The World Health Organization and Its Response to Epidemic Outbreaks: A History of Challenges

La Organización Mundial de la Salud y la respuesta a brotes epidémicos: una historia de desafíos

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Abstract:
In this paper we analyze the management of pandemic outbreaks by the World Health Organization (WHO). After presenting an overview of the actions, achievements and setbacks of this UN agency in its efforts to address health crises—efforts that have resulted in both praise and criticism of the fulfillment of its mandate—, we look at the various challenges the WHO faces due to the increasing participation of private actors and non-governmental organizations in global health governance.

Resumen:
En este trabajo se analiza la gestión a brotes pandémicos por parte de la Organización Mundial de la Salud (OMS). A través de un repaso histórico, se revisaron las acciones, los logros y los tropiezos que ha tenido este organismo del Sistema de las Naciones Unidas para atender las crisis sanitarias y que han resultado tanto en felicitaciones como críticas hacia el cumplimiento de su mandato. Asimismo, se analizan los diferentes desafíos a los que la WHO ha tenido que hacer frente ante la creciente participación de actores privados y organismos no gubernamentales en la gobernanza global de la salud.

Key Words:
Epidemic outbreak, World Health Organization, pandemic, international organization, global health governance.

Palabras clave:
Brote epidémico, Organización Mundial de la Salud, pandemia, organización internacional, gobernanza global de la salud.

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Introduction

In the wake of World War II, the international community created a series of international organizations (IOs)—most of which fell under the umbrella of the United Nations System—to promote the prosperity of the world's nations and avert the flare-up of another world war. The United Nations agency responsible for managing health issues is the World Health Organization (WHO).

Until recently, human health was deemed a secondary issue on the political agenda, but there can be no denying it is an indicator of well-being, wealth, justice, freedom and even security.[1] In other words, a healthy population is a reflection of a society that has guaranteed its citizens access to health services and decent living conditions. The political, economic and social importance of health becomes all the more evident during a health emergency.

As has occurred several times over recent decades, responses to epidemic outbreaks (or epidemics) have the potential to disrupt trade and shut down airports, exacerbate poverty, create fear and destabilize armies.[2] As a result,

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1 Sophie Harman, "Global Health Governance", in T. G. Weiss and R. Wilkinson (eds.), *International Organization and Global Governance*, London, Routledge, 2014.

2 *Idem*.

governments are generally wary about reporting outbreaks of diseases out of fear of having sanctions and restrictions imposed on them.[3]

So even though our globalized world has permitted new private actors a say in affairs of international import, health issues remain firmly in the political arena.[4] And while there is more than one example of a non-government organization (NGO)[5] that uses its economic and technical clout to wield influence,[6] to the extent that the flow of people across borders increases, how States respond to health emergencies will remain an exercise in political power, generally guided by the policies and recommendations of IOs.

It is in light of the above that this paper analyzes the role of specialized international health organizations in addressing epidemics and pandemics since the nineteenth century. Following a brief overview, in which we sum up the mandates and work of the first IOs with universal scope, like the International Office of Public Hygiene (OIHP) and the League of Nations Health Organization (LNHO) in the early twentieth century, we go on to discuss in greater detail the creation of the WHO, its mandate, structure and functions over the close to 75 years it has existed, with particular emphasis on its capacity to respond to health crises that range from the appearance of HIV/AIDS to the present SARS-CoV-2 pandemic. Finally, we look at the role the WHO currently plays in global health governance.[7]

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3 Naomi Nagata, "International Control of Epidemic Diseases from a Historical and Cultural Perspective", in Madeleine Herren (ed.), *Networking the International System: Global Histories of International Organizations*, Heidelberg, Springer, 2014, 78.

4 S. Harman, *op. cit.*

5 Private organizations like the Bill & Melinda Gates Foundation and innovative global funds, like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Gavi, the Vaccine Alliance (formerly the Global Alliance for Vaccines and Immunization), among others.

