programme remains significantly under-funded, while the Evaluation Tool is purely voluntary. The new Director-General will have to convince states to fund WHO emergency operations, build core capacities, and comply with IHR norms. This will not be easy if history is a guide. WHO's emergency operations have not garnered robust financial support. Further, the US Global Health Security Agenda, which provided USD\$1 billion is unlikely to be reauthorized. Thus, internal reforms, mobilizing resources, and successful IHR implementation remain the greatest challenges.

Anti-microbial resistance

Ensuring health security requires effective therapeutic countermeasures. Yet, antimicrobial resistant pathogens present a major health hazard. AMR is already taking 700,000 lives per year,¹⁶ from townships and shantytowns in South Africa¹⁷ and India to large hospitals in Europe and the North America.¹⁸ WHO's challenge is not simply financial, but also involves multiple sectors: antimicrobial use in medicine and animal husbandry, global trade in falsified and substandard medicines, and pharmaceutical industry incentives to develop new classes antibiotics.¹⁹ It requires cooperation among complementary regimes, such as the Food and Agriculture Organization, World Organization of Animal Health,²⁰ and Drugs for Neglected Diseases initiative. Innovative financing models, including the new Global Antibiotic Research and Development Facility, are needed to stimulate research.²¹ The UK Review on Antimicrobial Resistance recommended a Global Innovation Fund endowed with \$2 billion to support research, along with \$16 billion every ten years for a market entry reward system to support 15 new drugs per decade—a modest security dividend for creating a pipeline of effective therapeutic countermeasures.²² Failure to act could result in an unthinkable scenario where antimicrobials are no longer effective to combat enduring and emerging infectious diseases.²³

Universal health coverage

Health system strengthening is integral to achieving all health priorities, reflected in at least three overlapping mandates: WHO-led strategies, IHR core capacities, and the SDG target of universal health coverage.

WHO has launched multiple initiatives to strengthen national health systems. To achieve IHR capacities, the agency formed the Joint External Evaluation Tool. To build human resources, it published a global strategy, *Workforce 2030*.²⁴ Its framework on integrated, people-centred health services^{25,26} extends matrices of health system effectiveness to empowerment, equity, participation, accountability, and cross-sector collaboration. The new Director-General's task is to ensure that these norms catalyse action. Normative guidance for local and national activities could draw on recommendations from the WHO Consultative Group on Equity on Universal Health Coverage²⁷ and the Independent Accountability Panel for the Global Strategy on Women's, Children's and Adolescents' Health.²⁸ Yet, WHO's own capacity to support national health systems remains weak, with most resources earmarked for specific diseases or programs. In short, WHO's highest norm is not reflected in its budget, operations, and priorities.

The new Director-General will have to direct international assistance and domestic spending toward the critical elements of UHC, including skilled human resources, surveillance, management, laboratories, clinics, and affordable vaccines and medicines. Historically, donors have found it preferable to invest in narrow, measurable targets, rather than seeing the long-term value of UHC, with domestic funding often following suit. A visionary WHO leader must change that perception.

The SDGs also may help change this dynamic, with their target (3.8) of achieving “universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”²⁹ This comes with great challenges.

First, countries often take a narrow approach to UHC, focused on clinical care,³⁰ rather than giving full weight to population-based measures. WHO's definition of UHC encompasses promotion, prevention, treatment, rehabilitation, and palliative care,³¹ but the SDG's UHC target does not incorporate public health.

Second, access to medicines will require keeping drugs affordable, even as patent laws continue to pose barriers to less-expensive generics; powerful new medicines, such as for Hepatitis C and cancers, come with high prices. While the UN High-Level Panel on Access to Medicines' recommendations are primarily directed at actors other than WHO, the Director-General should be their champion-in-chief, insisting that states and international organizations press for affordable access. This will require a more muscular approach to the World Trade Organization, placing health closer to the centre of its decisions on intellectual property.

