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COVID-19 pandemic exposes deep fault lines in global health governance

Lessons for the WHO

Lucky Imade

Coronavirus should be a wake-up call for world leaders to work together.
– Madeleine Albright

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Abstract

A specter is hunting the world – the specter of a deadly infectious disease – novel coronavirus (COVID-19), which has resulted in 758,390,564 and 6,859,093 confirmed cases and deaths, respectfully, worldwide as of 11 March 2023 (World Health Organization 2023). The lethality and adverse effects of the COVID-19 pandemic have generated increased awareness and interest in reforming the global health system. This study seeks to explain the major conceptual fault lines in global health governance (GHG) that hindered infectious disease-control efforts during the COVID-19 outbreak. This will enable the WHO to reform or consider alternative models of GHG in preparation for the next pandemic. The study finds that a global coordinated response has been conspicuously absent in an attempt to combat the COVID-19 pandemic due largely to stumbling blocks such as state sovereignty, gaps in international legal frameworks, and inadequate institutional coordination and collaboration. The article concludes with some novel, innovative, and prescriptive policy approaches toward filling a lacuna in global health architecture.

Keywords: World Health Organization (WHO), global solidarity, COVID-19 pandemic, International Health Regulations (IHR), sovereignty, Global Health Governance (GHG)

American University of Nigeria
ugolucky2@aol.com

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Introduction

The global uncoordinated response to COVID-19 exposes deep fault lines, inadequacies, gaps, and impediments inherent in the current global health architecture, which have exacerbated the crisis and thus underscored the main argument in this article that an uncoordinated global response strictly driven by national public health policy in an age of globalization is fraught with uncertainty. The study seeks the basic building blocks of good governance in an attempt to fortify global health.

Global Health Governance (GHG) has come a long way. It dates back to the 1850s when the first International Sanitary Conference, which was held in France, set in motion rules and conventions in an effort to regulate communicable diseases among European nations. Since then, the world has witnessed too many pandemics (such as the Justinian plague, the Black Death (Bubonic Plaque), and the Great Plaque of 1605), claiming millions of lives (Cartwright, 2014). We have seen vividly how susceptible humans are to these communicable diseases without any solutions in sight on how to control them. But what we have not seen are efforts to control communicable diseases during the pre-scientific revolution. The fact that the advent of technological innovation during the post-scientific revolution could not even stop or control the 1918 Spanish Flu, the series of cholera pandemics, the series of Ebola outbreaks in West Africa, the SARs outbreak of 2003, and most recently the COVID-19 pandemic has demonstrated that GHG has taken its last breath. What has been missing in the fight to reduce the risk of the emergence and reemergence of communicable diseases is the lack of a much more nuanced, novel, and systemic approach from an interdisciplinary perspective.

The more central thesis here holds that an uncoordinated global response driven by nationalism in an age of globalization is to a large degree a recipe for failure; conversely, global solidarity built on the concept of cosmopolitanism and multilateralism, including the expansive global health ecosystem stands as an important bulwark against the next pandemic. COVID-19 is quite different from other pandemics for reasons not far-fetched, hinging mostly on the geopolitical portents of the Sino-American rivalry that brought the balance of power politics back to international relations and thus exacerbated the already tense situation, which drove the wedge between the WHO's member states. This study explores the factors that best explain the deep fault lines in GHG and global solidarity that hinder infectious disease-control efforts during COVID-19.

The study proceeds in three parts as follows: The first provides reasons why GHG is in dire need of reform to augment infectious disease-control efforts. The second pinpoints major impediments to the way of GHG and global solidarity. The third concludes by proposing reform from an interdisciplinary perspective that includes but is not limited to conceptualizing how to strike the balance between nationalism and international cooperation while overcoming the fact that states remain the preeminent actors and driving force in the global health arena; an international legal framework, one that is resilient, flexible, reliable, effective, and of high normative standards to address the perceived deficiency in IHR; a more nuanced, novel, coordinated, collaborative, and inclusive approach to the proliferation of non-state actors on the stage of GHG; and lastly, strategies to help bridge the governance gaps in preparation for the next pandemic and ensure international cooperation. This paradigm shift underscores the need for the overarching goal of good governance that provides strategic oversight, one that enhances synergy among all stakeholders to work together with WHO in mitigating emerging and reemerging threats of infectious disease outbreaks.

Why is reforming Global Health Governance vital to infectious disease-control efforts?

There is no universally accepted definition of GHG among scholars and policymakers alike. Thus, this ambiguity in the literature speaks volumes to the myriad of definitions out there.

However, this study conceptualizes GHG as "formal and informal institutions, rules, and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively" (Fidler, 2020a: 6).

The COVID-19 pandemic outbreak reveals serious flaws in international cooperation, and more importantly its devastating impact on humanity and the economic well-being of nation-states necessitates a paradigm shift in public health policymaking (Legge, 2020a). While there is a plethora of literature published about global public health, little is available on strengthening global solidarity in enhancing infectious disease-control efforts. Given the ambiguity and confusion in the scholarly and policy debates of what constitutes GHG, what seemed to be missing in the scholarly literature is a conceptual clarity of the overarching goals of the desired governance landscape that resonates with a large proportion of the stakeholders. Governance is far more than just building architecture. As the cases of SARs, Zika, and Ebola have shown, limited "fixes" do not go far enough due to the complexity of the GHG system. We need to be creative and proactive in finding a suitable systemic approach to today's problem while looking further to proffering sustainable solutions in combating the next pandemic.

