2 PLAYING POLITICS

The World Health Organization's Response to COVID-19

Matthew M. Kavanagh, Renu Singh, and Mara Pillinger

Understanding WHO as a Political Institution

The challenges of the World Health Organization (WHO) begin, perhaps, with its name—framed as one organization, spanning the globe, and tasked with securing, as defined by article 1 of its constitution, "the attainment by all peoples of the highest possible level of health" (WHO, 1946). Yet the gap between the expectations of WHO and how global political actors have shaped its structure and its capacities is vast—never more so than during the COVID-19 pandemic.

It is necessary to look at WHO from at least two perspectives: (1) its role as a scientific, technical, and humanitarian organization and (2) as an international organization and venue for international political negotiation, diplomacy, and policy-making. These two different, at times conflicting, missions leave WHO in a precarious position and have opened it to criticism over the years (Siddiqi, 1995). Some argue that WHO's importance stems primarily from its political and agenda-setting functions, whereas others argue the technical information-gathering, standard-setting, and cooperation-related activities are paramount and that the agency's political nature detracts from these activities (Clift, 2014; Jamison et al., 1998; Retreat, 1996; Ruger & Yach, 2009). There have even been calls over the years to split these functions (Hoffman & Røttingen, 2014).

In practice, though, WHO's mandate to "act as the directing and coordinating authority on international health work" requires both, even where they sit uneasily together (WHO, 1946). Indeed, some of the agency's most important work in recent years, such as fighting the recent Ebola outbreak in the Democratic Republic of the Congo in an active war zone, would not have been possible without combining science, politics, and diplomacy. Yet this combination has also led to perhaps the biggest threat to the organization since its founding as the United States—WHO's biggest financial contributor—declared its intention to withdraw in July 2020 over accusations that WHO is acting as a "political, not a science-based, organization" (Sabbagh & Stewart, 2020).

Founded in 1948, the WHO was established as a specialized agency of the United Nations (UN), governed by an executive board and parliamentary World

Health Assembly (WHA), both made up of member states. Its creation followed an extended negotiation over the direction of international health, culminating in the merging of functions that had previously been held across various international entities (Lee, 2009). During its first decades, WHO stood at the center of a global network of scientists and policy-makers, enjoying recognition as the international leader in issues of health and disease. The eradication of smallpox by a global program led by WHO demonstrated the power of international coordination and technical expertise (Burci, 2018). Over the years, however, WHO has repeatedly been challenged by political rivalries, expanding and competing priorities, fiscal constraints, and competition with other private and public organizations in global health (Davies, 2010; Youde, 2018). With regard to public health emergencies, the severe acute respiratory syndrome (SARS) outbreak of 2003 was a watershed when WHO, under the leadership of Director-General Gro Harlem Brundtland, took the nearly unprecedented step of directly, publicly criticizing China, a powerful member state, for its lack of transparency. Brundtland also rallied governments to respond with a set of scientifically based control measures. These actions eventually led, in 2005, to a major revision of the legally binding International Health Regulations (IHR) treaty. The revised IHR placed new obligations on states to share information about outbreaks within their borders and gave WHO new powers to gather and share data, declare "public health emergencies of international concern" (PHEICs), and issue recommendations about how countries should respond (Heymann et al., 2013). Yet WHO quickly came under scrutiny for how it exercised these powers during the 2009 swine flu (H1N1) epidemic and the 2014 Ebola outbreak in West Africa, leading to multiple inquiries and reform efforts to make WHO more effective (Gostin et al., 2016; Moon et al., 2017). During the former, the agency was criticized for acting too aggressively, and during the latter, for not acting aggressively enough (Kamradt-Scott, 2016).

In this chapter we seek to explain how political factors and history help explain WHO's actions—both where it has stumbled and where it is innovating to address problems in new ways. We begin with the challenges that existed at the outset of the pandemic, explain WHO's actions in three specific areas, and then seek to explain these actions. WHO's capacities have been shaped by member states in a set of evolving geopolitical contexts. In the current pandemic, many past strategies have proven untenable as its responsibilities, particularly vis-á-vis high-income countries, have rapidly expanded and forced WHO to innovate.

Three Sets of Challenges

Against this backdrop, the roots of WHO's COVID-19 response can be found in three sets of political and structural challenges: the decentralized structure of the organization, the competing and conflicting pressures of member states, and the finances of the organization.

First, WHO is far less of a unitary "world" "organization" than its name suggests. In practice, it is characterized by familiar geopolitical divisions and

tensions between the organization's headquarters and regional offices. Advanced industrialized countries began to lose their control over the WHA by the 1970s as decolonization led to a growing number of voting members from developing nations (Chorev, 2012; Cueto et al., 2019). This brought a loss of influence and prestige for wealthy nations and a deepening of WHO's focus primarily in low- and middle-income countries (LMICs). Meanwhile, WHO's Secretariat is based in Geneva, but much of its operations function through six semiautonomous regional offices. The Director-General has remarkably weak authority over these offices, each of which is led by a regional director elected by its member states and with command over its own budget. The increasing focus on LMICs has further decreased the political heft of Geneva. With three-quarters of staff and more than half of total expenditure under the control of the regional offices, the decentralized structure creates centers of power and jockeying between member states, as well as variable capacities between regions (Clift, 2014; Lee, 2009). Although this structure can have the advantage of fostering closer relations, better coordination, and cooperation between WHO and governments, it can also cause "pathological fragmentation," creating inefficiencies, overlaps, and unaccountability resulting from a principal-agent problem between the Geneva and regional offices (Graham, 2013; Hanrieder, 2015). During the West African Ebola outbreak, for example, disjuncture and miscommunication between the country, regional, and headquarters levels contributed to the agency's failure (Kamradt-Scott, 2016; Wenham, 2017). The post-Ebola restructuring built a new Health Emergencies Program that has significantly improved the capacity of WHO headquarters to coordinate and respond, including by creating direct lines of reporting authority between Geneva and the regional offices (Ravi et al., 2019). Yet the continuing weakness of WHO Geneva (where much of the global political and media attention is focused) compared to the regional offices (where much of WHO's influence and capacity lies) is notable.