6 Laurie Garret and Kammerle Schneider, "Global Health: Getting it Right", in Anna Gatti and Andrea Boggio (eds.), *Health and Development: Toward a Matrix Approach*, Basingstoke, Palgrave Macmillan, 2009, 5.

7 David P. Fidler defines *global health governance* as "the use of formal and informal institutions, rules, and processes by states, intergovernmental organizations and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively." *David P. Fidler, The Challenges of Global Health Governance*, New York, Council on Foreign Relations, 2010, 3.

The institutional foundations of world health

The first international public health organizations were created in the nineteenth century. Known as *quarantine organizations*, these set up regional offices in colonized territories to protect Europe from epidemics and create quarantine regimes in the Mediterranean.[8] But the real institutional roots of world health, what Harman calls the first phase of global health governance,[9] date back to the mid-nineteenth century, a scientific golden age marked by breakthroughs in biomedicine, the discovery of X-rays, the invention of the stethoscope and, more importantly, the study of diseases caused by microbes.

Diseases like cholera, plague, typhoid and yellow fever were spread by international trade and affected countries' economic interests, hence the decision to cooperate and come up with a coordinated international response to outbreaks, which, in turn, paved the way for 14 international sanitary conferences between 1851 and 1938.[10] The aim of these conferences was to prevent the spread of diseases via international trade (mainly shipping) and migratory routes, and promote better hygiene among populations.[11] They later led to the adoption of international health regulations and the creation of permanent international public health organizations.[12]

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8 In chronological order: the Constantinople Health Council (1838), the Tangier Sanitary Council (1840), the Sanitary, Maritime and Quarantine Council of Egypt (1843) and the Sanitary Council of Teheran (1867). See Neville M. Goodman, *International Health Organizations and Their Work,* London, J. & A. Churchill Ltd., 1952.

9 S. Harman, *op. cit.*

10 Adam Kamradt-Scott, *Managing Global Health Security: The World Health Organization and Disease Outbreak Control*, Basingstoke, Palgrave Macmillan, 2015, 25.

11 S. Harman, *op. cit*.

12 For example, after the seventh conference held in Venice in 1892, the Sanitary, Maritime and Quarantine Council of Egypt became a permanent regional organization entrusted with implementing the health policies adopted at the conferences in member territories. Riikka Koskenmaki, Egle Granziera and Gian Luca Burci, "The World Health Organization and its Role in Health and Development", in Anna Gatti and Andrea Boggio (eds.), *Health and Development: Toward a Matrix Approach,* Basingstoke, Palgrave Macmillan, 2009, 17.

Outside Europe, the United States set up the International Sanitary Bureau in 1902, whose alternate purpose was to help comply with the various quarantine, inspection and exclusion regulations that hindered the movement of goods in America. In 1923, this office was renamed the Pan American Sanitary Bureau, which was the predecessor of the Pan American Health Organization (PAHO).[13]

In 1907, after the 11th International Sanitary Conference (1903), the International Office of Public Hygiene (OIHP) was created in Paris, France. The first health organization with an international reach, the mission of the OIHP was to monitor the appearance and spread of diseases. It emerged at a time of enormous progress in the study of disease transmission, which, in turn, spurred international cooperation in the area of disease control.[14]

The end of World War I marked a change in paradigm *vis-à-vis* the importance of international organizations as necessary instruments of multilateralism. The League of Nations, established in 1920, advocated a new common interest: world peace. In keeping with this goal, for the first time nations saw controlling epidemics as essential to preventing conflicts and wars.[15] So, in 1922 a health division was set up. Headquartered in Geneva and known as the LNHO, it was designed to address postwar health problems like flu and typhus in Europe.[16]

The main tasks of the LNHO were to respond to and advise countries on health matters, depending on their specific needs, encourage solidarity between nations via study trips and the exchange of doctors, and craft frameworks for special agreements between neighboring countries.[17] This

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13 A. Kamradt-Scott, *op. cit.,* 27.