Why is reforming GHG so vital to infectious disease-control efforts? First, the devastation brought about by the COVID-19 pandemic has altered the global health landscape as it is not business as usual anymore with significant economic and social impacts. According to WHO, there are 758,390,564 confirmed cases, and 6,859,093 confirmed deaths worldwide as of 11 March 2023 (World Health Organization, 2023). The lethality and adverse effects of COVID-19 have generated increased awareness and interest in reforming the global health system.

Second, the consequences of lockdowns, quarantines, and other restrictive measures emanating from variations in national responses to combat COVID-19 have spilled over to human-rights violations in some parts of the world with inevitable ramifications for peace and security worldwide. Addressing the Security Council via videoconference on COVID-19, the UN Secretary-General notes "Collective security and our shared well-being are under assault on many fronts … our challenge is to save lives today while buttressing the pillars of security for tomorrow" (United Nations, 2020). According to the UNDP report entitled "The COVID-19 Outbreak Has Intensified Domestic and Gender-Based Violence (GBV) Globally", there were several cases of increase in domestic violence during the 17 March lockdown in France, up to about 30%. The same incidents were reported in Cyprus, Singapore, and Argentina with an increase of about 30%, 33%, and 25%, respectively, via emergency calls (UN Women, 2020). For example, to underscore the importance of human-rights protection, Dr. Lauren Tonti of Harvard University argues, "China's disease management tactics, such as censorship and mass quarantine, violate human rights, civil liberties, and International Human Rights Article 3's explicit call for respecting 'dignity, human rights and fundamental freedoms of persons'" (Tonti, 2020: 6).

Third, the COVID-19 outbreak also exposes deep flaws in the legal foundations of the GHG, which necessitates strengthening the global health law landscape to harmonize the inconsistent national responses that were put in place to combat the common threat of future pandemics. Some legal scholars argue that the bedrock of global health security is international law, which guarantees the "right to health" (Taylor, 1992). Yet, international law is silent on control of infectious diseases as evidenced by international regulations governing infant formula and pharmaceutical safety (Health, 1995). This structural defect in international law reinforces the urgency for the international community to come together via GHG to revamp the existing norms and framework, including the moribund International Health Regulations (IHR).

Fourth, the challenges posed by globalization in an interdependent world. That is, the fact that globalization has made the state to be superfluous in areas that transcend its

border such as trans-border health risks, triggered by the transnational nature of goods and services, which have to a greater extent put enormous strain on state capacity to protect domestic populations from the emerging and reemerging threats of communicable diseases. States alone can no longer act to deal effectively with these myriads of issues without a well-coordinated global response and international cooperation that some experts call "Network Governance", which means a well-coordinated global response effort is achieved not only through member states but also through other stakeholders like IGOs, NGOs, MNCs, groups, and civil society organizations (Mosugu, 2022). Network governance will coordinate the confusing roles of numerous non-state actors with discordant values with varying degrees of influence in health governance.

Fifth and finally, the issue of equity, inclusion, and structural inequalities. This comes with social, political, and strategic ramifications, necessitating a well-coordinated global response. The issue of the Indonesian government's refusal to share samples of the H5N1 influenza virus with the WHO, claiming infringement on its sovereign rights on the grounds of structural inequalities, is a classic case in point (this topic will be revisited in a later section). And most recently, an NBC news report on coronavirus updates entitled "Mexico raise concerns at UN over unequal vaccine access" made headlines as the president of Mexico called on the UN to address "vaccine hoarding and equity so that all countries have the possibility of vaccinating their inhabitants" (Garrido, 2021). As Michael Jennings of Fabian Society puts it: "The complexities of global health, and the needs of the billions excluded from the benefits of vaccine science and innovation, demand a truly global response" (Jennings, 2021: 5).

In sum, the untold human suffering brought about by the COVID-19 pandemic coupled with the fault lines in GHG: the issue of sovereignty, gaps in normative frameworks, inadequate coordination and collaboration on a global scale, the advent of globalization and exclusion of some key players in the global health system from other sectors, point to the fact that a robust response to the next pandemic requires the international community to reimagine GHG.

The issue of state sovereignty

One of the greatest impediments to building a global public health architecture that will ensure global solidarity is the issue of state sovereignty – the idea of territorial integrity and political independence – which implies that the state has complete control over what transpires within its border without any external interference (Tuca, 2015). However, most states have used sovereignty to circumvent several international conventions and principles designed to enhance global health governance. As Kolitha Wickramage argues, "In an increasing globalized world effective international communicable diseases control requires states to embrace basic norms informing global health governance. However, recent international public health crises have shown that states continue to use national sovereignty to justify non-compliance with these norms" (Wickramage, 2017: 25).

In light of the above, it becomes imperative to spell out the nature and scope of how to reconfigure, transform, and reconstitute the concept of state sovereignty, which has been the subject of profound debate and concern in an era of populist nationalism. The controversy surrounding the ongoing debates between nationalist vs. cosmopolitan worldviews weighs heavily on the conflict between populist nationalism and cosmopolitanism. On the one hand, proponents of state sovereignty (from the nationalist worldview) argue that states remain the preeminent actors and the driving force in the global health arena making reference to Charter 1 Article 2(7) in the UN Charter, which states that "nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state or shall require the members to submit

such matters to settlement under the present Charter …" Since sovereignty and its exercise constitute the bedrock of international law, collective action must seek the consent of the states to make it effective.