Second, WHO has also always been subject to the competing priorities of its 194 member states and especially its donors. Cold War politics kept WHO torn between focus on biomedicine and social medicine, between a focus on Eastern Europe versus Asia, Latin America, and Africa (Lee, 2009). More recently, the tensions have been multipolar and multipriority. WHO has as many priorities as it has masters. Disease-specific efforts on human immunodeficiency virus (HIV) and polio, universal health coverage, pandemic preparedness, humanitarian emergency response, innovation, access to medicines, and a host of other priorities have been tasked to WHO at annual WHAs by overlapping coalitions of member states and promoted by nonstate actors such as the Bill & Melinda Gates Foundation. The 2017 election of Dr. Tedros Adhanom Ghebreyesus as Director-General, Ethiopia's former minister of health and of foreign affairs, marked the most open and competitive WHO election in which this complex prioritization challenge was clearly articulated. Yet WHO still faces a principal-agent problem, in which "when the signals from the principals are conflicting, it can paralyse the agent" (Youde, 2016). Chorev argues that the WHO Secretariat has not been a passive agent but has engaged in

strategic adaptation to external pressures—reframing demands and regimes to fit the organizational culture and building space for autonomy and action driven by the bureaucratic leaders of the organization (Chorev, 2012). That task has grown harder, though, as the principals' demands have grown, and it is particularly difficult in issue areas such as pandemic responses, which are high visibility and high priority and therefore subject to high levels of oversight from principals.

Finally, WHO is operating on a budget roughly the size of a large hospital in a wealthy nation. The budget is predominantly endowed by a handful of actors, with the United States contributing up to 20 percent of WHO's budget in recent years (WHO, 2019). The current biennial budget for 2020–2021 is set at $4.84 billion, without taking any potential additional, emergency expenditures into account. WHO's funding comes in two forms: assessed contributions from member states and voluntary contributions from member states, private organizations, and individuals. The latter are usually tied to specific uses and projects. Assessed contributions from member states based on income and population originally provided the majority of WHO's income (Lee, 2009). However, because assessed contributions were essentially frozen in the early 1990s, the scales have tipped (S. K. Reddy et al., 2018). Voluntary contributions now account for up to 80 percent of the organization's budget (Kaiser Family Foundation, 2020). Furthermore, member states often fail to pay their assessed contributions on time or at all (Daugirdas & Burci, 2019). This leaves WHO increasingly dependent on unstable voluntary contributions, subject to the whims of donors and constrained in how it can spend even the money that it has (K. Reddy & Selvaraju, 1994). In addition, half of the top ten contributors to WHO are also nonstate actors (e.g., the Bill & Melinda Gates Foundation) (WHO, 2020e). Private funders lack the same level of democratic accountability and institutional durability as states (Marion, 2020). Further, extrabudgetary funds also provide disproportionate funding in certain areas and make it difficult for WHO to make long-term plans (Davies, 2010; Lee, 2014; Youde, 2015). Member states have recognized these financial problems and taken partial steps to shift budgetary control back to the WHA and the Secretariat, yet they have consistently rejected efforts to increase assessed contributions (Daugirdas & Burci, 2019). These funding difficulties are visible in WHO's struggle to raise emergency funds for its response to COVID-19.

WHO would benefit from greater power, autonomy, and funding to fulfill its mandate. Although these benefits would apply to any number of health concerns that the agency addresses, COVID-19 provides a powerful example of both the high expectations and historically rooted institutional constraints the agency faces in its work.

WHO Response to COVID-19

COVID-19 quickly evolved from an isolated set of "viral pneumonia" cases into a full-blown pandemic that overwhelmed health systems, brought countries to a

halt, and pulled the global economy into a deep recession. As the leading global health agency, WHO has played a central role in alerting the world to the threat of and coordinating efforts to fight the disease. However, it also has become a target of criticism. Although sometimes deserving of—and learning and evolving from—such criticism, the body is also an easy target because of its status as an international organization that seems to have more capacity and freedom than it actually does. We can see these dynamics play out in at least three roles WHO has played in the COVID-19 response: gathering and reporting epidemiological data; issuing scientific and technical guidelines; and promoting development of, and equitable access to, diagnostics, therapeutics, and vaccines.

Sharing Epidemiological Data

A key piece of WHO's role is overcoming individual states' incentives to suppress damaging news of outbreaks and ensuring outbreak information is rapidly shared. On December 31, 2019, a statement about "viral pneumonia" by the Wuhan Municipal Health Commission and media reports of the outbreak were picked up by WHO office in China. This information was reported through various channels in accordance with the IHR and eventually verified by Chinese authorities. Other governments, including Taiwan's, inquired with WHO about similar reports they had received. By January 5, 2020, WHO had shared news about the outbreak on Twitter and through official channels, with the update that it was caused by a novel coronavirus coming shortly thereafter. On January 11, WHO tweeted that it had received the genetic sequence, with the first protocol for a diagnostic test published by WHO on January 13 (WHO, 2020a). WHO's actions were rapid, although it would later become clear that the disease had been circulating in China for some time. That country's authoritarian power structures played a role in delaying public reports, including downplaying human-to-human transmission until after international spread had occurred (Kavanagh, 2020). WHO had to engage in a series of high-stakes negotiations with China for greater information sharing and access for expert investigative teams, including access to Wuhan in late January and an international mission to China in mid-February, which resulted in important information about the mortality and transmission dynamics of the virus (WHO, 2020f).