14 Tine Hanrieder, *International Organization in Time: Fragmentation and Reform*, Oxford, Oxford University Press, 2015, 50.

15 For example, the League of Nations mobilized international support to help Poland, Russia and other Eastern European countries combat postwar epidemics of typhus transmitted by lice and other diseases. See N. Nagata, *op. cit.*, 82.

16 S. Harman, *op. cit*. The League of Red Cross Societies was also set up at the end of World War I in response to poor health conditions in Europe.

17 N. Nagata, *op. cit.*, 82.

required the setting up of technical committees of experts and field visits, establishing the LNHO as a pioneer in this area.[18]

Although the International Sanitary Convention and the OIHP provided the foundations for the creation of the LNHO, this was not based on the OIHP and nor did it incorporate it into its structure, mainly because the United States was not a member of the League of Nations. It was, however, a member of the OIHP,[19] which resulted in an awkward co-existence, marked by tension and legal confusion regarding their status, the relationship between the two organizations and the duplication of activities in the expanding arena of international public health.[20]

However, with the outbreak of World War II, both the OIHP and the LNHO suspended most of their activities. In 1943, the allied powers created the United Nations Relief and Rehabilitation Administration (UNRRA) to help countries liberated during the war get back on their feet as soon as possible and prevent outbreaks of diseases and epidemics.[21] Once the conflict was over, UNRRA functioned effectively, serving as a bridge between international health efforts before and after the war.[22] During this first phase of global health governance, private philanthropists also took great interest in financing medical research and treatments.[23]

In 1945, the delegations of Brazil and China proposed that health be included in the U.N. Charter[24] and on July 22, 1946, the WHO Constitution—signed by the representatives of 51 U.N. members and ten other

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18 Fraser Brockington, *World Health,* London, Penguin, 1958, 206.

19 Norman Howard-Jones, "International Public Health: The Organizational Problems Between the Two World Wars. Epilogue", in *WHO Chronicle*, vol. 32, no. 4, 1978, 157.

20 T. Hanrieder, *op. cit.*, 50.

21 N. M. Goodman, *op. cit.*, 117.

22 R. Koskenmaki, E. Granziera and G. L. Burci, *op. cit.*, 18.

23 For example, John D. Rockefeller set up the Rockefeller Institute for Medical Research in 1901 and the Rockefeller University Hospital in 1910. S. Harman, *op. cit.*

24 David Macfadyen, Michael D. V. Davies, Marylin Norah Carr and John Burley, *Eric Drummond and his Legacies: The League of Nations and the Beginnings of Global Governance,* Basingstoke, Palgrave Macmillan, 2019, 275.

countries—was adopted. The Constitution came into force on April 7, 1948, the day on which World Health Day is celebrated every year.[25]

To facilitate the merging of multiple IOs into one single entity, the WHO Interim Commission was formed, also in 1946, to oversee the transition. The Commission immediately took over the epidemiological intelligence work of the OIHP, the LNHO and UNRRA, with a view to responding to disease-related emergencies and, at the same time, initiated negotiations to persuade PAHO to join the WHO, even though the former wanted to retain its independence.[26] Finally, on July 1, 1949, PAHO became the regional WHO office for the Americas, with autonomy over its own budget and work program.[27]

One of the arguments for adopting this structure was that it was more effective at treating local health problems,[28] but in time, the WHO's regional offices acquired more influence than their founders had foreseen and than was provided for in the WHO Constitution.[29] This precedent justified the defense of equivalent agreements by other regions, with the result that, by 1951, another five regional offices had been created to serve the West Pacific, Southeast Asia, the Middle East, Europe and Africa.[30]

The creation of the WHO marked the adoption of an interdisciplinary approach to world health. Firstly, the WHO and its regional offices became the main body for the management of international policies. Secondly, other United Nations agencies came to view health as a major issue.[31] Thirdly, health came to be considered key to development, economic reform and the building of postwar infrastructure. As such, it was covered by the mandate

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25 R. Koskenmaki, E. Granziera and G. L. Burci, *op. cit.*, 18.