On the other hand, opponents of state sovereignty (from the cosmopolitan worldview) posit that globalization has rendered the concept of sovereignty irrelevant in the microbial world (Stevenson & Cooper, 2008). In short, the territorial jurisdiction of the modern nation-state over public health is increasingly constrained by globalization as evidenced by the significant increase in transboundary health issues in conjunction with global health diplomacy (Chattu & Chami, 2020). Arguing along the same lines, David Fidler writes: "The sovereignty of the states looms large in formulating a global response to emerging infections, despite the fact that the process of globalization undermines the sovereignty of the state to deal nationally with these infections …" (Fidler, 1996a: 80). This affirms that the primary responsibility of safeguarding their citizens against infectious disease rest with the states. However, if the states are handicapped in fulfilling this responsibility, they are expected to seek outside support. If they intentionally refuse, block access, and put their own citizens at risk, the international community has the full obligation to intervene.

In today's world, COVID-19 has subjected the notion of sovereignty to critical scrutiny in academic literature more often now than ever before due largely to the fact that "the co-evolution of human immune systems and pathogens is no longer primarily the local affair that it has been historically; this affair is now taking place on a global scale" (Pirages, 2007: 622). This assertion speaks volumes to two principles that are regarded as valid normative and empirical tests of whether states are actually receptive to exogenous norms and rules pertinent to global public health governance. First, "health is a human right that must be safeguarded by states" and second, "safeguarding public health is an essential element of preserving collective security in today's globalized world" (UDHR 1948).

Despite these principles, some experts argue that nationalist governments, particularly in the Global South, are still blocking cooperative UN efforts in the global response to emerging infections (Gostin, Moon, & Meier, 2020). For example, during SARS and more recently at the onset of COVID-19 outbreaks, Fidler argues that "China had imposed at home and promoted abroad a version of sovereignty intolerant of domestic dissent and foreign criticism" (Fidler, 2020a: 15). As such, Beijing's skepticism of international community meddling in its domestic affairs under the pretext of global solidarity against COVID-19 outbreak is reflected in its effort to block global cooperation in the name of sovereignty.

In Indonesia, during H5N1 influenza outbreak, Jakarta's decision not to share influenza A virus (H5N1) samples with WHO and invoke Convention of Biodiversity (CBD) as its right to "Viral Sovereignty – a concept that suggests viruses circulating within any state fall under exclusive sovereign control of said state" (Caplan & Curry, 2007) is another classic example of how sovereignty is used to circumvent norms of global public health governance and hence a clear violation of the aforementioned exogenous norms and rules governing global public health.

In Myanmar during the HIV/TB epidemics, the government has allowed the deterioration of public health infrastructures, blocking international organizations from helping out, citing sovereignty and thus raising concerns about HIV/TB epidemics spreading to neighboring countries.

In the United States during the Trump administration's "America First" doctrine, resisting the adoption of basic norms was highest on Washington's agenda as public health and the WHO were nonchalantly shoved to the side for geopolitical and sovereignty reasons. Despite the WHO's enormous efforts to coordinate a global response to COVID-19, member states have too often pursued policies of isolationism that are often detrimental to its global mandates. As Michael & Andrew put it:

> Although there is no single best approach to protecting public health, humanity's collective experience would suggest that there are certain gene rules that states should follow to reduce communicable disease transmission. Transparency of process, the timely sharing of information between agencies and governments, scientific co-operation in lieu of competition, harmonised approaches to treatment, and the commitment on the part of states to strengthening public health systems and healthcare delivery while seeking to address social and environmental determinants of health, all play a role in reducing the burden of disease. (Stevenson & Cooper, 2008: 1381)

Because of globalization and the transnational nature of the pathogen, global solidarity that could have been the bedrock of GHG is taking its dying breath and handicapped by the irony that "globalization jeopardizes disease-control nationally by eroding sovereignty, while the need for international solutions allows sovereignty to frustrate disease control internationally" (Fidler, 1996b: 81). In striking the balance between nationalism and globalism, the utility of the concept some scholars referred to as "sovereignty as responsibility" (Deng, 1995) that works effectively in supporting good governance in Africa is essentially relevant in strengthening global solidarity in infectious disease-control efforts. What the concept means basically when applied to GHG is that the primary responsibility for promoting good health and well-being for populations rests with the state. But the legitimacy of state sovereignty comes with essentially the responsibility of providing its citizens with a comprehensive health plan in partial fulfillment of its obligations under the legal framework of a human right to health as part of global public goods.

A normative framework based on a false premise

Globalization has exposed the fault lines in the international legal framework currently in place for emerging and reemerging infectious disease control – faults that have been in existence for a while with several warnings from infectious disease experts, but have gone unheeded (Osterholm, 2005). The WHO has affirmed that emerging infectious disease "represents a global threat that will require coordinated global response" (WHO, 1995). Globalization has helped in no small measure through trade and travel to increase the spread of communicable diseases at an exponential rate to different parts of the world.

Because of the transnational nature of public health threats, state sovereignty is taking its dying breaths in the microbial world as stated earlier. But the fact remains: relying strictly on national public health policy is waning as human vulnerability has gone beyond the range, scope and limits of nation-states. The challenges presented by the globalization of communicable diseases are strictly beyond national public health policy and require international law and global solidarity to combat them (Aginam, 2002). International law and international cooperation are intertwined. However, you cannot get one without the other, and it is important here to stress not only their distinctiveness, but also their complementarity. Indeed, International law and global health governance are mutually constituted into what some scholars refer to as global health law (Meier & Gostin, 2020).