Here WHO's limited power was on display. Because the IHR contain no enforcement mechanism, WHO had no real recourse if the Chinese government decided to stop sharing information or refused access to international experts. The option of publicly "shaming" the government as under SARS was a risky strategy with a more powerful China of 2020 and could lead to significant delay. WHO instead sought to stay on good terms with Chinese authorities, focusing on praise and private diplomacy. But although WHO arguably had few other cards to play, it may have overplayed its hand. Dr. Tedros' press conference upon his return from China strongly praised China's response, which included harsh lockdowns many believed were problematic (Kavanagh & Singh, 2020). This strong praise would

later come to be used against the Director-General by those seeking to cast doubt on WHO's independence and who claimed he was too close to China.

Similarly, the question of human-to-human transmission would become a political flash point, with critics claiming a cover-up by China and pointing to an early WHO tweet on January 14, 2020, that "Preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission" (WHO, 2020b). But that same day in a press conference, officials at WHO Geneva suggested it was possible there *was* human-to-human transmission, a reality confirmed by WHO's regional office on January 19, 2020, and an investigative trip to Wuhan by WHO officials on January 20 to 21, 2020 (WHO, 2020b). On January 30, the Director-General declared a PHEIC, WHO's highest level of alert. Although this followed the advice of an independent expert IHR Emergency Committee, some still claimed that it should have happened sooner (Pillinger, 2020a; WHO, 2020g). On March 11, 2020, the Director-General stated that COVID-19 was a pandemic; even though declaring an outbreak a "pandemic" is a colloquial term, with no formal or legal meaning (unlike the PHEIC declared in January), the statement would later provide fodder for those critical of WHO (WHO, 2020g).

Taken as a whole, though, WHO's efforts to push countries to share data rather than hide it have been successful. An online dashboard displays daily case counts for nearly all WHO member states (WHO, 2020j). In the first six months of the pandemic, WHO conducted press briefings at least three times a week, sharing data and scientific updates. Its success is perhaps best illustrated in the breach, as only two countries, Turkmenistan and North Korea, have at the time of this writing continued to claim they have no confirmed COVID-19 cases, despite evidence to the contrary. In mid-July 2020, a health advisory team from WHO was allowed to visit Turkmenistan and did not question the government's assertion publicly but urged health authorities to act "as if COVID-19 was circulating" (Auyezov & Gurt, 2020).

Issuing Scientific Guidelines

A second important part of WHO's COVID-19 response has been gathering and aggregating scientific information and issuing guidance to governments and the public about how to respond. One of the first and highest-profile pieces of guidance advised countries not to enact travel restrictions or bans—first from China and then from other parts of the world (WHO, 2020i). This is rooted in the IHR's goal of moving away from border restrictions and quarantines that were highly disruptive to global trade. Restricting travel from countries experiencing disease outbreaks has not proved effective in stopping disease, with porous borders and significant opportunity costs (Pillinger, 2020b). They also undermine movement of goods and people needed to fight disease. WHO also seeks to avoid travel restrictions because they give countries incentive to hide outbreaks. In this case, however, many countries ignored WHO's advice, racing to close borders to China. Early

reports suggest that countries that had not closed their borders had done as well or better in preventing the spread of COVID-19 than countries that had, such as the United States and Italy (Kiernan et al., 2020). This recommendation, however, has opened WHO to criticism—most pointedly by US President Donald Trump, who said WHO "actually criticized and disagreed with my travel ban at the time I did it. And they were wrong" (Hjelmgaard, 2020).

WHO has issued a vast range of other scientific pronouncements, guidance, and advice, with more than one hundred different documents on the SARS-CoV-2 virus, case identification, personal protective equipment, contact tracing, health worker protection, community response, and much more. It has published so much that it had to publish a guide to its guidance (WHO, 2020l). It is notable that most of this work was well received and quickly taken up around the world. However, a few critical issues have generated significant attention and controversy, including WHO's response on lockdowns, masks, and whether COVID-19 is "airborne."

WHO for many months advised against widespread mask mandates, worrying that masks would "create a false sense of security, with neglect of other essential measures" and "take masks away from those in health care who need them most" (WHO, 2020d). It was only on June 5, 2020, several months into the pandemic, that WHO recommended the widespread use of masks (WHO, 2020h). However, by that point, WHO was behind the curve. More than one hundred countries had already adopted some form of nationwide mask-wearing mandates before WHO updated its guidelines, and 95 percent of countries were already recommending mask usage in public in at least some cases (Community Initiatives, 2020). And WHO's initial endorsement of masks was lukewarm, noting that lack of "high-quality" scientific evidence to support their use and numerous disadvantages of wearing them, including "potential discomfort" and "difficulty with communicating clearly" (Mandavilli, 2020). Critics have said that mandating masks was long overdue as a simple, inexpensive, and effective measure, and they fault WHO delay.

Relatedly, WHO had a long and complicated public messaging challenge around whether COVID-19 was technically airborne (i.e., spread through small, aerosolized droplets that can float through the air, rather than just through larger droplets that quickly fall to the ground). The agency acknowledged the possibility of airborne spread after a group of 237 international experts and scientists published a commentary in *Clinical Infectious Diseases* urging them to do so (Lewis, 2020; Morawska & Milton, 2020). As with masks, WHO has also remained adamant in emphasizing the uncertainty of scientific evidence and in recommending mitigation strategies through other means (Mandavilli, 2020).