26 Kelley Lee, *The World Health Organization (WHO)*. Abingdon, Routledge, 2009, 75.

27 A. Kamradt-Scott, *op. cit.,* 27.

28 R. Koskenmaki, E. Granziera and G. L. Burci, *op. cit.,* 19.

29 T. Hanrieder, *op. cit.,* 53.

30 A. Kamradt-Scott, *op. cit.*, 27.

31 For example, the United Nations International Children's Emergency Fund (UNICEF) to combat child hunger and sickness, the United Nations Population Fund (UNFPA) for reproductive health, and the United Nations Development Programme (UNDP), which champions the right to health.

of financial institutions like the World Bank.[32] For many involved in postwar reconstruction efforts, there was a clear link between the provision of social wellbeing and international peace and security.[33]

WHO mandate, structure and functioning

The primary function of the WHO is to lead and coordinate international health initiatives.[34] According to Article 2 of its Constitution, not only is it entrusted with combatting infectious diseases, but it is also required to address nutrition and housing, economy and work, maternal and child, and mental and environmental health matters.

The WHO is managed by a director-general and membership is open to all States in keeping with its aspirations of universality, which it has practically achieved with 194 members.[35] The WHO's main bodies are: the World Health Assembly (WHA), which is its supreme decision-making body; the Executive Council, which implements the Assembly's decisions and policies and manages events that require immediate action; and the Secretariat, headed by a director-general, experts and support staff.

Each regional office has a regional director and an intergovernmental regional committee. These offices focus on technical support and the building of national capacities, facilitating information gathering and the monitoring of health trends.[36] Nonetheless, their high degree of autonomy poses an obstacle to coherent program planning and the management of the WHO in general.[37]

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32 S. Harman, *op. cit.*

33 A. Kamradt-Scott, *op. cit.*, 24.

34 T. Hanrieder, *op. cit.*, 51.

35 WHO membership is open to all States, even those that are not UN members. Consequently, the WHO deems Liechtenstein a full-fledged member, while the territories of Niue and the Cook Islands participate as associate members and Taiwan as an observer of the World Health Assembly.

36 R. Koskenmaki, E. Granziera and G. L. Burci, *op. cit.*, 19.

37 Fiona Godlee, "The World Health Organisation: The Regions-Too Much Power, Too Little Effect", in *British Medical Journal*, no. 309, no. 6968, December 10, 1994, 1568.

As regards WHA delegates, the WHO Constitution states that these must be "should be chosen from among persons most qualified by their technical competence in the field of health".[38] In this respect, WHO bureaucracy has become very protective of its reputation and has gone to great lengths to be objective, efficient and effective. Notwithstanding, these attributes alone have not been sufficient to get certain Member States to automatically adapt their policies to WHO guidelines.[39]

One of the major challenges the WHO faces is the coordination of global health initiatives. This task has been further complicated to the extent that the number of States has increased, while the emergence and growing influence of non-governmental actors that function as health managers poses yet another obstacle. This has caused countries to show a lack of confidence in the organization's management and avoid assessed contributions on a recurring basis.

Since the 1980s, the WHO has been operating on an extremely tight budget, partly due to the introduction of neoliberalism and further accentuated by the 2008 financial crisis. There have been two repercussions to this: firstly, WHO technical cooperation consists primarily of consulting services as opposed to financial aid or operational activities,[40] and secondly, the WHO has come to depend more and more on extrabudgetary financing (which represents approximately 80% of its total budget)[41] from voluntary contributions by States, private and philanthropic actors.[42]

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38 WHO, "Constitution of the World Health Organization", in *Basic Documents. 49th edition,* Geneva, WHO, 2020, 5.

39 A. Kamradt-Scott, *op. cit.,* 41.

40 G. L. Burci and Claude-Henri Vignes, *World Health Organization*, The Hague, Kluwer Law International, 2004, 195, quoted in A. Kamradt-Scott, 40.