Third, countries may be tempted to follow the easiest route to UHC, leaving out the worst off and hardest to reach. This strategy places at risk the poor, immigrants, and communities living in remote geographic regions. An approach prioritizing those who are furthest behind and most marginalized, as part of a broader frame of equity, is essential.³²

Fourth is the weakness of many health systems, above all the shortage of health workers, which more than a decade after WHO's landmark World Health Report³³ remains immense.³⁴ The UN high-level commission on health employment created new momentum that the next Director-General should seize.

Finally, the cost of UHC is high, with US\$37 billion annually in additional spending required.³⁵ This is on top of a several trillion-dollar gap in achieving the full SDG agenda.³⁶

Non-communicable diseases

The world is experiencing an epidemiological transition to non-communicable diseases (NCDs), which have become the leading cause of death in developing countries, many of which have dual-burdens of infectious and non-communicable diseases. NCDs account for 63% of all deaths globally, with four out of five occurring in low- and middle-income countries, as do nine in ten premature (before age 70) NCD deaths.³⁷

The new Director-General will have major push back from vested interests, but must include high-cost/high-value drugs in its essential medicines list, while ensuring their affordability. This will require bridging divides among governments, innovator and generic pharmaceutical companies, and civil society. Moreover, regulations in food, tobacco, alcohol, air pollution, and zoning could markedly reduce NCDs. WHO has a vital role in building evidence, sharing lessons (on policies' effects as well as political pathways to overcome resistance), and strengthening legal norms. The next Director-General could set a bold target of comprehensive NCD regulations in all countries within a decade—including full FCTC implementation, WHO “best buys” for evidence-based interventions, and tight pollution control standards. National legislative models offer a guide to reform, such as Mexico's sugary drinks tax, Buenos Aires' salt restrictions, and New York's ban on trans fatty

acids. Hungary's Public Health Product Tax is among the most comprehensive NCD prevention laws in the world.³⁸

Climate Change: Mitigation and Adaptation

Although climate change is often framed as a threat to habitats and the environment, it has powerful health effects. Severe weather events can raise sea levels, erode soil, and force people from their homes. Climate change could fuel heat waves, increase pollution, alter the geographical reaches of disease vectors, and produce crop failures. These dynamics increase injuries, malnutrition, infectious diseases, asthma, and cardiovascular disease. Climate change, moreover, amplifies the physical and mental health consequences of forced migration, as people flee from uninhabitable regions of the globe.³⁹

The Paris Agreement—with its explicit recognition of the right to health—represented a political watershed.⁴⁰ Political leaders promised to “mitigate” (addressing root causes) and “adapt” (helping communities and ecosystems to cope). Governments agreed to a \$100 billion Green Climate Fund, but only 2% of funding from a climate adaptation fund for the world's poorest countries focuses on health harms.⁴¹ Yet, WHO's work plan on climate change and health⁴² has not been a high priority. Key WHO actions would foster links between health and other sectors, share good practices, implement cutting-edge technical guidance, and build political will for health adaptation. With outdoor pollution causing 3 million deaths every year⁴³ and indoor pollution >4 million,⁴⁴ the world's global health leader must become an environmental leader.