The WHO's lukewarm attitude and reluctance to push a more robust legal strategy has drawn criticism from legal experts and policymakers. This is heavily informed by its heavy reliance on medical doctors and scientists at the expense of diversifying its workforce. Thus, in more than 75 years of its existence, the WHO has only come out with two legal frameworks – the Framework Convention on Tobacco Control (FCTC) (Taylor & Bettcher, 2000) and International Health Regulations (IHR) (WHO, 2015), both have served as tools for non-communicable diseases control and as a legal instrument for infectious disease control respectively.

IHR from a historical perspective

Global health law has undergone a dramatic transformation since the 1850s. As Obijiofor Aginam rightly pointed out: "From 1851 to the end of the nineteenth century, ten such international sanitary conferences were convened, and eight sanitary conventions were negotiated on a cross-border spread of cholera, plaque, and yellow fever across the geopolitical boundaries of (European) nation states" (Aginam, 2002). The first International Sanitary Conference held in France during this period laid the groundwork for international health diplomacy with the purpose of enacting new rules and conventions for regulating communicable diseases that cut across most European nations at the time. This diplomatic feat later set the pace for the evolution of a legal framework for communicable disease control evident in the adoption of the 1951 International Sanitary Regulations that later morphed into International Health Regulations (IHR) in 1969 (Aginam, 2002).

The aforementioned groundwork of international health diplomacy underscores the importance of IHR as an indispensable legal tool for combating communicable diseases. At the onset, the IHR requirements were originally limited to six diseases: "cholera, smallpox, plague, yellow fever, relapsing fever and typhus" (Vessereau, 1988). With some modest amendments in 1973 and 1981, it was reduced to three diseases: "cholera, plague and yellow fever" (Vessereau, 1988). IHR was revised in 2005 following anxiety and worry about its response to SARS. The newly revised and improved IHR – dubbed (IHR, 2005), contractual agreement among all 194 member states and premised on the principle of "maximum security against the international spread of diseases with a minimum interference with the world traffic" (WHO, 1983).

Furthermore, since 2005 IHR mandates have evolved to encompass other new and reemerging infectious diseases, as well as nearly all public health risks, including those originating from weapons of mass destruction – nuclear, biological, radiological, and chemical. The newly revamped IHR's mandates include developing core capacities in order "to prevent, protect against, control and provide a public health response to the international spread of diseases" (Article 2 IHR). Nonetheless, most states in the Global South have failed to meet these obligations due largely to their health and financial capacities (Bartolini, 2021). IHR was designed to strengthen the already existing bilateral and multilateral agreements for communicable disease control and laboratory between WHO's member states. More importantly, As Fidler summed it up:

> The IHR also grants WHO the authority to take actions that can challenge how governments exercise sovereignty. First, the IHR authorizes WHO to collect disease-event information from non-governmental sources, seek verification from governments about such information, and, if necessary, share the information with other states. Second, the IHR grants the WHO director-general the power to declare a public health emergency of international concern, even if the state experiencing the outbreak objects. Third, the IHR gives WHO the authority to reinforce the requirement that a state party shall provide the scientific and public health justification for trade or travel restrictions that do not conform to WHO recommendations or accepted disease-control measures. Fourth, the IHR requires states parties to protect human rights when managing disease events – protections for which WHO, as a champion of human-rights approach to health, is a leading guardian. (Fidler 2020b: 6)

The first test of the efficacy of the newly revised IHR (2005) after it entered into full force came during the 2009 H1N1 influenza pandemic. Post-pandemic evaluations revealed two important facts concerning the response of the newly revised IHR (2005) to the H1N1 influenza pandemic. First, the extent to which the IHR (2005) serves as the normative framework for global infectious disease control. Second, the extent to which IHR (2005) reconciles the controversy surrounding global infectious disease norms compliance and state sovereignty.

Despite the 2005 revision of IHR to help prepare for the next pandemic and other recommendations from a panel that reviewed the Ebola response, albeit there were some significant improvements to the legal health instrument, in the aftermath of the COVID-19 pandemic, experts have pointed to massive rot in IHR, necessitating a major overhaul to reflect the realities on the ground. Some of the limitations of IHR during the COVID-19 response were: "(1) notifying WHO of public health risks; (2) declaring a PHEIC where necessary in the international response; (3) coordinating national responses commensurate with public health risks; and (4) fostering global solidarity for infectious disease prevention, detection, and response" (Meier & Gostin, 2020: 378).

Moreover, state parties have failed to report accurately and in a timely manner due to fear of severe economic consequences (Henkin, 1979). For example, imposition of restrictions for reporting infections are numerous around the world such as Ebola in West Africa, SARS in Canada, H1N1 in Mexico and the United States, MERS in Saudi Arabia, COVID-19 in China, and the most recently reported Omicron variant in Southern African countries. These cases were not anomalies because "when countries balance their IHR obligation to report against the risk of economic sanctions, they may wait as long as possible before sharing vital information" (Gostin & Katz, 2016: 282). This is an infraction against Articles 6 and 7 of the IHR. For example, China also failed to comply with another IHR provision – Article 43 of the IHR by implementing not-so-science-based draconian protective measures (censorship and mass quarantine) in response to COVID-19 that infringed upon the human rights of its citizens. The most egregious example came recently from the Xi'an Hospital in China that led to the firing of its Medical Chief and several other staff that denied an expectant mother access to its facility due to COVID-19 harsh rules, which unfortunately led to the woman losing her baby (Davidson, 2022).