41 Voluntary contributions make up 80 percent of the WHO's budget, but come from just 20 sources and more than half are made by the governments of industrialized nations. Since 2012, the Bill and Melinda Gates Foundation has been the second-largest contributor to the WHO, after the U.S. government. Marcos Cueto, Theodore M. Brown and Elizabeth Fee, *The World Health Organization. A History*, Cambridge, Cambridge University Press, 2019, 326.

42 Jennifer Prah Ruger, "International Institutional Legitimacy and the World Health Organization", in *Journal of Epidemiology and Community Health*, vol. 68, no. 8, August 2014, 698.

Rather than serving global health, these voluntary contributions are used to finance health and technical assistance that panders to the political, economic and strategic interests of certain countries or organizations,[43] leading to disorganized, unbalanced short-term financing in lieu of effective general project coordination and a world health policy masterplan with long-term financing.[44]

By the same token, even though each WHO member has one vote in the WHA, which would appear democratic, governance of the WHO is generally perceived as unfair and unbalanced, once again, due to the influence of private and philanthropic actors, and encroachment by powerful, developed countries on the WHO's affairs by means of voluntary and extrabudgetary contributions allocated to specific ends and programs.[45]

The WHO's response to epidemics

The WHO and other international organizations have been entrusted with the task of providing early warnings on a wide range of issues. The WHO plays a central role in the prevention, control and eradication of infectious diseases worldwide. Nonetheless, State leaders and public opinion have become increasingly skeptical of its advice and recommendations.

Furthermore, there is no specific document defining the parameters of the WHO's responsibilities, obligations or powers when it comes to eradicating diseases. This void is filled by the International Health Regulations (IHR), an instrument of international law designed to help protect States against the global spread of disease, and public health risks and emergencies. Among other things, the IHR require States Parties to assess, report and respond to public health events and shore up their national surveillance and response capacities.[46]

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43 *Idem.*

44 *Ibid.*, 699.

45 *Idem.*

46 R. Koskenmaki, E. Granziera and G. L. Burci, *op. cit.*, 22.

Also, the WHO is the only organization with the power to declare a pandemic. Yet because of its loss of legitimacy, not all its members have implemented its recommendations or taken its advice.[47] This is especially true in cases where governments perceive that the policies proposed by organizations like the WHO go against their interests.[48] That said, we will proceed to look at the main actions the WHO has taken to combat epidemics since it was founded.

From the global Malaria Eradication Program (MEP), the Smallpox Eradication Program (SEP) and the Program to Eradicate Tuberculosis (PET) to more recent cases like HIV/AIDS, severe acute respiratory syndrome (SARS), AH1N1 influenza, Ebola and SARS-CoV-2, the WHO has functioned as a coordinating authority, despite the growing participation of non-governmental actors. Yet, on occasion, the methods the Secretariat has employed to fulfill its mandate have been deemed controversial.

In the first three cases, the WHO gradually developed a conventional approach to the control and eradication of the diseases in question. The MEP, for example, served as the WHO's first attempt to completely eradicate an infectious disease, but for several reasons,[49] it failed.[50] Conversely, the SEP is generally applauded as the agency's greatest public health achievement. Nonetheless, Kamradt-Scott points out that both programs were mass global eradication campaigns that attracted a great deal of support and resources.[51]

Perhaps the greatest global health folly was the refusal to acknowledge the emergence of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and, with it, failure to take action to check its spread

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47 Songying Fang and Randwall W. Stone, "International Organizations as Policy Advisors", in *International Organization,* vol. 66, no. 4, Fall 2012, 540.

48 *Ibid*., 541.

49 One of the main criticisms was that the WHO supported the program because the United States and its allies wanted to expand international markets and continue its ideological conflict with the USSR and communism. See J. P. Ruger, *op. cit.,* 699.