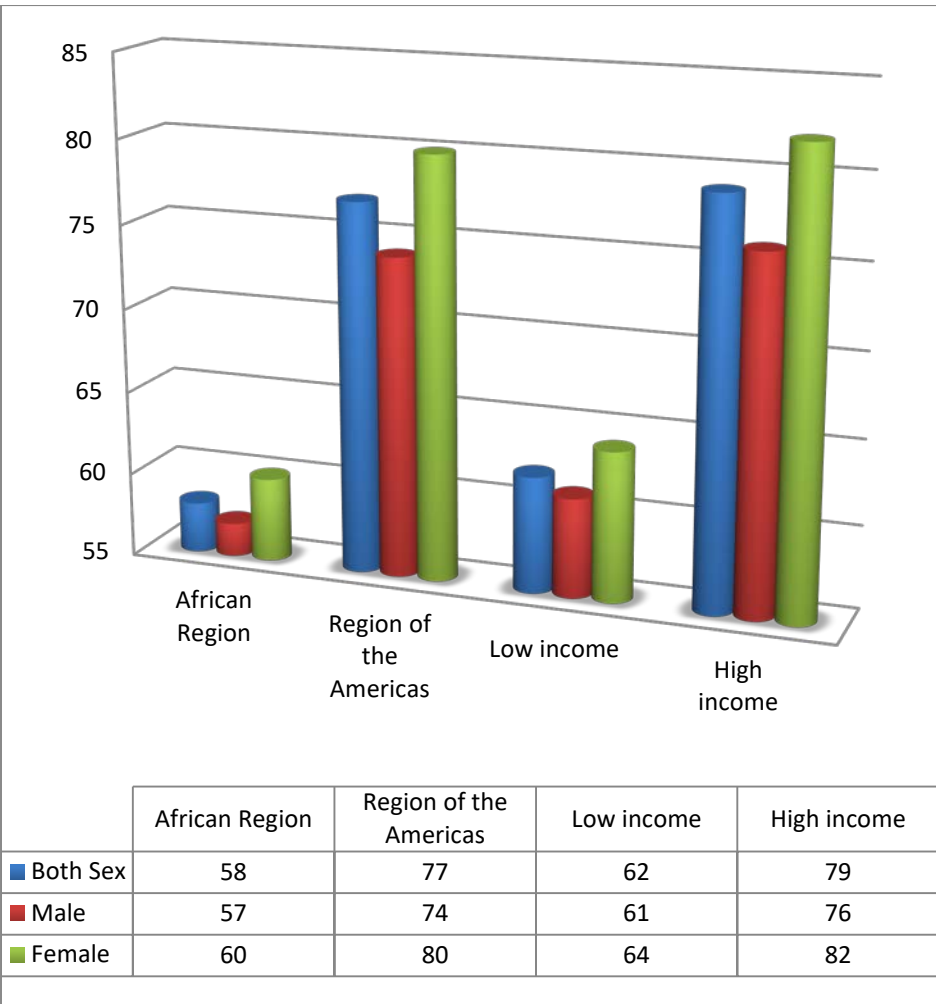
EQUITY: A FAIR SHARE FOR ALL

The new Director-General should become a global advocate for equity, the driving force behind the right to health, captured in the SDGs' core value, “no one is left behind.”⁴⁵ Although many health-related Millennium Development Goals were met, the world's poorest and most marginalized were left behind (Figure 3). The new Director-General could drive policies and funding toward closing the equity gap: ambitious rights-based benchmarks, disaggregated data, R&D directed toward the poor, mental health services, and national health coverage for vulnerable populations including immigrants.

The Director-General's agenda should also include national health equity strategies developed through inclusive participatory processes, with a budgeted action plan.^{46,47} The next Director-General should join with UN Secretary-General António Guterres to hold a UN Special Session on Health Equality. Funded action on the social determinants of health would yield major gains in population health, fairly distributed.

Even more boldly, the next Director-General could heed the call of outgoing Secretary-General Ban Ki-moon, urging the international community to “recognize the value of a comprehensive framework convention on global health (FCGH).”⁴⁸ Based in the right to health, the FCGH would enhance accountability, reduce marginalization, improve policy coherence, and mobilize financing—all with the primarily objective of reducing health disparities.⁴⁹ The next Director-General should answer this call to action.