During COVID-19, much of the criticism has centered on WHO moving too slowly in a rapidly evolving pandemic. But it is worth remembering that in the past, such as during the H1N1 pandemic, the criticism has gone in the other direction. Governments complained of costly and disruptive efforts necessary to implement WHO recommendations. Rapid recommendations can also create

backlash against the international agency if the measures are later proven to be unnecessary, as during H1N1. Regardless, during COVID-19 controversies have occurred amid a fast-moving scientific context, unfolding in real time in the glare of media headlines. WHO's position as global technical leader has taken a hit from controversies that may have gone unnoticed in other contexts.

Access to Diagnostics, Therapeutics, and Vaccines

A third major part of WHO's response has been seeking to expand access to diagnostics, therapies, and future vaccines worldwide—where WHO has innovated, building new strategies in the face of new threats and an absence of other authoritative actors. WHO launched the Access to COVID-19 Tools (ACT) Accelerator in April 2020—with words of strong commitment from heads of state, particularly from Europe, Africa, Latin America, and the Caribbean. Notably missing from this nominally global effort were the United States and Russia, who declined to participate in any form, and China, who participated only at a very low level. This initiative aims to facilitate coordination between governments, scientists, businesses, civil society, philanthropists, and global health organizations to expedite the development and production of COVID-19 tests, treatments, and vaccines, and to provide equitable access. There is a particular emphasis on developing an allocation strategy to ensure that LMICs receive an equitable and accelerated delivery of vaccine doses, treatments, and other commodities, with the logic that no one is safe in a pandemic until everyone is safe (WHO, 2020c).

The fundamental challenge, however, is that global solidarity has been hard to find, as ethical distribution would require powerful states to share access to limited supplies even as their populations clamor for greater access. Although the ACT Accelerator was launched in April 2020, with fanfare by heads of state, it initially struggled to secure funding: as of late September, it had raised only $4 billion of the needed $38 billion, and $15 billion of this shortfall was said to be urgent (WHO, 2020k). But despite WHO's efforts to coordinate procurement, action has been fragmented and duplicative. For example, the African Union is seeking its own pooled procurement. Multiple different technology pools emerged, but with little commitment from leading companies. Particularly on vaccines, WHO has struggled to prevent the development of "vaccine nationalism" (i.e., competition among countries to secure limited stocks of vaccine for their own populations, especially by high-income countries that can afford to place massive preorders for multiple vaccines, which *de facto* limits access for other countries). The Trump administration's initiative to accelerate vaccine, treatment, and diagnostics development for COVID-19, Operation Warp Speed, recently brought about the largest contract to date with Sanofi and GlaxoSmithKline at $2.1 billion (Johnson, 2020). In addition, the European Commission announced an EU vaccines strategy on June 17, 2020, that prioritizes securing the production of vaccines in the European Union and sufficient supplies for its own member states over that of others

(European Commission, 2020), even though key EU governments have already committed to supporting the COVAX facility of the ACT Accelerator. Large advance purchases by European governments raise the possibility that these governments will wind up essentially negotiating against COVAX or restricting the vaccine doses that are actually available for it to purchase, undercutting WHO's coordinated strategy (Paun, 2020; Ren, 2020).

Political Backlash during COVID-19

Within months of the COVID-19 outbreak, finger pointing began, and WHO was in for its share of criticism. As in past international challenges, this has involved a normal stream in independent evaluations—including a major review agreed upon at the WHA and headed by former heads of state Ellen Johnson Sirleaf and Helen Clark, former prime minister of New Zealand. But it has also included a highly charged irregular political stream as politicians in the United States, Brazil, Taiwan, and other nations have publicly attacked WHO and its Director-General, accusing it of failures and of too close of a relationship with China. Meanwhile African leaders rallied to the defense of the first African head of WHO (Shaban, 2020). This once-in-a-century pandemic is testing the politics of WHO in ways it has never been tested before.

Political Explanations for WHO's COVID-19 Response

Born out of a post-World War II era of internationalism and multilateralism, WHO was meant to embody the principles of solidarity and transparency in keeping with the UN's founding ideals. Concerns over how to combat infectious disease epidemics from cholera, typhus, smallpox, and others have been a driving force behind international cooperation for centuries. And yet, the COVID-19 pandemic appears to have accelerated a trend away from global cooperation, leaving WHO in a precarious position.

WHO's political history, its structure, and its leadership help explain why WHO has taken on so much, where it has succeeded, and why it has been unable to meet some of the high expectations of the organization. Chorev's (2012) assertion that WHO's Secretariat creates space and initiative through strategic adaptation remains true, but rather than broad ideological swings, we increasingly see specific and directly opposing demands that are harder to reconcile or elide.

When it comes to information sharing, WHO has succeeded where it has *because* of its political nature rather than in spite of it, and it has failed where member states have restricted its capacity. For example, internal emails from January 2020 reveal that WHO officials were deeply frustrated by China's failure to share information in a timely manner. As discussed, their generally positive and praising tone toward China was a deliberate, strategic attempt to coax the Chinese government into sharing vital epidemiological data and allow international

expert investigators into the country (Associated Press, 2020). The debate will rage on over whether this was successful (China did share epidemic data and the genome sequence that enabled testing in weeks) or whether the Director-General should have been more publicly critical. (Lockdowns mimicked elsewhere have been highly problematic, and many have criticized Chinese data as incomplete and misleading.) But, regardless of position, WHO's struggle is clear—it has no coercive power at its disposal. States have, in the IHR, required WHO to consult with a member state before sharing data it gathers for that country and provided no sanction for states who do not comply with their IHR obligations to report. In that context, WHO has only diplomacy—particularly when dealing with a state such as China, a permanent security council member and the second largest economy in the world. It is notable that all the data that modelers used early in the epidemic came through WHO's access to China; indeed, even the US government relied on its participation in WHO mission to get direct access to Wuhan. WHO, given financial constraints, has only so much capacity and must rely on member states and others located within a given country for much of the reporting and surveillance work.