In light of the above, it becomes imperative to strengthen global health law with enforcement mechanisms, which is necessary to effectively provide a robust well-coordinated global response in identifying, preventing and controlling the next pandemic.

Institutional coordination and collaboration

The United Nations' establishment of the World Health Organization (WHO) in 1948 as one of its main specialized agencies for health marked a watershed moment in the history of GHG. It sets the pace for the emerging system of a global health system that is still unfolding today. The WHO was charged with the mandate of maintaining global health security. In response to the growing influence of GHG in combating communicable diseases, the WHO was also charged with the mandate of coordinating and collaborating global health norms and institutions in conjunction with providing global leadership in building the global health architecture. Since 1948 the global health landscape has undergone a dramatic transformation.

In today's world, however, global health is taking on a different dimension characterized by diverse, complex and a multiplicity of players with a vast array of global health mandates, mechanisms, agendas and actions. More importantly, for the past three decades, the global health risks have gone far beyond the corridor of the health sector to embrace other sectors within the mandates of multilateral institutions – WTO, WFP, FAO, UNDP, UNAIDS, G-7, the Global Fund, UNFPA, UNICEF, the Gates Foundation, and the World Bank (Garrett, 2015).

The emergence of these multiple stakeholders creates a hostile and chaotic environment that profoundly marginalizes and undermines the WHO's authority as the standard bearer and custodian of global health. As a consequence, the "WHO has struggled to remain credible, its financial resources have shrunk, tensions have grown between its Geneva headquarters and its regional offices" (Garrett, 2015: 81). Moreover, the WHO's inability to coordinate the "new kids on the block", coupled with populist nationalism, knocked the WHO

out of the center stage of GHG, thus losing its grip, as one expert puts it, "on one of the most complex organizations that exists" (Clift, 2014). Although, the WHO has made some remarkable progress in other areas but its efforts in achieving its overarching goals of coordinating and collaborating with this plurality of actors in the global health arena, remain elusive, which invariably triggered the calls to revamp the global health architecture.

However, as Dr. Fukuda puts it:

> The difficulty that I have with a lot of calls for reform is that it suggests that the actual issue is in WHO, that is what has to be reformed, when in fact many of the fundamental issues are with the countries themselves. And that is the unstated part of the reality (Ravelo, 2020).

Dr. Fukuda's statement is supported by the fact that "Only one in three WHO member states has achieved health capacity goals mandated by the IHR" (WHO, 2015). Most member states abandoned and bypassed the WHO, created alternative health sectors and retreated into isolationism when global solidarity was most needed while looking for a convenient scapegoat to shield their dismal response to the COVID-19 outbreak. However, for the WHO to remain relevant to the scheme of things, it has to undergo some modifications to fit the purpose for which it was set up, and those modifications include but are not limited to coordinating and collaborating with the proliferation of non-state actors in the global health arena; galvanize enough political will to stand up to member states not in compliance with core capacity obligations of the IHR; address the issues of sovereignty, solicit non-tied funding and discourage populist nationalism among its member states.

WHO: institutional failures or scapegoat?

The WHO's timely response, transparency, accountability, and independence in combating communicable diseases has been a subject of longstanding debate that has intensified in the wake of the COVID-19 pandemic. As stated above, critics worldwide are calling for institutional reforms of WHO due to its weaknesses in responding to the COVID-19 pandemic. Clift summed up these weaknesses better when he says WHO, "is too politicized, too bureaucratic, too dominated by medical staff seeking medical solutions to what are often social and economic problems, too timid in approaching controversial issues, too over-stretched and too slow to adapt to change" (Griffiths, 2020). He went further to argue that "the WHO is both a technical agency and a policy-making body … The excessive intrusions of political considerations in its technical work can damage its authority and credibility as a standard bearer for health" (Griffiths, 2020). For example, a highly politicized global health landscape dominated by US–China rivalry, in which WHO was dragged in the middle as a scapegoat disrupted WHO's operational viability. Moreover, the ways and manners in which COVID-19 PHEIC has declared call into question the cozy relationships between WHO's D.G. and Chinese President Xi Jinping. The timing of the declaration seemed favorable and deferential to China, which led to the deputy Japanese prime minister referring to WHO as acting like a "Chinese Health Organization" (Colton, 2020). As one scholar sums it up: "The manner in which China and the United States politicized COVID-19 for a geopolitical purpose bodes ill for international health cooperation" (Fidler, 2020c: 19).

However, any meaningful stock-taking of the WHO should be done within the context of its original responsibilities that fall within the parameter of three core functions as mandated by its constitution (Ruger & Yach, 2009) – (1) normative functions; (2) directing and coordinating functions; and (3) research and technical cooperation functions. As far as normative, directing, and coordinating functions are concerned, the WHO has failed abysmally in this regard as indicated by the review above. But on research and technical cooperation functions, the WHO has done so well by combating infectious diseases and helping developing countries to set up basic healthcare facilities by training their workers via capacity-building programs, including massive vaccination campaigns in rural settings that

have eradicated smallpox and polio, containing the spread of malaria fever, HIV/AIDS (WHO, 2013). But there is room for improvement. Despite these success stories, what is painfully obvious is the fact that the WHO lacks both political will and funds to combat emerging infections and thus leaving the WHO bereft of its forward momentum in building global solidarity. As Robert Haass has noted:

> A pandemic that begun in one country and spreads with great velocity around the world is the definition of a global challenge … What is missing is any sign of a meaningful global response … The near irrelevance of the World Health Organization, which should be central to meeting the threat at hand, speaks volume to the poor state of global governance. (Haass, 2020: 5)