Figure 3: Health disparities on life expectancy at birth (2013)



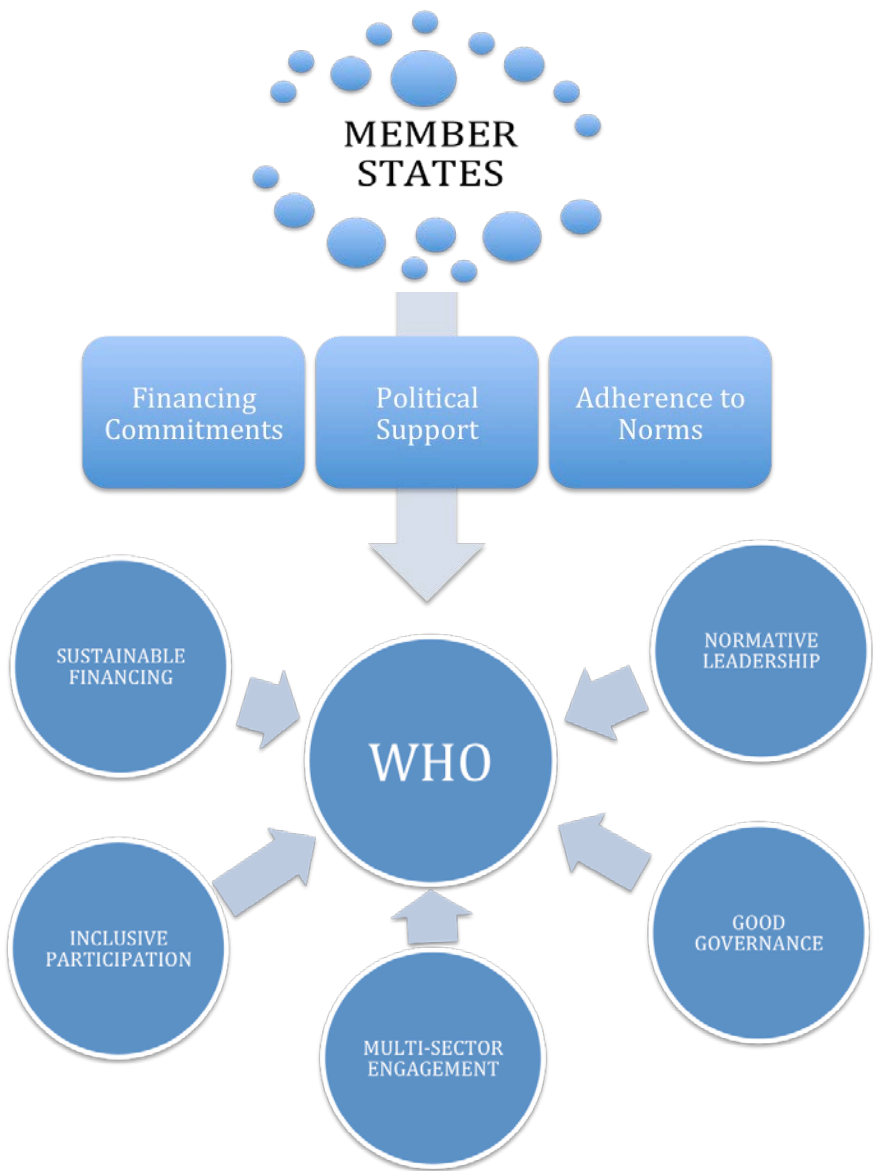
Data are selected from the highest and lowest regions and groups. Age floor crossing is adjusted from 55. Source: WHO. World Health Statistics 2015. 2015. http://apps.who.int/iris/bitstream/10665/81965/1/9789241564588_eng.pdf?ua=1 (accessed on May 25, 2017).

BUILDING A 21ST CENTURY WHO

Empowering a 21st century WHO, fit for purpose, should be among the world's most important tasks. That requires reforming the Secretariat including regional and country offices, as well as spurring member states to act as stakeholders in the Organisation's success. Critiques of WHO performance frequently understate member states' contributions

to organizational dysfunction—unwilling to sustainably fund and politically support the agency and its mission. Here are 5 building blocks for a reinvigorated WHO (Figure 4):

Figure 4: Formula for a reinvigorated WHO: five building blocks + member state support



Inclusive participation: civil society and communities

Newer global health entities such as the Global Fund, GAVI, and UNITAID include civil society as full partners. UNAIDS affords affected communities a powerful voice, albeit with non-voting governing board status. WHO, however, remains stuck in heavily state-centric governance. This is a missed opportunity, as civil society can bring fresh ideas, become potent advocates for WHO priorities, give voice to the most marginalized, and hold states and other powerful actors—and WHO itself—accountable.