Looking beyond China, though, we see many governments sharing information that may surprise us: WHO was successful in receiving data from countries in Africa, Latin America, and the Middle East that have been reluctant to do so in other settings. This is at least in part because states feel ownership over the organization and particularly because the regional offices are staffed by their own nationals, fostering greater trust and communication. A Geneva-based organization of technocrats alone would be unlikely to have received this level of cooperation. In this context many criticisms are unfair but also expected. On guidance, the decline, and then sudden rise, of WHO's influence in high-income countries under COVID-19 explains many of the challenges. It is of little surprise that countries ignored WHO advice on border closures as their populations demanded it. Forty-seven countries did the same during the 2009 H1N1 pandemic, and many did at the start of the COVID-19 pandemic as well (Worsnop, 2017, 2019).

But other realities are less expected. As described in the beginning of the chapter, high-income countries pulled away from WHO as LMICs gained more power, with even more of its work focusing on LMICs. WHO has felt a strong burden to ensure its recommendations are relevant to its core LMIC audience, having experienced backlash from good ideas that are infeasible in low-resource settings. There would also be political-optical, and arguably ethical, challenges involved if WHO issued different sets of guidance for different resource contexts. Meanwhile, high-income countries tend to worry less if WHO's recommendations are geared toward establishing a globally applicable baseline, because they can supplement those recommendations with guidance from other sources. For example, the US Centers for Disease Control and Prevention (CDC) generally issues its own guidelines (often developed through close working consultation with WHO), which are looked to by other wealthy countries around the world. However, under COVID-19 the United States has floundered, and the CDC has

been sidelined. This has had the effect of *increasing* the attention on WHO, including from higher-income countries.

Much of what WHO has said and shared has been used widely in higher-income countries and LMICs alike—with many countries looking to the organization's expertise to step up COVID-19 testing (WHO polymerase chain reaction [PCR] protocol is particularly valuable), set standards for health workers, and shut down transmission. But when it came to both masks and airborne transmission, WHO has been accused of lagging far behind (Tufekci, 2020). Part of what delayed WHO, though, was exactly this focus on LMICs—as officials worried over limited PPE supplies in many countries and the implications of stating the virus was airborne in contexts where investments in ventilation would come at the cost of other interventions. There have been struggles across the regionalized structure to reach consensus and strong pushback from some to moving too quickly. In other circumstances, this slower, more conservative approach is what states have demanded. However, as higher-income countries' experts looked to WHO, with its staff a fraction of the size of the US CDC's, speed and answers for high-resource settings instead were demanded.

WHO's rise reflects a century of evolution in global health governance that sought to facilitate cooperation among states on health concerns that extend beyond national borders. However, the rise of aggressively nationalist rhetoric and priorities in some countries has tipped the scale back toward Westphalian governance, a focus on state sovereignty, and a resistance to interference in domestic affairs. This shift has created significant hurdles for the pursuit of global public health, including during the COVID-19 pandemic, where it has resulted in several powerful governments refusing to cooperate with WHO or even challenging its recommendations and authority outright even as—and perhaps because—those governments have performed poorly (Eckermann, 2017; Lasco, 2020; Wilson et al., 2020; Żuk & Żuk, 2020). In this context, massive criticism of WHO—for being too slow, for offering recommendations political leaders dislike, for failing to curb the actions of China—are driven largely by domestic political considerations. But that does not diminish the existential threat to the organization as the United States announced its withdrawal and Brazil, which has long been a powerful supporter of WHO, threatened the same.

Meanwhile, work under the ACT Accelerator has been an innovative response to the crisis, even in a context in which WHO has insufficient political and convening power. It has fundamentally been tasked by member states with solving a massive problem of collective action and global trade as it seeks to rapidly advance science and equitably distribute it. Powerful countries have every incentive to push their own scientists to achieve the breakthrough and backstop that with advanced orders in the market economy for as much of a vaccine or other technology as they can afford. The gambit with the ACT Accelerator and its various pillars has been that there is enough uncertainty about which vaccines will succeed that states can be brought to the table to cooperate through fear of losing out completely if they do not, as well as by the argument vaccinating high-risk

people around the world will bring a swifter end to the pandemic. But WHO's rallying calls for solidarity, rational arguments about risk distribution, and appeals to science have so far been insufficient to fully overcome the powerful pull of vaccine nationalism. WHO also lacks a sufficient pool of funding from which to work as a base: its Contingency Fund for Emergencies has been chronically depleted (most recently by the Ebola outbreak in the Democratic Republic of the Congo) and most of the rest of its funding is tied to other functions. Member states did pledge $8 billion, although the majority has not yet been delivered (Sulcas, 2020). Meanwhile an online concert, "One World: Together at Home," planned by Lady Gaga and the NGO Global Citizen raised one of the larger contributions at $128 million, although not exclusively for WHO (Global Citizen, 2020).

It is too early to fully assess which WHO efforts will work. But it is important to remember again that WHO has no stick to match its carrot. The international organizations that *do* have sticks—the UN Security Council, the World Trade Organization—have been notably avoided by member states as venues for negotiation. The international order in which WHO was established and the underlying shared values that it embodies have been waning as the forces of nationalism and populism have strengthened in recent years. In the postwar era, there was a rise in globalization and global governance as the dominance of state-centric relations shifted toward cooperation between states, international organizations, and nonstate actors. In this context, WHO became a driver of global health governance, with an emphasis on sharing medical and epidemiological data and research across borders, monitoring of public health by global networks, and emphasizing collective public health interests. But in a context in which these efforts are challenged, so too will WHO's efforts to ensure equitable access.