50 A. Kamradt-Scott, *op. cit*., 19.

51 *Idem*.

worldwide.[52] The WHO's inaction was partly attributed to the absence of early responses.[53] Another reason countries declined to acknowledge the disease was that they believed doing so would harm their tourism industries and other foreign industrial investments[54] (just as occurred with SARS-CoV-2). Furthermore, officials were loath to include HIV/AIDS on the agenda because of its apparent connection to homosexuality, prostitution and drug use.

African countries officially recognized the HIV/AIDS problem and requested the assistance of the international community (specifically the WHO) in March 1986 at the First Regional Conference on AIDS in Brazzaville, Congo, four years after the first case was reported.[55] Likewise, at the 1986 WHA in Geneva, the United States and Europe were called on to take global action to combat HIV/AIDS.[56] Following the creation of a specific program to address the HIV/AIDS problem, in 1995 the WHA announced the Joint United Nations Programme on HIV/AIDS (UNAIDS) and designated it the key initiative for establishing a global response to the epidemic, relegating the WHO to a back seat.[57]

During this time, the work of the WHO was further hampered by the incursion of private associations and philanthropic actors into the global health arena, which ushered in a new phase in global health governance.[58] Today, the mass movement of people across borders in our highly interconnected

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52 Young Soo Kim, "World Health Organization and Early Global Response to HIV/AIDS: Emergence and Development of International Norms", in *Journal of International and Area Studies*, vol. 22, no. 1, June 2015, 26; Peter Piot, "AIDS: From Crisis Management to Sustained Strategic Response", *The Lancet*, vol. 368, no. 9534, August 5, 2006, 527.

53 The United States, for example, was not interested in internationalizing the issue because it was more concerned with protecting its own citizens and finding a foreign scapegoat (just as it did recently by blaming China for the COVID-19 outbreak). In this case, the finger was pointed at Haiti because of its connection with African countries, which had a large number of AIDS patients like the United States and which, in turn, blamed Western countries for the spread of the disease. Y. S. Kim, *op. cit.,* 27.

54 *Ibid.*, 28.

55 *Ibid.,* 29.

56 *Ibid.*, 28.

57 Nitsan Chorev, *The World Health Organization between North and South*, Ithaca, Cornell University Press, 2012, 153.

58 S. Harman, *op. cit.*

world means microbes and the diseases they cause can also travel at an unprecedented speed and reach previously unknown locations.[59] It was in this context that the SARS outbreak occurred in China in 2002.

The Chinese government's initial response to the outbreak was secrecy and inaction.[60] Local dailies were banned from reporting on the epidemic, but the WHO nonetheless played a prominent role in containing it. After receiving early warnings of the SARS outbreak via the Global Outbreak Response and Alert Network (GOARN), the WHO filed its first request for information with the Chinese Health Ministry on February 10. Once it had analyzed the information, it intervened and issued an international alert on March 12, 2003, even though the Chinese Health Ministry prevented the two WHO teams sent to investigate the outbreak from leaving Beijing.[61] These initial actions by the WHO persuaded the leaders of the Chinese government (who were not well informed as to the gravity of the crisis) to acknowledge the outbreak and take firm measures to check its spread, even though they had initially been skeptical of the WHO's motives.[62]

Following its successful handling of the SARS outbreak of 2003 with policies and procedures that had proven effective at containing and eliminating the disease,[63] the WHO came to enjoy increased authority. However, in the midst of the global emergency, questions were raised as to the scope of the WHO's role and authority.[64]

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59 A. Kamradt-Scott, *op. cit.,* p. 2.

60 As with outbreaks in previous decades and centuries, the reasons later given by the government for its policy of secrecy included fear of undermining consumer confidence, scaring off foreign investment and shaking political stability. The fact of the matter is that the alert issued by the WHO caused a steep drop in tourism and business trips to China. S. Fang and R. W. Stone, *op. cit*., 553.

61 *Idem*.