On the question of reforming the WHO, some scholars, public health experts, and pundits have proposed the following recommendations: Model #1 – called for a "reformed WHO" that is responsive to the needs of the country as well as the region appropriately through decentralization of staffing of WHO's offices to the local level. Model #2 – proposed a "WHO Plus" arrangement to include: 1). Peer-review process to replace the redundant self-assessment process of the core competencies of IHR. 2). Model #3 – proposed an executive agency that will be responsible for providing "strategic operational and technical" expertise during health emergencies. Model #4 – a proposal to create a separate agency to replace the WHO. This model was the least favorite among the participants because the idea that creating a separate entity could be a panacea for IHR compliance was treated with skepticism due to the challenges of state sovereignty and territorial integrity (Commission on Global Health Risk Framework for the Future, 2016).

Sridhar and Gostin's article on reforming the WHO recommends five proposals for putting the WHO back at the helm of affairs along the same line as aforementioned Model #2: "(1). Give real voice to multiple stakeholders; 2). Improve transparency, performance, and accountability; (3). Closer oversight of regions; (4). Exert legal authority as a rule-making body; and (5). Ensure predictable, sustainable financing" (Sridhar & Gostin, 2011). Claire Chaumont, a Harvard public health policy scholar also made some interesting recommendations on the way forward for WHO: (1). Strong sanctions for countries failing to comply with WHO's mandate; (2). Narrow mandate to four specific areas – "production of global public goods, management of externalities", technical assistance and stewardship of global health at the global level; (3). Increased untied funding; (4). Open governance to include alternative voices from civil society and other private philanthropists; and (5). Broad technical expertise to include other disciplines outside the public health realm while maintaining its technical focus (Chaumont, 2020).

From the above analysis, it is obvious that the WHO was both a scapegoat and an institutional failure. To put the WHO back on track at the helm of affairs as the leading agency in charge of GHG, it is imperative to strengthen global solidarity by bridging the governance gap.

The governance gap: lessons for WHO

The COVID-19 pandemic has brought to the fore the need to revamp the GHG in preparing a coordinated and orderly response to the next pandemic. The governance gap seen thus far in the fight against the COVID-19 pandemic came about as a result of what Fidler referred to as a byproduct of "the gap between what we think we have as governance and the actual essence of governance, which is the exercise of political power" (Commission on Global Health Risk Framework for the Future, 2016). If there is any lesson to be drawn from previous pandemics, it is that without political will, governance will not see the light of the day. The working definition of governance for communicable disease control according to a workshop organized by experts in the field states:

> In the context of infectious disease outbreaks of global significance, governance encompasses a range of integrated policy, information management, command, and control mechanisms for facilitating collective action to achieve the objectives of prevention, detection, and response. Of necessity, these mechanisms integrate actions across intergovernmental organizations, sovereign nations, communities, the corporate sector, humanitarian agencies, and civil society. They operate in not only the realm of health, but also to a variable extent in collateral spheres to include agriculture/food security, diplomacy, education, finance, migration/refugee care, security, and transportation. (Commission on Global Health Risk Framework for the Future, 2016)

In support of the above definition, Fudan University professor Zhing Weiwei writes that "the main divide in the future may well not be over democracy and autocracy, but between good governance and bad governance" (Gardels, 2020: 5). An overview of good governance here draws heavily on UN ESCAP list of eight characteristics of good governance – "transparency, accountability, public participation, rule of law, responsiveness, consensus-oriented, equity and inclusiveness, effectiveness and efficiency". Caveat: they are not mutually exclusive as there are several overlaps between the characteristics.

Transparency – The COVID-19 pandemic exposes the difficulties of information and data sharing at all levels. For example, China's disposition toward withholding information, downplaying and controlling news surrounding the actual date the COVID-19 outbreak started and the causes and origin of the virus, demonstrates the futility of the global response effort. Critics also pointed fingers at the Director-General of WHO for being too cozy with China and for intentionally declaring the COVID-19 outbreak a PHEIC a week later for reasons based on political expediency and power politics that undermine science and GHG (Lo, 2020). Following the COVID-19 pandemic, the H1N1 influenza pandemic, the world has witnessed other pandemic outbreaks where controversial PHEICs were declared such as H1N1 influenza, Ebola, and Zika. But there is still a dark cloud over what criteria constitute an emergency situation that warrants a potential PHEIC declaration. The modalities for such declaration to ensure adequate time for science-based information sharing, transparency and accountability have not been fully addressed.

Accountability – According to a public health expert, David G. Legge, "The accountability of governments to their people is a core value of inclusive, informed, and participatory democracy. Strengthening the democratic accountability of governments for their role in global policymaking and for the implementation of national public health policies would be a significant step to democratising global health governance" (Legge, 2020b: 4). There is no provision in IHR 2005 that seeks accountability for the WHO's dismal performance in responding to infectious disease outbreaks. "IHR does not have robust accountability mechanisms for compliance, enforcement, oversight and transparency" (Roojin, 2020; Hoffman & Groux, 2016).

The mandate given to the Independent Panel for Pandemic Preparedness and Response (IPPR) should look into what went wrong and to make recommendations regarding the aforementioned concerns about IHR for better response to the next pandemic. As Sridhar and Gostin noted, "Good governance also requires clear objectives, transparent decision-making, information dissemination, monitoring progress, and accountability" (Sridhar & Gostin, 2011: 3). For example, some non-state actors are so influential and have welded enormous power in GHG and thus are not accountable to the WHO or any other public health authority. This does not augur well for better preparation for the next pandemic.