Finally, WHO's response to COVID-19 cannot be explained without reference to the increasing size and diversity of other global health actors with which WHO must now compete—for funds, legitimacy, and the limited political attention of states. For example, the COVAX facility, the ACT arm focused on global procurement of a vaccine, is anchored by two public-private partnerships—Gavi and the Coalition for Epidemic Preparedness Innovations (CEPI). Neither of these organizations has the reach nor legitimacy of WHO, but neither do they have the baggage that comes from being governed by a parliament of more than 190 member states. As WHO frames its mission, it has at times taken on a far larger portfolio than its capacity allows in an effort to ensure its mandate and its existing funding is not further diminished in a competitive space.

Looking Forward

On July 6, 2020, the Trump administration officially notified UN Secretary-General António Guterres of its intention to withdraw from WHO membership as the political maneuvering behind the scenes of WHO broke into public. Although the move was criticized as neither legal nor advisable (Gostin et al.,

2020; Kavanagh & Pillinger, 2020), it represented an existential threat to WHO. Outside the period covered in this book, Joe Biden was elected US president and pledged to halt the withdrawal. The WHO, however, still faces an uncertain political future. As much as anything, the maelstrom around the WHO is a symptom of a geopolitical realignment toward a multipolar world. WHO has been caught up in a high-politics confrontation between the United States and China, with the EU seeking a path between and the African Union seeking to defend the first-ever African Director-General. This comes as WHO seeks to grapple with a pandemic in which its structure, its political foundations, and its split personality as both technical-scientific agency and venue of international relations have left the organization open to criticism. Amid all of this, WHO's successes can be underappreciated. As the UN Security Council all but closed up shop, WHO has forged ahead in bringing states together in negotiation. As the US CDC has been sidelined at home, WHO has managed to rapidly build a credible base of science from which policymakers can act (even if it cannot force them to do so).

The organization often leads with its identity as a scientific and humanitarian agency, yet it is also a creature of international politics, an international organization governed and financed by, and thus beholden to, member states. Its historical loss of influence in high-income countries and focus on LMICs have been upended by a global spotlight during COVID-19, as many of the countries believed most capable have stumbled badly in their response. Yet its structure provides WHO far less capacity than it would need to meet the expectations of its member states. Reversing this requires addressing the balkanized structure of regional offices, dramatically expanding assessed contributions to ensure sufficient resources, and rewriting the IHRs to give WHO new powers to uncover information that member states refuse to share and sanction states that do not meet their international obligations. As the pandemic dissipates, there will be inevitable reviews and calls for reform. Whether member states are willing to make the big-picture changes needed to give WHO what it needs is yet unclear.

References

Associated Press. (2020, June 2). *China delayed releasing coronavirus info, frustrating WHO.* AP News. https://apnews.com/3c061794970661042b18d5aeaaed9fae

Auyezov, O., & Gurt, M. (2020, July 15). *WHO urges Turkmenistan to take steps "as if COVID-19 was circulating."* Reuters. https://www.reuters.com/article/us-health-coronavirus-turkmenistan-idUSKCN24G276

Burci, G. L. (2018). Health and infectious disease. In T. G. Weiss & S. Daws (Eds.), *The Oxford handbook on the United Nations*. Oxford University Press.

Chorev, N. (2012). *The World Health Organization between north and south*. Cornell University Press.

Clift, C. (2014). *What's the World Health Organization for?* Chatham House.

Community Initiatives. (2020). *What countries require or recommend masks in public?* https://masks4all.co/what-countries-require-masks-in-public/

Cueto, M., Brown, T. M., & Fee, E. (2019). *The World Health Organization: A history*. Cambridge University Press.

Daugirdas, K., & Burci, G. L. (2019). *Financing the World Health Organization: What lessons for multilateralism?* SSRN Scholarly Paper ID 3434603. Social Science Research Network. https://papers.ssrn.com/abstract=3434603

Davies, S. (2010). *Global politics of health*. Polity.

Eckermann, E. (2017). Global health promotion in the era of "galloping populism." *Health Promotion International, 32*(3), 415–418. https://doi.org/10.1093/heapro/dax030

European Commission. (2020, June 17). *Coronavirus: Commission unveils EU vaccines strategy.* https://ec.europa.eu/commission/presscorner/detail/en/ip_20_1103

Global Citizen. (2020, April 19). *One world: Together at home' raised almost $128 million in response to the COVID-19 crisis.* https://www.globalcitizen.org/en/content/one-world-together-at-home-impact/

Gostin, L. O., Hongju Koh, H., Williams, M., Hamburg, M. A., Benjamin, G., Foege, W. G., Davidson, P., Bradley, E. H., Barry, M., Koplan, J. P., Roses Periago, M. F., El Sadr, W., Kurth, A., Vermund, S. H., & Kavanagh, M. M. (2020). US withdrawal from WHO is unlawful and threatens global and US health and security. *The Lancet, 396*(10247), 293–295.

Gostin, L. O., Tomori, O., Wibulpolprasert, S., Jha, A. K., Frenk, J., Phumaphi, J., Piot, P., Stocking, B., Dzau, V. J., & Leung, G. M. (2016). Toward a common secure future: Four global commissions in the wake of Ebola. *PLoS Medicine, 13*(5), e1002042.