62 The dilemma facing the Chinese government was deciding which was more dangerous: trust or mistrust. However, the efforts of the WHO and the Chinese government yielded fruit in June, when the number of new SARS cases fell to a minimum.

63 A. Kamradt-Scott, *op. cit.,* 182.

64 There were, for example, those who inferred the Director-General and the Secretariat had overstepped their authority, that they had exercised power independently of their mandate and that, on doing so, the WHO bureaucracy had ushered in a new era of post-Westphalian health governance. See *Ibid.* 22.

Furthermore, during the early phases of the AH1N1 influenza epidemic, criticism of the WHO's actions centered mainly on the timing of the declarations of pandemic alert.[65] Initially, the WHO categorized AH1N1 as a Phase 3 threat, but its June 2009 declaration of the AH1N1 pandemic (Phase 6) elicited reactions from governments and public health bodies the world over. The declaration triggered the implementation of national pandemic preparedness plans, measures for the manufacture and distribution of vaccines and greater emphasis on border control.[66]

Critics began to raise their voices when the virus failed to show the characteristic feature of a pandemic (Phase 6: sustained spread of the virus in multiple geographic regions), turning the WHO classifications into a subject of political and public debate.[67] The WHO itself later acknowledged deficiencies in the alert phases: the spread of the virus to multiple regions did not necessarily mean the disease would be serious.[68]

The WHO was also criticized for caving in to commercial interests. Some of its expert advisors had financial ties with pharmaceutical companies that produced flu antivirals and vaccines, and while a series of internal and external investigations were initiated to evaluate the WHO's actions, the Secretariat was absolved of any irregularities, evidencing the agency's lack of transparency.[69]

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[65] The pandemic alert phases described in the IHR are an effective way for countries to identify risks and take action to address the possible threat of a pandemic. Phases 1 through 3 are used to warn of emerging problems that require no action by national governments. These are followed by phases in which the event is deemed serious enough to justify action. Phase 4 is characterized by the human-to-human spread of the virus and Phase 5 denotes community level outbreaks in at least two countries in a geographic region. Phase 6 denotes a change in definition from a potential to an ongoing pandemic and is designated when the virus continues to spread to multiple geographical regions. Sudeepa Abeysinghe, "When the Spread of Disease Becomes a Global Event: The Classification of Pandemics", in *Social Studies of Science*, vol. 43, no. 6, December 2013, 907.

[66] S. Abeysinghe, *Pandemics, Science and Policy: H1N1 and the World Health Organization*, Basingstoke, Palgrave Macmillan, 2.

[67] S. Abeysinghe, "When the Spread of Disease...", 907.

[68] *Ibid.*, 912.

[69] A. Kamradt-Scott, *op. cit.,* 22.

Almost immediately after declaring a full-blown Phase 6 in 2009, calling the end of the pandemic turned out to be a difficult process for the WHO because it had not been a serious threat in the first place. Then, after a protracted period of ambiguity, Director-General Margaret Chan declared the post-pandemic phase on August 10, 2010.[70] That said, the WHO's narrative did not manage to effectively define the concept of "pandemic", leaving the very notion of pandemic and the various alert phases open to question.[71]

In December 2013, an outbreak of hemorrhagic fever in West Central Africa attacked Guinea and, months later, Liberia and Sierra Leone. In March 2014, it was confirmed that it was Ebola, spread by the Zaire ebolavirus. On top of the health crisis, the affected African countries were struggling economically and faced a shortage of labor due to the structural adjustments proposed by the World Bank, which, among other things, had eroded public health funds.

Other social and political factors that explained the outbreak and the ineffectual response of public health authorities were prolonged civil wars in the region and mass migration from rural areas to cities with poor sanitation, scant health infrastructure and a grave shortage of health personnel.[72]

In this case, the first responders were members of international NGOs. In June 2014, the director of Doctors Without Borders announced that the organization had reached its limit and could not send teams to sources of new outbreaks.[73] The WHO failed to take the lead. Its director-general, Margaret Chan, seemed to blame the affected countries, putting their lack of public health infrastructure and trained medical personnel down to poor planning.[74] Finally, in her last speech to the World Health Assembly in 2017, Chan assumed responsibility for the WHO's shortcomings during the Ebola crisis and admitted that the agency had been too slow to respond under her supervision and that she was personally responsible.[75]

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70 S. Abeysinghe, "When the Spread of Disease...", 917.