WHO's new Framework for Engagement with Non-State Actors should have brought community participation to the centre of WHO's activities.⁵⁰ The Framework's primary focus, however, is managing conflicts of interest, doing little to change the basic structure of civil society participation. For example, WHO strictly limits non-state actor participation in governance to those in "official relations," which include international business associations and foundations as well as NGOs. Moreover, entities in "official relations" must demonstrate international scope or membership, which freezes out community groups in low- and middle-income countries. The Director-General can invite non-state actors to attend WHO meetings, but participation is a privilege rather than a right.

Contrast this to human rights standards, which include "participation of the population in all health-related decision-making at the community, national and international levels."⁵¹ Global health advocates have proposed several ideas to foster community participation: a "Committee C", consisting of NGOs, philanthropic organizations, multinational health initiatives, and international agencies;⁵² an NGO forum to provide formal input to member states; and structured and inclusive hearings.⁵³ None has garnered widespread support.

It is time for new thinking and bold action. Early in his or her term, the new Director-General should convene influential civil society and community members to propose new possibilities for "meaningful participation" and "accountable representation."⁵⁴ Participation in governance could be broadened through regional and local hearings as well as web-based input. While new ideas must fit within WHO's constitution, the Assembly should be open to amending its founding document to reflect powerful governance norms of the 21st century.

Multi-sector engagement

Nearly a decade ago, the WHO Commission on the Social Determinants of Health recognized that "maldistribution of health care" is a major social determinant of health (SDH). Yet, "the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age."⁵⁵ This broad socioeconomic agenda remains on the margins of WHO priorities. WHO does not have an SDH department, but only a small team that doesn't appear on WHO's organizational chart.⁵⁶ Social determinants of health receive <1% of the Organization's budget.⁵⁷ The next Director-General should create an SDH department, while diversifying staff competencies to include more anthropologists, social scientists, economists, and engineers who can enhance WHO's work outside the health sector.

Beyond WHO's internal reforms, the next Director-General could convene multi-sector ministerial meetings—the environment, finance, water, sanitation, education, justice, social welfare, agriculture—to build national capacities. Outputs could include right to health impact assessments to inform actions across sectors to ensure consistency with the right to health. While WHO urges governments to abide by a Health in All Policies strategy, the Organization needs to follow suit.

WHO also should deepen engagement with other multilateral entities, including human rights treaty bodies, to vigorously defend the right to health and influence key

decisions at the World Trade Organization, World Bank, International Monetary Fund, and other venues that impact on health outcomes.

Good governance: Transparency and accountability

External evaluations have ranked WHO low in effectiveness, organizational learning, transparency, and accountability.⁵⁸ The UN Joint Inspection Unit 2014 review of 28 UN agencies corporate evaluation functions found WHO to be “below average,” while the One-World Trust on WHO accountability found “large scope for improvement.”^{59,60} The United Kingdom’s Department of International Development recently evaluated WHO organizational strength as merely “adequate.”⁶¹

The current Director-General has sought to instil greater accountability. The program budget and its “results chain” link Secretariat outputs to national and global outcomes, with mid-term and biennial reviews. The goal is to foster real-world outcomes and evaluate how results link to resources.⁶² WHO is integrating a comprehensive risk framework into its performance-based management process.⁶³ The Organization’s new independent performance evaluation programme is a promising first step, and warrants Director-General and member state support.

The new Director-General should deepen commitments to transparency and accountability. WHO could introduce real-time monitoring of performance gaps to promptly correct course.⁶⁴ The Director-General should also authorise annual, multi-stakeholder assessments of WHO performance at regional and country level,⁶⁵ including community perspectives. The process and results must be transparent, and the Organization must act, and be seen to act, on the basis of objective performance evaluations.