Graham, E. R. (2013, May). International organizations as collective agents: Fragmentation and the limits of principal control at the World Health Organization. *European Journal of International Relations*. http://journals.sagepub.com/doi/10.1177/1354066113476116

Hanrieder, T. (2015). The path-dependent design of international organizations: Federalism in the World Health Organization. *European Journal of International Relations, 21*(1), 215–239. https://doi.org/10.1177/1354066114530011

Heymann, D. L., Mackenzie, J. S., & Peiris, M. (2013). SARS legacy: Outbreak reporting is expected and respected. *The Lancet, 381*(9869), 779–781.

Hjelmgaard, K. (2020, April 11). Fact check: President Donald Trump vs. the World Health Organization. *USA TODAY*. https://www.usatoday.com/story/news/factcheck/2020/04/11/coronavirus-fact-check-donald-trump-vs-world-health-organization/5128799002/

Hoffman, S. J., & Røttingen, J-A. (2014). Split WHO in two: Strengthening political decision-making and securing independent scientific advice. *Public Health, 128*(2), 188–194.

Jamison, D. T., Frenk, J., & Knaul, F. (1998). International collective action in health: Objectives, functions, and rationale. *The Lancet, 351*(9101), 514–517.

Johnson, C. Y. (2020, July 31). European drugmakers Sanofi and GSK strike $2.1 billion deal with U.S. for a coronavirus vaccine. *Washington Post*. https://www.washingtonpost.com/health/2020/07/31/coronavirus-vaccine-deal-sanofi-gsk/

Kaiser Family Foundation. (2020, April 16). The U.S. Government and the World Health Organization. https://www.kff.org/coronavirus-covid-19/fact-sheet/the-u-s-government-and-the-world-health-organization/

Kamradt-Scott, A. (2016). WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa. *Third World Quarterly, 37*(3), 401–418.

Kavanagh, M. M. (2020). Authoritarianism, outbreaks, and information politics. *The Lancet Public Health*. https://www.doi.org/10/ggpxrb

Kavanagh, M. M., & Pillinger, M. (2020, July 7). Leaving the WHO will hurt Americans' health. *Foreign Policy.* https://foreignpolicy.com/2020/07/07/trump-leave-who-world-health-organization-american-health/

Kavanagh, M. M., & Singh, R. (2020). Democracy, capacity, and coercion in pandemic response—COVID 19 in comparative political perspective. *Journal of Health Politics, Policy and Law, 45*(6), 997–1012.

Kiernan, S., DeVita, M., & Bollyky, T, J. (2020, April). Tracking coronavirus in countries with and without travel bans. *Think Global Health*. https://www.thinkglobalhealth.org/article/tracking-coronavirus-countries-and-without-travel-bans

Lasco, G. (2020). Medical populism and the COVID-19 pandemic. *Global Public Health, 15*(10), 1417–1429. https://doi.org/10.1080/17441692.2020.1807581

Lee, K. (2009). *World Health Organization*. Routledge.

Lee, K. (2014). World Health Organization. In *Handbook of governance and security*. Edward Elgar Publishing.

Lewis, D. (2020). Mounting evidence suggests coronavirus is airborne—but health advice has not caught up. *Nature 583*(7817), 510–513. https://doi.org/10.1038/d41586-020-02058-1

Mandavilli, A. (2020, June 5). W.H.O. finally endorses masks to prevent coronavirus transmission. *The New York Times.* https://www.nytimes.com/2020/06/05/health/coronavirus-masks-who.html

Marion, S. (2020, May 20). Withdrawing from the WHO would hurt global security—and global respect for the U.S. *The Washington Post*. https://www.washingtonpost.com/politics/2020/05/20/withdrawing-who-would-hurt-global-security-global-respect-us/

Moon, S., Leigh, J., Woskie, L., Checchi, F., Dzau, V., Fallah, M., Fitzgerald, G., Garrett, K., Gostin, L., & Heymann, D. L. (2017). Post-Ebola reforms: Ample analysis, inadequate action. *BMJ, 356,* j280.

Morawska, L., & Milton, D, K. (2020, July). It is time to address airborne transmission of covid-19. *Clinical infectious diseases: An official publication of the Infectious Diseases Society of America*. https://doi.org/10.1093/cid/ciaa939

Paun, C. (2020, August 7). *Europe has yet to live up to its Covid-19 promises.* Politico. https://www.politico.com/news/2020/08/07/europe-has-lots-of-covid-talk-but-few-results-392493

Pillinger, M. (2020a, January 26). Analysis: The WHO held off on declaring the Wuhan coronavirus a global health emergency. Here's why. *The Washington Post*. https://www.washingtonpost.com/politics/2020/01/26/who-held-off-declaring-wuhan-coronavirus-global-health-emergency-heres-why/

Pillinger, M. (2020b, February). Virus travel restrictions don't work. *Foreign Policy.* https://foreignpolicy.com/2020/02/23/virus-travel-bans-are-inevitable-but-ineffective/

Ravi, S. J., Snyder, M. R., & Rivers, C. (2019). Review of international efforts to strengthen the global outbreak response system since the 2014–16 West Africa Ebola Epidemic. *Health Policy and Planning, 34*(1), 47–54.

Reddy, K. N., & Selvaraju, V. (1994.) *Health expenditure by government in India 1974–5 to 1992–92.* National Institute of Public Finance & Policy.

Reddy, S. K., Mazhar, S., & Lencucha, R. (2018). The financial sustainability of the world health organization and the political economy of global health governance: A review

of funding proposals. *Globalization and Health, 14*(1), 119. https://doi.org/10.1186/s12992-018-0436-8

Ren, G. (2020, August 14). Scramble to preorder COVID-19 vaccines may leave poorer countries behind. *Health Policy Watch.* https://healthpolicy-watch.news/scramble-to-preorder-covid-19-vaccines-may-leave-poorer-countries-behind-threatening-global-response/

Retreat, P. (1996). *Enhancing the performance of international health institutions.* The Rockefeller Foundation. Social Science Research Council, Harvard School of Public Health.