71 *Ibid*., 920.

72 M. Cueto, T. M. Brown and E. Fee, *op. cit*., 321.

73 See *Idem*.

74 *Ibid.,* 323.

75 See *Ibid.*, 326.

Today, the world faces another pandemic caused by SARS-CoV-2, which spread worldwide in 2020. The WHO finds itself in the eye of the hurricane, due to the tendency to blame international organizations for the mismanagement of crises and the prioritization of short-term interests (like the temporary suspension of commercial activities).[76] So while these may appear to be extraordinary circumstances, the initial political patterns of the pandemic are actually quite ordinary, as illustrated by the previous examples. Nonetheless, the WHO now has the opportunity to shore up its leadership and craft more transparent mechanisms to address prolonged health crises.[77]

Final comments

A key issue in modern-day debate on global health is leadership or lack thereof. The incursion of dozens of actors on the global health arena in recent decades and the diverse, diverging ideas they have brought to the table has caused leadership problems, with the result that, when it comes to assuming responsibility, there is no direct authority. Likewise, debate on how global health should be addressed has been bogged down in a tug-of-war between the provision of health as a public good, a private good or a combination of both, the emergence of technocratic solutions to health problems, and the putting of scientific progress over politics.

Since the international sanitary conferences, the principles of the international health system have basically remained unchanged. An institutional analysis of the WHO reveals that it has played a crucial role in managing epidemics and nipping emergencies in the bud by promoting changes to health policies. Notwithstanding, its budgetary and structural weaknesses, its lack of coordination and inability to come up with a long-term strategy would seem to be its Achilles' heel, not to mention good reason to challenge

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[76] Tana Johnson, "Ordinary Patterns in an Extraordinary Crisis: How International Relations Makes Sense of the COVID-19 Pandemic", in *International Organization*, vol. 74, no. Supplement, December 2020, E150, at *https://doi.org/10.1017/S0020818320000430* (date of reference: January 22, 2021).

[77] Ching-Fu Lin, "COVID-19 and the Institutional Resilience of the IHR (2005): Time for a Dispute Settlement Redesign", in *Contemporary Asia Arbitration Journal*, vol. 13, no.1, May 2020, 269.

its authority and legitimacy. Some countries have even gone so far as to question its relevance and its director-generals.

Nonetheless, the WHO has remained a committed institution that has learned from its mistakes. Throughout its mandate, it has contributed to increased life expectancy, a reduction in child mortality and the eradication of smallpox, to cite just a few examples. The WHO has also served as a center for the sharing of information on epidemics, provided emergency assistance in crises, launched ambitious disease control programs and advocated the right to health and medicines as global public goods. The topic of several institutional debates held in Geneva in recent years with the participation of all actors in global health governance has been how to transform the WHO into an organization with an increased capacity to bring about substantial improvements in the health of the world population, principally in compliance with the Sustainable Development Goals.

The former aside, achieving good health is a constant battle, one that is clearly far from over. As such, the WHO's mandate has never been more important. And as experience has shown, in some cases it is not so much a lack of tools that matters when attempting to manage an epidemic, but a reticence to look beyond short-term gains and political and economic priorities. This same experience indicates that investment in health infrastructure and personnel is more necessary than ever.

Finally, it should be noted that, despite the number of actors now intervening in the global governance of health, the international community continues to look to the WHO as the lead actor when it comes to addressing global health problems. In this respect, it should be acknowledged that IOs are entities striving to fulfill their mission in a world of almost 200 countries with competing agendas, interests and priorities.