Participatory Approach – The World Health Assembly (WHA), the decision-making body of the WHO, comprises health ministers from 194 member states, and meets annually to deliberate and make decisions on key policy agendas proposed by the Executive Board in Geneva, Switzerland. Having 194 health ministers making decisions that will affect diverse issues relating to the health sector will not augur well for good governance

as "global governance must be understood as also involving NGOs, citizen's movements, multinational corporations, and global capital market … and global mass media of dramatically enhanced influence" (The Commission on Global Governance, 1995). Thus, the governing body must take into consideration what Fidler calls the "unstructured plurality" of actors in GHG so that no entity is left behind (Griffiths, 2020; Fidler, 2007). Moreover, it is absolutely unfair and grossly irresponsible for anyone to perpetrate racism and xenophobia on innocent citizens of Asian backgrounds via public health and foreign policies (Yeung, 2020).

The rule of law – From all indications, international law remains an indispensable tool in strengthening GHG. But the fact remains: IHR – one of the most important sets of legal instruments for governing pandemic threats is deficient, inadequate, and obsolete. It has come under extreme attack by nationalist governments through flagrant disregard and noncompliance to its legal obligations. For example, Indonesia, Myanmar, the US, and China stand at the forefront out of the 194 member states accused of violating the IHR mandates through travel restrictions, mandatory quarantines and other draconian restrictive measures put in place, which constitute human-rights violations.

The WHO's silence in investigating these accusations sends a clear message of the WHO being complicit and differential to these countries regarding human-rights violations. In addressing IHR's inadequacy, WHO should endeavor to strike a balance during lockdowns to avoid social inequalities between non-pharmaceutical interventions and the social burdens on society at large (Chu, 2020). To ensure the rule of law supplants the rule of the jungle, the WHO's enforcement mechanism must be strengthened to give the WHO teeth to bite and political will to go after the defaulters through the newly proposed pandemic treaty as recommended by the IPPR report.

Responsiveness – Robust accountability demands responsiveness on the part of WHO to deliver public goods to all stakeholders without infringement on their fundamental human rights in an effective, efficient and timely manner. To achieve this, the WHO must step up its response strategy called: Strategic Preparedness and Response Plan (SPRP) (WHO, 2019). SPRP according to the WHO is to prevent, protect, and curtail further transmission of COVID-19 and the next pandemic worldwide. The issues of national responsibilities should also be addressed so that national core competency must be met by all member states, most especially in the Global South by extending more incentives and facilities to enhance their efforts.

Consensus-oriented – Compromises, consensus, and coalition-building are the basic building blocks for good governance. Building COVID-19 outbreak response outside an agenda that seeks to mediate between countless different needs, perspectives, and expectations of a diverse and interdependent world is a recipe for failure. For example, consensus was far-fetched as exemplified by the struggle between nationalists and cosmopolitan worldviews over state sovereignty. As some experts have noted, this conflict is "dividing an interconnected world, nationalist governments have implemented isolationist policies that undermine global solidarity. As government rapidly imposed international travel bans, many nations engaged in medical protectionism" (Gostin, Moon, & Meier, 2020: 1616) that hindered collective action.

Equity and inclusiveness – The COVID-19 pandemic has exacerbated the gaps, barriers, and inequalities in global health architecture. Jutta Urpilainen, European Commissioner for International Partnership, has responded to these gaps and inequalities via Team Europe[1] by taking a bold initiative of donating more than $46 billion to assist the EU's partner countries in "addressing health and socio-economic impact of COVID-19" (Urpilainen, 2021). For example, this initiative has helped to establish COVID-19 treatment hospitals and testing centers in Mauritius. Team Europe has also provided 500 protective equipment to healthcare workers in Mauritania. She is of the opinion that

> ensuring healthy lives and promoting well-being for all, at all ages, is a 360-degree affair, and success depends on us all, and on our effective cooperation across sectors. Working together, as Team Europe, we increase our impact on the path to sustainable recovery and to building inclusive, resilient health systems that leave no one behind. (Urpilainen, 2021)

Team Europe's efforts underscore the need to tackle other problems that are not health-related such as social welfare, cultural beliefs, and other socio-economic issues that undermine healthcare delivery. As Elias, Heymann and Lopez-Acuna note, "Rather than reinvent global health architecture, creating a strong mechanism for inclusion of non-state actors in the system, led by the WHO as the coordinator, can lead to swifter mobilization of state, non-governmental organization (NGO), and private-sector teams and assets" (Commission on Global Health Risk Framework for the Future, 2016). Furthermore, the workshop participants recommended the integration of the "emergency health responses" function of the WHO with the existing global humanitarian system.

Currently, there is no global system for equitable distribution of vaccines (Yanzhong, 2021). As Ambassador Jimmy Kolker, a career Foreign Service Officer with an extensive background in global health diplomacy puts it, "Without some sort of agreement or formula, there are formidable obstacles to scaling up vaccine use around the world" (Kolker, 2020: 36). And this has resulted in vaccine nationalism. Indonesia's issue with structural inequalities in access to vaccines is a classic example, "the concern that samples provided freely by developing countries are used by companies in wealthy countries to develop vaccines and other products that the developing countries can't afford" (Roos, 2008).