Ruger, J. P., & Yach, D. (2009). The global role of the World Health Organization. *Global Health Governance: The Scholarly Journal for the New Health Security Paradigm, 2*(2), 1–11.

Sabbagh, D., & Stewart, H. (2020, July 21). Mike Pompeo attacks WHO in private meeting during UK visit. *The Guardian*. http://www.theguardian.com/world/2020/jul/21/mike-pompeo-attacks-who-in-private-meeting-during-uk-visit

Shaban, A. R. A. (2020, April 9). African leaders trump Trump for attack on WHO, back Ethiopia's Tedros. *Associated Press.* https://www.africanews.com/2020/04/09/african-leaders-trump-trump-for-attack-on-who-back-ethiopia-s-tedros/

Siddiqi, J. (1995). *World health and world politics: The World Health Organization and the UN system*. University of South Carolina Press.

Sulcas, A. (2020, May 7). *Solidarity, solidarity, solidarity: The ACT Accelerator, the $8 billion, and the Global Fund.* IHP. https://www.internationalhealthpolicies.org/featured-article/solidarity-solidarity-solidarity-the-act-accelerator-the-8-billion-and-the-global-fund/

Tufekci, Z. (2020, April 16). Why the World Health Organization failed. *The Atlantic.* https://www.theatlantic.com/health/archive/2020/04/why-world-health-organization-failed/610063/

Wenham, C. (2017). What we have learnt about the World Health Organization from the Ebola outbreak. *Philosophical Transactions of the Royal Society B: Biological Sciences, 372*(1721), 20160307.

Wilson, K., Halabi, S., & Gostin, L. O. (2020). The International Health Regulations (2005), the threat of populism and the COVID-19 pandemic. *Globalization and Health, 16*(1), 70. https://doi.org/10.1186/s12992-020-00600-4

World Health Organization. (1946). *WHO constitution*. https://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. (2019). *Contributors*. http://open.who.int/2018-19/contributors/contributor

World Health Organization. [@WHO]. (2020a, January 11). BREAKING: WHO has received the genetic sequences for the novel #coronavirus (2019-NCoV) from the Chinese authorities [Tweet]. *Twitter.* https://twitter.com/WHO/status/1216108498188230657

World Health Organization. [@WHO]. (2020b, January 14). Preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission of the novel #coronavirus [Tweet]. *Twitter.* https://twitter.com/WHO/status/1217043229427761152

World Health Organization. (2020c, June 26). *ACT-Accelerator update.* https://www.who.int/news-room/detail/26-06-2020-act-accelerator-update

World Health Organization. (2020d). *Advice on the use of masks in the context of COVID-19.* https://apps.who.int/iris/handle/10665/331693

World Health Organization. (2020e, May 29). *How WHO is funded.* https://www.who.int/about/planning-finance-and-accountability/how-who-is-funded

World Health Organization. (2020f, January 22). *Mission summary: WHO field visit to Wuhan, China 20–21 January 2020.* https://www.who.int/china/news/detail/22-01-2020-field-visit-wuhan-china-jan-2020

World Health Organization. (2020g). *Of WHO's response to COVID-19.* https://www.who.int/news-room/detail/29-06-2020-covidtimeline

World Health Organization. (2020h). *Timeline: WHO's COVID-19 response*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline

World Health Organization. (2020i, January 10). *WHO advice for international travel and trade in relation to the outbreak of pneumonia caused by a new coronavirus in China.* https://www.who.int/news-room/articles-detail/who-advice-for-international-travel-and-trade-in-relation-to-the-outbreak-of-pneumonia-caused-by-a-new-coronavirus-in-china

World Health Organization. (2020j). *WHO coronavirus disease (COVID-19) dashboard.* https://covid19.who.int

World Health Organization. (2020k). *UN welcomes nearly $1 billion in recent pledges—to bolster access to lifesaving tests, treatments and vaccines to end COVID-19.* https://www.who.int/news/item/30-09-2020-un-welcomes-nearly-1-billion-in-recent-pledges-to-bolster-access-to-lifesaving-tests-treatments-and-vaccines-to-end-covid-19

World Health Organization. (2020l, July 17). *A guide to WHO's guidance on COVID-19*. https://www.who.int/news-room/feature-stories/detail/a-guide-to-who-s-guidance

Worsnop, C. Z. (2017). Domestic politics and the WHO's International Health Regulations: explaining the use of trade and travel barriers during disease outbreaks. *The Review of International Organizations, 12*(3), 365–395. https://doi.org/10.1007/s11558-016-9260-1

Worsnop, C. Z. (2019). Concealing disease: Trade and travel barriers and the timeliness of outbreak reporting. *International Studies Perspectives, 20*(4), 344–372. https://doi.org/10.1093/isp/ekz005

Youde, J. (2015). MERS and global health governance. *International Journal, 70*(1), 119–136. https://doi.org/10.1177/0020702014562594

Youde, J. (2016, December 27). The Rashomonization of the World Health Organization. *Duck of Minerva*. https://duckofminerva.com/2016/12/the-rashomon-ization-of-the-world-health-organization.html

Youde, J. (2018). *Global health governance in international society*. Oxford University Press.

Żuk, P., & Żuk, P. (2020.) Right-wing populism in Poland and anti-vaccine myths on YouTube: Political and cultural threats to public health. *Global Public Health, 15*(6), 790–804. https://doi.org/10.1080/17441692.2020.1718733