In the last election, the Director-General ran unopposed in a process criticized as lacking transparency and inclusiveness. The 2017 election has a series of steps, more open to public scrutiny. Even with this new process, WHO elections need to be more transparent, both for the Director-General and Regional Directors, including candidates opening their campaign financing to public scrutiny.⁶⁶ One proposal worth considering to foster regional office accountability would be to phase out Regional Director elections, replacing them with Director-General appointees made in consultation with the region’s member states.⁶⁷

As WHO focuses on Secretariat accountability, even more important will be member state accountability in supporting WHO plans of action, strategies, codes, and other WHA resolutions. The next Director-General could establish an accountability framework encompassing state expectations and commitments based on Organizational norms, beginning with state self-assessments and WHO’s own data, and moving towards multi-stakeholder external evaluations, with results made public by country.

Normative leadership

Central to its position as the world’s leading health authority is WHO’s normative functions: setting standards, creating strategies, establishing norms, promulgating regulations, and negotiating treaties. Even as WHO’s operational role receives increasing scrutiny following Ebola, WHO normative responsibilities remain its most important function, embedded in its constitution. Above, we offer normative opportunities for WHO: technical guidance on climate change and health; norms for integrated, people-centred health services; national equity strategies and rights-based benchmarks; health financing targets and pathways; and right to health impact assessments. Director-General candidates have suggested other topics for normative development such as nutrition standards and access to medicine.^{68,69}

WHO has exercised normative leadership in negotiating two major treaties: the Framework Convention on Tobacco Control (FCTC) and the IHR (2005). The Pandemic Influenza Preparedness (PIP) Framework overcame a major impasse on virus sharing and

equitable benefits for pandemic influenza.⁷⁰ Although the PIP Framework is not a binding treaty, it uses contract law to bind pharmaceutical and biotechnology companies to share medical technologies and licenses. As such, the Framework offers an innovative multi-stakeholder agreement as a global model for future normative development.

The FCTC's success has spurred academic and civil society interest in further treaties, such as on R&D, AMR, NCDs, and alcoholic beverages. The next Director-General ought to choose normative priorities, while demonstrating diplomatic skill and resolve to forge a global consensus. Binding law has unique normative power, with the potential to hold actors to account and fight for health within competing international legal regimes, such as trade and illicit drug control. Accordingly, the new Director-General should consider a transformative treaty such as the FCGH to achieve greater equity, participation, multi-sector engagement, financing, and accountability.⁷¹

A BULWARK OF HEALTH AND UNIVERSAL HUMAN RIGHTS

The next director-general will face a new world environment inimical to WHO's cherished values—international cooperation, cross-border solutions, and global public goods. Heightened nationalism and xenophobia erect barriers (literally and figuratively) to achieving health-for-all and universal health coverage. Political movements distrustful of international institutions and treaties threaten the solidarity upon which global health depends. Widespread inequality within and among countries undermines equity, justice, and an ethos of shared destiny.

This political environment would challenge any director-general. Yet making the director-general's task far more difficult still, WHO member states have long criticized the Organization's performance while withholding the means for it to do better. The international community can ill afford to perpetuate this unvirtuous cycle—a perennially weakened WHO, unable to live up to its founding vision. Member states must re-commit to WHO, yielding some sovereignty for the common good. That requires financial and political backing of the Director-General, abiding by international health norms, and forging bold new norms. WHO *can* become a 21st century model of effectiveness, inclusiveness, and accountability, standing up for the universal right to health. With strong leadership and reinvigorated member state commitment, WHO can serve as an inspiring contra-example to today's destructive politics, demonstrating that the community of nations are indeed stronger together.

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Declaration of interests: LOG is Director of the World Health Organization Collaborating Center on National and Global Health Law. The author would like to recognize Eric A. Friedman who contributed extensively to this article

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