This situation has serious global health ramifications that are essentially detrimental to the drive for a coordinated global response to COVID-19 (Kassam, 2020). The sustainable solution rests heavily on taking seriously the South Africa and India jointly proposed "TRIPS Agreement Waiver proposal – that would temporarily waive intellectual property rights protections for technologies needed to prevent, contain, or treat COVID-19, including vaccines and vaccine-related technologies" (WTO, 2021). This will obviously bridge the vaccinated–unvaccinated divide worldwide. In sum, arguing along the same line, on the third anniversary of the WHO's declaration of COVID-19 as a global pandemic (11 March 2023), more than 190 global leaders under the auspices of the People's Vaccine Alliance, signed an open letter urging the international community to desist from prioritizing "profiteering and nationalism" above the "needs and aspirations of humanity" and demands an unequivocal assurance that this will not be repeated in the preparation for the next pandemic (People's Vaccine, 2023). The letter further stressed support for the new "WHO's mRNA hub, which is currently sharing vaccine technology with producers in 15-low-and middle-income countries" around the world (Johnson, 2023).

Effectiveness and efficiency – Historically, the WHO's effectiveness and efficiency have been called into question as well in the wake of COVID-19. Most of the critics have pointed to the fact that WHO is underfunded, overstretched, too bureaucratic, lacks political will, heavy reliance on medical staff, and lacks legal strategy and enforcement mechanism. In addition to that is the issue of defective IHR (2005) that has been revised several times, but is still deficient according to After Action Reviews (AARs) as evidenced in the WHO's member states implementation of the 13 IHR core capacities based on the self-assessment annual report (Stoto, 2019). As Fidler notes: "Relying on the International Health Regulations as the centerpiece of international law on emerging disease control may not be the most effective international legal strategy" (Fidler, 1996a: 83).

To make the WHO more effective and efficient will require changing its "jack-of-all-trades" approach and focusing more exclusively on areas in which its relative efficiency is greatest. This will allow the WHO to perform its core function of coordinating and collaborating with a vast array of non-state actors while simultaneously outsourcing other global

health activities to experts in the field (Dhillon & Negin, 2016). This model is predicated on principal-agent theory, which is perhaps reminiscent of an organization that delegates in order to stay focused on maximizing its comparative advantage. As Hanrieder noted, because the WHO is "lacking the material capabilities to perform its function on its own, WHO … draws on its formal authority and convening power to mobilize other organizations and non-governmental associations for research, surveillance and technical assistance activities" (Hanrieder, 2015: 191). Thus, research emanating from these vast areas of clinical studies, epidemiology, disease mapping, biomedical, anthropology and international politics are incorporated into policy, practice, and as part of the response (Farrar, 2014).

Conclusion and recommendations

There is no doubt that from 1851 when the first conference was organized to the present battle over the newly proposed pandemic treaty in 2022, it is noteworthy to say that the international community has made some remarkable progress toward controlling or containing emerging and reemerging communicable diseases. Notwithstanding these enormous achievements and advances that have been made thus far against infectious diseases, establishing a normative framework for a well-coordinated international response to the next pandemic is still conspicuously absent.

The US–China rivalry has left the WHO (supposedly the custodian of global health) weakened and running out of steam due to geopolitical portents. Most critics think the WHO has outlived its usefulness, become politicized and no longer "fit-for-purpose", but no credible replacement is in sight. The IHR that has been portrayed since after 2005 revision as the mainstay of the WHO's global legal framework is fraught with false foundation, member states are circumventing its rules and conventions for political expediency and the issue of sovereignty still rears its ugly head as one scholar calls COVID-19 pandemic a "Westphalian virus" due to the fact that member state still use sovereignty as a leverage to avoid compliance.

But shortcomings notwithstanding, a multilateral response in combating COVID-19 remains fundamental. The international community under the auspices of the prime minister of Australia, Scott Morrison has bluntly requested a "proper, transparent, independent review as to what happened, where did it happen, how did it start?" (Ravelo, 2020). This is crucial in determining where the WHO has fizzled out in its international obligations. What the COVID-19 pandemic, and certainly one of many more to come, shows is that global solidarity will not come to fruition until the growing ideological fault line between the United States and China is resolved, seek some kind of detente and expedite actionable strategy in reconciling the major differences between them and clearing up, to a greater extent, the major huddles on the way of reaching international cooperation through the newly proposed pandemic treaty.

Furthermore, if the new pandemic treaty is to be successful in bridging the governance gap enumerated above, it must enhance infectious disease-control efforts by taking into cognizance what we called the "Pandemic Response Deal": First, reform the WHO and its moribund IHR with teeth to bite embedded in political will, coupled with diversified sources of financial independence; second, encourage global solidarity at the expense of populist nationalism; third, elevate public health above the margins of low politics to become an integral part of "global public goods" in international affairs; fourth, accommodate other stakeholders as legitimate players in the scheme of things, public health is no longer the prerogative of medical doctors and scientists alone anymore, the WHO should also look at other related predicaments beyond the health realm and endeavor to include social determinants of health in protection of the poor and most vulnerable, which are mainly women and children in developing countries; and fifth, introduce equity and inclusiveness that will pave the way for access to vaccine based on needs rather than allowing pharmaceutical companies to capitalize on the profits by giving priority to Advanced Industrialized Countries first. This will eradicate vaccine inequity, nationalism and profiteering that have undermined

Less Developed Countries' access to vaccines. Failure to carry out this paradigm shift in the "Pandemic Response Deal" will render the international community, most especially the WHO, unprepared for the next pandemic.

Note

[1] Team Europe is a combination of the European Union, its member states, the European Investment Bank, and other European financial institutions.

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